A RAW DEAL?

IMPACT ON THE HEALTH OF CONSUMERS
RELATIVE TO THE COST OF PHARMACOTHERAPY

Research and writing by James Rowe

Centre for Applied Social Research (RMIT) for the Salvation Army Research and Advocacy Unit
Acknowledgements

This project would not have been completed without the commitment and tireless assistance of many people. Of most importance are those 60 participants who readily talked of deeply personal experiences that were often painful, sometimes embarrassing, but always an indication of the strength of those telling them. Despite the seemingly insurmountable odds some face, often through no fault of their own, their determination to make life better, for themselves and others, shone through. Their contributions are the best example of this. Thank you.

Thanks are owed to the North Yarra Community Health Service for providing a welcoming research environment at MINE (incorporating the Next Door Clinic) and especially to Chris Hardy and Danny Jeffcote of the latter for recruiting participants and providing a wonderful source of information and ideas. Thanks are similarly owed to Sue White and Access Health for introducing me to service users who became research participants and providing feedback on issues that arose throughout the course of interviews. The work of these individuals and their staff is an inspiration and the care and support that they provide for their clients is unlimited.

The research could not have been completed without the flexibility and encouragement of Sean Swift and Melissa Virtue of SHARPS in Frankston and of Leanne Prochazka and Troy Waddell of the Foster Street Clinic in Dandenong.

Thanks to the steering committee for your guidance, time and feedback. A special mention to Sarah Lord of the Pharmacotherapy Advocacy, Mediation and Support Service for sharing her intimate knowledge of the difficulties facing clients of opioid maintenance programs along with her endless encouragement. Special mention must also go to John Ryan and Amy Kirwan of ANEX for attention to detail in clarifying the intricacies of maintenance programs in Victoria as well as for reading, correcting (and re-reading and re-correcting) my ‘writing’.

This research was wholly funded by the Salvation Army through its Research and Advocacy Unit. Its genesis was a discussion with Jenny Plant, Manager of Salvation Army Crisis Services. The funding and interest of the Army is a fine reflection of their continuing advocacy and support of those ‘on the margins.’
# Table of Contents

1. Key Findings & Recommendations  1  
   Recommendations  2  
2. Executive Summary  4  
3. Research Aims  20  
4. Methodology  23  
5. The Costs and Benefits of Opioid Pharmacotherapy Treatment: A Literature Review  29  
   Introduction  29  
   A brief history of pharmacotherapy in Victoria  34  
   Questioning opioid maintenance programs  40  
   The costs of opioid maintenance treatment – the client  48  
   The costs of opioid maintenance treatment – the community pharmacy  54  
   Addressing costs for clients and pharmacists – An argument for subsidisation  57  
6. Survey Data  64  
   Demographics  65  
   Health  74  
   Participants’ opioid maintenance programs  80  
7. The Benefits of Opioid Maintenance Treatment  84  
   Stability  84  
   Ceasing illegal drug use  87  
   Decreasing illicit drug use  89  
8. The Costs of Opioid Maintenance Treatment  95  
   Food and Families  98  
   The role of emergency services  102  
   Social isolation  104  
   Denied pharmacotherapy  105  
   Illicit drug use  108  
   Crime to cover costs  110  
   ‘Liquid Handcuffs’  111  
   Travel costs  113  
9. Dispensing Fees and their Effects on Client-Dispenser Relations  117  
10. Conclusion: the Need for Subsidisation  132  
11. References  137  
12. Appendices  143  
   Survey Tool 1  143  
   Survey Tool 2  150
Key Findings

- That opioid maintenance treatment is one of the most successful treatment interventions for problematic and/or dependent illicit opioid users;
- That opioid maintenance treatment provides opioid dependent individuals with the stability needed to address issues such as housing and health – as well as underlying issues that may contribute to their drug use in the first instance;
- That opioid maintenance treatment leads to, at best, to cessation of illicit opioid use and, at worst, a significant reduction in illicit opioid use;
- That opioid maintenance treatment produces the best outcomes, for client and community alike, the longer that a client is retained in treatment;
- That the need to pay regular dispensing fees is an obstacle to entering, and remaining in, opioid maintenance treatment. This is especially the case for those on government income support;
- That the Pharmaceutical Benefits Scheme (PBS), as regulated by Part VII of the National Health Act 1953, discriminates against those on opioid maintenance programs by failing to subsidise dispensing fees for those on programs;
- That clients often prioritise the payment of dispensing fees over basic necessities, including food and accommodation;
- That income-poor clients are compelled to rely on emergency relief services to meet food and accommodation needs;
- That a significant minority of clients engage in illicit sex work and acquisitive crime to meet the financial obligations of their treatment (i.e. dispensing fees);
- That the difficulties meeting the financial obligations of opioid maintenance treatment often contributes to a deterioration in the relationship between dispensing pharmacist and client;
- That the accumulation of debt through the inability to pay dispensing fees is a primary reason for the involuntary discontinuance of treatment;
- That dispensing fees are the single greatest obstacle to retention in opioid maintenance treatment;
- That the withholding of opioid maintenance pharmacotherapies encourages illicit heroin and/or other opioid use;
- That involuntary discontinuance of treatment is invariably followed by a return to problematic heroin use.
Recommendations

**Recommendation 1:**
That pharmacists receive fair remuneration for the dispensing of opioid maintenance programs as prescribed by the Commonwealth-regulated Schedule of Pharmaceutical Benefits ($8.15). This would go some way towards addressing the reluctance of many pharmacies to participate in the scheme and to covering losses incurred through bad debt (which would be expected to decline significantly under a subsidised program).

**Recommendation 2:**
That, in the interests of equity, individuals who are on opioid maintenance programs are treated no differently than any other individual receiving prescribed medication for a diagnosed health problem. Federal discrimination in the form of PBS arrangements that place the burden of dispensing fees on consumers are not justifiable from a human rights perspective.

**Recommendation 3:**
That the Commonwealth Government amend the Pharmaceutical Benefits Scheme to include methadone, buprenorphine and buprenorphine / naloxone combinations alongside other medications in Section 85 of the *National Health Act 1953*. The cost represented by this amendment would be easily outweighed by the savings to the Commonwealth, State and Territory Governments across Australia.

**Recommendation 4:**
As an emergency interim measure, the Victorian Government immediately move to extend the subsidisation of opioid maintenance programs from those under the age of 18 and those subject to Juvenile Justice Orders to all financially vulnerable clients (i.e. those with health care cards).
Research Aims

This research was undertaken with the aim to document the costs of the Victorian opioid\(^1\) maintenance treatment program on financially vulnerable clients of these programs? In doing so, it considers the notion of cost from several perspectives, including individuals’ social functioning, their health and their ability to remain in treatment. An inability to continue treatment, particularly if desired and considered to be of benefit to the individual, will further impact upon an individual’s life. Typically, entry into treatment leads to an escalation in levels of opioid dependency to counter their capacity and / or willingness to use illicit drugs. The policy that gives rise to this treatment should thus confer a responsibility to protect consumers against the potentially devastating withdrawal effects that will accompany having their treatment involuntarily and unexpectedly discontinued (Brogan 2004).

The findings within the report require urgent attention from policy-makers to address an increasingly inequitable situation for the tens of thousands of financially vulnerable individuals engaged in opioid maintenance programs. This research provides an explicit case for policy reform.

- It demonstrates that the longer the retention in opioid maintenance treatment, the greater the health outcomes;
- It provides evidence that the introduction of subsidised dispensing fees for low-income individuals would improve their retention rates in opioid maintenance pharmacotherapy programs;
- It demonstrates the cost-effectiveness of a subsidised program; and
- It demonstrates the need for reform of the National Health Act 1953 to subsidise dispensing fees and, in doing so, to address the unjustifiable distinction made between these opioid maintenance pharmacotherapies and other medications and pharmaceuticals covered by the PBS.

The costs of an illicit heroin addiction are high, and they are not restricted to the user alone. They are, however, significantly lessened by opioid maintenance programs. Removing individuals from treatment revisits the costs of heroin dependency upon the individual and broader community alike. The irony is that these costs significantly outstrip the cost of subsidising the dispensing fees paid by low-income earners in opioid maintenance programs.

---

\(^{1}\) The term opioid is preferred to opiate since it refers to all agonists (natural, semi-synthetic and synthetic).
Methodology

Although considerable research has been conducted into the efficacy or otherwise of opioid maintenance programs, there has been little research into factors that affect the retention rates of these programs. Of most concern for this project, there has been very little research into the impact on low-income earners who have to pay for the dispensing of opioid medication upon which they are dependent.

One of the reasons for the aforementioned lack of research is the difficulty inherent in quantifying often intangible characteristics of disadvantage. In addition, every individual within opioid maintenance programs has their own unique experience of treatment and associated costs and benefits. Consequently, open-ended interviews were thought most appropriate method by which to ascertain the experiences of a number of individuals who were both on opioid maintenance programs and also in receipt of government income support – an amount of money that provides for little beyond one’s immediate needs. An initial 30 interviews were conducted at Access Health in Grey St, St Kilda, followed by 30 interviews at the Next Door clinic in Smith St, Collingwood. In addition to being interviewed, the first 60 participants completed surveys to provide complementary contextual data.

Following the conduct of interviews, another 60 surveys were conducted. These were designed with a greater emphasis upon the impact of dispensing fees of participants’ abilities to meet the costs of other needs. Thirty surveys were completed in Frankston at the Southern Hepatitis/HIV/AIDS Resource Prevention Service (SHARPS) and a final 30 at the Foster Street Clinic in Dandenong, a primary health facility under the auspices of South East Alcohol & Drugs Services (SEADS).

Finally, three dispensing pharmacists ‘on the ground’ were interviewed. Pharmacists were chosen on the basis that they dispensed pharmacotherapies to many of the research participants. Their perceptions of dispensing fees and their influence on client-pharmacist relationships provided a complementary perspective to that of their clients.

The Costs and Benefits of Opioid Pharmacotherapy Treatment: A Literature Review

The use of illicit opioids and associated harms is a social and public health issue that continues to demand new and innovative means of redress. The cost of heroin in terms of lives lost is a stark reality in Victoria where 2,141 individuals have died from heroin-related deaths in the period 1991–2005.

Opioid maintenance treatment is recognised as the ‘gold standard’ of treatment for opioid dependence. In 2005, the World Health Organisation (WHO) placed methadone and buprenorphine on the WHO Model (Complementary) list of Essential Medicines. In July 2001, the National Drug and Alcohol Research Centre concluded the National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD) – and found that methadone
maintenance treatment also represented the most cost-effective for opioid dependence in Australia. The evaluation concluded:

- [MMT] has been one of the best researched treatments for opioid dependence;
- [MMT] is the only treatment for opioid dependence which has been clearly demonstrated to reduce illicit opiate use more than either no treatment, drug-free treatment, placebo medication, or detoxification in controlled trials; and is the most frequently prescribed pharmacotherapy in use globally for heroin dependence (House of Representatives Standing Committee on Family & Community Affairs 2003, 154).

Problems associated with opioid maintenance treatment

Since the review of methadone, two further opioid pharmacotherapies have been used in opioid maintenance programs in Victoria – buprenorphine and buprenorphine / naloxone in a 4:1 combination. Obviously, in an area as complex as heroin dependency, there will be complications associated with treating a dependence on what is essentially an illegal drug by providing continued access to a stable, pharmaceutically monitored drug that is, nonetheless, also an opioid. In this respect, methadone has side effects, including severe constipation, excessive perspiring, dehydration and poor libido. It can cause lethargy among consumers – particularly when taken in higher doses – restricting their ability to live potentially active and fulfilling lives. Additionally, pharmacists are not immune from the stigma associated with heroin use and a not insignificant number of opioid maintenance clients report discriminatory attitudes from those whose role is to dispense medication and health advice. Such attitudes are not helped by evidence of buprenorphine being diverted from pharmacists and subsequently injected – a practice with serious health risks.

The introduction of the 4:1 combination of buprenorphine and naloxone in April 2006 added a pharmacotherapy that increased the possibility of clients’ access to takeaway doses while addressing the issue of diversion of buprenorphine in its pure form. When the medication is taken sublingually as intended, the naloxone has less than 10 per cent bioavailability and the drug’s actions are indistinguishable from those of buprenorphine. When injected, however, the naloxone is highly bioactive and can precipitate moderate to severe withdrawal in someone with opioid dependence. Consequently, the introduction of a buprenorphine/naloxone combination has permitted the revision of takeaway guidelines – addressing some of the constraints inherent in presenting for daily dosing.

There are still policy-makers who argue that opioid dependency would be better addressed by a greater commitment to using abstinence-based pharmacotherapies in treatment. The preference for drugs such as naltrexone is expressed by senior figures in both treatment and policy fields, including the last Health Minister in the previous Howard federal government. Naltrexone is a drug that binds to the opioid receptors and blocks the effects of opioids introduced to the body. Advocates for its use argue that blocking the euphoric effects of opioids counters the positive reinforcement experienced upon injecting opioids. They argue that, as a result, drug-seeking behaviour and craving of drug-related euphoria will diminish.
However, support for naltrexone and accompanying criticism of maintenance programmes ignores the unanimity of research findings that demonstrate not only the benefits of the latter, but how these benefits increase with the length of time a client is retained in treatment. Further, while abstinence based treatment using naltrexone has been found to be successful, success is typically enjoyed by “highly motivated” clients who may have employment and / or a strong social support system. In contrast, the majority of opioid dependent individuals’ seeking treatment or assistance are income-poor, isolated and unemployed. There is a risk that without support structures, these individuals may relapse into opioid use. If they do so while using naltrexone, the results can be potentially fatal. A period of naltrexone induced abstinence will greatly reduce an individual’s tolerance to opioids and place them at considerably greater risk of overdose if they do relapse. In March 2008, a number of drug specialists wrote to the *Medical Journal of Australia* to call for the restriction of the drug’s use (Lintzeris et al. 2008).

Use of the aforementioned pharmacotherapies in opioid maintenance treatment is not without complications. Further, the cost of the treatment to the individual client cannot be ignored.

**The costs of opioid maintenance treatment – the client**

In Victoria, the majority of opioid maintenance treatment clients rely on income support payments as their primary source of income (HMA 2007). The actual cost of pharmacotherapies is fully subsidised by the Commonwealth government under the Pharmaceutical Benefits Scheme (PBS). However, the client incurs costs through dispensing fees charged by their pharmacist.

In 2004, the costs of dispensing pharmacotherapies in Victoria were, on average, $5 per day. Most pharmacists prefer weekly or fortnightly payment to minimise the time taken to dispense opioid pharmacotherapies and to offer inducements in the form of cheaper rates (e.g. $60 per fortnight). Nonetheless, at a discounted weekly rate of $30, a consumer will pay $1,560 per annum.

An average weekly dispensing fee of $30 is a comparatively modest amount when considered alongside the costs of an active heroin dependency. However, many undertake opioid maintenance treatment to escape not just heroin, but a lifestyle characterised by illegal income raising activities. This who ask how can methadone not be afforded given the past money an individual has spent on heroin fail to appreciate the transition between living two different lives. A genuine desire to remove oneself from dependent heroin use is typically accompanied by a desire to leave the endless cycle of crime and / or sex work undertaken to support the exorbitant costs of their drug use. This means surviving on government income support – just $472.80 per fortnight for an individual with dependent children at the time of writing.

Financial struggles are a norm for all individuals in receipt of government income support. While dispensing fees may seem to comprise a relatively affordable sum to those in employment, they absorb a significant proportion of income support payments. Still, these fees must be paid to access the best known medical treatment in terms of removing dependent heroin users from chaotic, unhealthy and often criminal lifestyles. The price of treatment is increased when one adds the travel costs required to makes the frequent visits to one’s dispensing pharmacist, impacting further on their financial well-being, whilst compromising educational or employment opportunities through the necessary commitment of time.
The heart of the issue goes beyond purely financial costs and to the question of why this group of individuals must pay costs that are paid for other Australians through the means of the PBS? Are patients on opioid maintenance programs not considered deserving of the same health care as other Australians? Unfortunately, the structure of maintenance programs is such that cost is prioritised over health – it is the ability of patients to meet the cost of the treatment as opposed to health needs that determines whether an individual will begin and / or be retained in treatment.

Given the evidence that the efficacy of treatment correlates with time of retention in treatment, the greatest cost of an inability to meet dispensing fees is the ending of treatment – involuntarily and often abruptly without alternate arrangements. This means the individual must face the inevitable withdrawal from prescribed, but now denied, opioid medications that they are physically if not psychologically dependent upon. A return to illicit heroin use is an all too likely option to ward off the horrors of opioid withdrawal. If the costs of a return to illicit heroin use are to be avoided, the burden upon those individuals who struggle to pay their dispensing fees must be alleviated.

The costs of opioid maintenance treatment
– the community pharmacy

The need to collect dispensing fees also raises problems for community pharmacies participating in opioid maintenance programs – a major disincentive to their ongoing participation. Average dispensing fees have remained unchanged since 1985, representing an insufficient reimbursement to meet the requirements of maintenance programs. Further, an average of 20 per cent of expected fees is written off as bad debt accrued through pharmacists’ dispensing of opioid pharmacotherapies to clients without receiving the expected fees (Clark et al. 2004). The lack of adequate remuneration for their role in opioid maintenance programs has led pharmacists to withdraw their services because they can no longer justify the cost of providing them.

Although there is evidence that the greater majority of pharmacists participating in opiate maintenance programs enjoy a good relationship with their clients, many experience ‘disturbances’ during the course of their duties, whether verbal abuse, incidents of theft or arguments about fee payment.

In 2007, the Pharmacy Guild of Australia recommended that the Australian Government subsidise pharmacies for dispensing and supervising pharmacotherapy treatment (HMA 2007). This recognises the importance of retention in treatment for positive outcomes and that dispensing fees are a significant obstacle to retention for many clients. The value of long-term treatment for opioid dependence is also recognised by Victoria’s public health authorities. Retention is prioritised to the degree that a relapse of illicit heroin use is not sufficient to terminate treatment – predominantly given the potential consequences of termination (Drugs & Poisons Unit 2006). Such views are held by internationally authoritative organisations, such as the World Health Organisation and the United Nations Office of Drug Control (WHO et al. 2004).
An argument for subsidisation

The use of methadone and buprenorphine in pharmacotherapy maintenance programs is internationally recognised as one of the most effective treatments for opioid dependence. Studies examining links between reduced criminal activity and involvement in treatment have found such links to be dependent on many factors, including the proportion of users who enter treatment and the length of time for which they are retained in treatment (Digiusto et al. 2006). The issue of retention is emphasised in numerous Australian and international studies.

Subsidisation doubtless assists retention in light of the financial difficulties that dispensing fees present to income-support dependent clients. A small number of studies, addressed in the report proper, found that the elimination of fees substantially increased retention. In Victoria, groups considered at high risk of discontinuing treatment (those aged 18 years and under and Juvenile Justice clients on community-based orders) have dispensing fees subsidised wholly for a specified period of time.

This report addresses the issue of dispensing fees and their impact on the lives of clients with limited income. It draws attention to the urgent need for an alternative payment scheme to be introduced – in the interests of clients, dispensers and, ultimately, the broader society.

Survey Data

One hundred and twenty individuals were surveyed over the course of the research. This figure includes a greater proportion of males, although the final gender balance is a reasonable reflection of the gender balance of those on opioid maintenance programs in Victoria. Participants’ ages ranged from 18 to 62 years with a mean age of 34.7 years. Less than five per cent of participants were aged less than 25 – indicative of a general trend of using heroin for some years before needing to engage with treatment programs.

The surveys revealed high rates of individuals with limited education and relying on income support as their main source of income. This was no surprise given the research focus on those clients of opioid maintenance programs who were recipients of government income support. There were minor variations in demographics, income support and, in particular, trends of accommodation; these are addressed in detail within the report. Not only did accommodation trends differ on the basis of location, but they differed substantially on the basis of gender with one notable finding being the greater proportion of women gaining access to limited public housing – one of the few affordable forms of accommodation in the present real estate market. Men were more likely to survive in tenuous and insecure living environments.

Participants reported high levels of physical and psychological illness. Although over a third of participants reported no significant physical health problems in the preceding 12 months, more than one-quarter had suffered from asthma, whilst one-fifth had suffered from bronchitis in the 12 months preceding the survey. Further, the range of physical health issues reported ranged from relatively minor ailments to severe and ongoing ailments requiring continued and sometimes costly medical care.
The greater majority of participants reported mental ill-health, in particular anxiety and depression. The majority reporting mental ill-health took prescribed medication to alleviate the symptoms of their illness. For some, a tenuous financial situation was a contributing factor for their depression – a situation added to by the cost of their prescribed treatment.

One of the main health concerns to arise was the inadequate diet. Nutrition is vitally important to individual health. When medical professionals talk about the health care needs of vulnerable individuals emerging from a background of heroin dependence, nutrition is of the highest priority. The average number of meals eaten by participants was 1.7 per day. For the majority of research participants, emergency services were the primary source of food.

Many participants had tried different forms of opioid pharmacotherapies, indicating that few were comfortable or satisfied with their initial pharmacotherapy experience and sought out available alternatives so as to find establish that option that best suited their needs. Given its relatively recent introduction, the prescription of the buprenorphine / naloxone combination has gained considerable favour among prescribing doctors with in excess of a third of research participants having been prescribed the medication.

What is apparent from the surveys completed by research participants is that a significant majority of low-income earners in opioid maintenance programs live lives defined by poverty, poor health and insecure accommodation - greatly compromising their chances of retention in treatment.

The Benefits of Opioid Maintenance Treatment

The benefits of opioid maintenance treatment are substantial. Obviously, were there were no perceived benefits, it is highly unlikely participants would persist with treatment given the impact of the associated financial obligations. Additionally, problems associated with opioid maintenance treatment are largely related to difficulties that compromised their retention in treatment rather than the treatment itself.

The main benefit of opioid maintenance programs is stability. This is essential if those with problematic drug issues are to reintegrate into ‘mainstream’ society. Stability allows space to in which to begin to address concerns related to housing, relationships and even reasons for self-medicating via illicit drug use. Most research participants had a level of stability unimagined when living lives once characterised by extreme chaos, criminal activity and poor mental and physical health.

Ceasing and decreasing illegal drug use

Some participants found that opioid maintenance programs ended their heroin use. For others, while opioid maintenance treatment did not mean ceasing all illicit opioid use, it invariably reduced it. Consequently, opioid maintenance programs provided the means to end or, at the least, greatly reduce, engaging in criminal activity and / or in sex work.
By significantly reducing their illicit drug use, individuals were able to achieve stability of a previously unattainable degree. However, it is apparent throughout the report that individual commitment and genuine engagement with one's maintenance programs is necessary to achieve eventual abstinence from illicit heroin use and, potentially, abstinence from all opioids – including opioid maintenance pharmacotherapies. Dispensing fees were the greatest obstacle to this commitment.

The Costs of Opioid Maintenance Treatment

For those surviving on relatively low rates of government income support, dispensing fees consume a considerable proportion of income. Just how much is contingent upon the cost of other necessities such as accommodation which, in the current market, may be beyond the means of most low-income earners. For some participants, the payment of dispensing fees, accommodation costs and food could not be met via legitimate means alone.

The money provided by government income support is such that many recipients are already living lives restricted by poverty once necessities such as food and housing have been paid for. Regular additional costs, such as treatment dispensing fees, only exacerbate this poverty and engender reliance on charitable services. Further, when resources are insufficient to provide for even the most basic necessities of life, the idea of being able to partake in social interaction of most types is unrealistic. Even such activities as meeting a friend may require transport fares and the price of a coffee – which, it is no exaggeration to state, is beyond the means of many. Many days are consequently spent in isolation, a circumstance that makes recovery all the more difficult for the lack of social interaction and informal support it provides. In doing so, it may have further implications for mental health via clients increased marginalisation from the 'mainstream'.

A significant concern associated with levels of financial insecurity, is the awareness that once debt has been accrued, or even if a payment can't be met for the first time, a dispensing pharmacist may refuse to dose a maintenance treatment client, a decision with dramatic consequences. Involuntary removal from the treatment that may be the very basis of one's new-found stability raises the likelihood of a return to a life in which their ongoing opioid dependence must be met through other means. Such concerns lead some clients to prioritise dispensing fees over all else – including food and accommodation. Certainly, participants in this research rarely had money enough for a fortnight's food, with the greater majority surviving on less than three meals per day. One of the few means of accessing nutritional food, a particular concern for those with children, was to steal it.

For some participants, unexpected circumstances may prevent their presenting at their dispensing pharmacist – whether motor vehicle breakdown, sick or hurt children requiring immediate assistance or another unforseen event. In addition to unexpected occurrences, physical ailments, whether long term afflictions such as chronic arthritis or short term illnesses such as heavy flu, may prevent presenting at one's pharmacist. If sickness, or further complications such as the transience that accompanies homelessness, render contact with one's dispensing pharmacist temporarily impossible, withdrawal is inevitable.
Although events such as the above are all related by research participants as reasons for failing to present for their pharmacotherapy dosage, the most common reason is overwhelmingly an inability to pay dispensing fees. Some pharmacists believe that those who fail to present for dosing are not taking their treatment seriously – or, alternately, are using illicit drugs. Such beliefs may fit stereotypes of ‘junkies’ as irresponsible individuals motivated by short-term gratification. However, they ignore the fact clients of opioid maintenance programs have actively engaged with a demanding treatment regime to cease their illicit drug use and associated behaviour. The evidence overwhelmingly supports the proposition that many clients simply do not have the money to pay their dispensing fees, or have accrued existing debt, and are unwilling to ‘beg’ for ‘free’ dosing or further credit.

A greatly concerning aspect of the inability to obtain one’s pharmacotherapy is that, rather than face the onset of withdrawal, some will resort to heroin use. While pharmacists may not allow debt to increase beyond a certain point, (or allow debt of any amount), many a heroin dealer will extend credit to a long-standing customer. The client’s intention may be short term – to overcome the onset of withdrawal. Nonetheless, there is real possibility that a resort to heroin use, however brief, will become a re-established dependency. The probability of such an outcome increases markedly if the individual in question has missed three days of doses (in the case of methadone) and must see their prescribing GP to acquire a new script in accordance with the Victorian guidelines for opioid maintenance treatment. A subsequent return to criminal activity may follow and the prospects and opportunities afforded by the stability of opioid maintenance treatment are lost.

The potential consequences of having maintenance treatment involuntarily discontinued have compelled some clients to turn to increasingly desperate measures to ensure their retention in treatment. A most unfortunate aspect of the inability to meet dispensing payments was, as reported by research participants, engagement in minor criminal activity or sex work to acquire the money to pay these fees. This is the very behaviour that opioid maintenance programs seek to counter by removing the continuous need for substantial amounts of money. However, those charged with determining the operation of treatment programs seem unaware of the struggle inherent in meeting both the financial obligations of opioid maintenance treatment and the cost of life’s other necessities. Crimes undertaken to pay for medically prescribed treatment still lead to criminal convictions if the offender is apprehended. In such an event, future opportunities and incentives – whether in employment, travel or educational arenas – are lost.

Another cost of opioid maintenance treatment is that of time. The requirement of frequent, if not daily, presentation at one’s pharmacy compromises the ability to undertake fulltime employment or education. Even those who have qualified for limited takeaway doses are unable to travel for extensive periods without completing a wealth of administrative paperwork and making their own arrangements to find and engage with doctors and pharmacists at their intended destinations.

There are also the costs associated with everyday travel to one pharmacy which, given rising petrol prices and public transport fares can be significant. For some, total transport costs are the equivalent of the dispensing fees that they are obliged to pay. An inability to meet these costs may lead to a resort to fare evasion on public transport and even greater financial burdens if apprehended.
The costs of opioid maintenance programs dispensing fees – approximately $60 per fortnight for most – must be considered in the proper context of fees being imposed on those with limited incomes that must be used to pay for food, accommodation and other needs additional to treatment. The may lead to numerous, not always tangible, consequences, including:

- A need to prioritise medication over food and accommodation – which may lead to having very little in terms of food and a less than secure standard of accommodation;
- A reliance on emergency services that, in effect, are compelled to cover the deficit caused by clients’ prioritisation of their dispensing fees. Consequently, money for food and accommodation expenses is recouped via emergency assistance from over-stretched community service organisations;
- A need to return to petty crime or sex work (and risk incarceration) in order to pay for treatment intended to stop precisely that behaviour;
- The sickness of withdrawal if these options are not available;
- Travel costs and the risks that accompany fare evasion;
- The return to heroin use if one cannot afford dispensing fees and treatment is involuntarily discontinued.

Consequently, for the sake of a debt of $60, or less, an individual whose life has gradually regained a semblance of stability and is benefiting from the associated opportunities that follow is suddenly left without access to legal opioids while remaining dependent upon opioids. The outcome is all too predictable. It is shameful when the ease of preventing such an outcome is considered.

**Dispensing Fees and their Effects on Client-Dispenser Relations**

The non-payment of dispensing fees and related debt has contributed to deteriorating relationships between many a client and their dispensing pharmacist – still another cost of dispensing fees. For many practitioners, the role of a pharmacist is to take a broader interest in their customers’ health as opposed to simply dispensing medication. Yet a relationship damaged by arguments over financial obligations severs any potentially beneficial link between client and pharmacist as sympathetic health care practitioner.

Despite the difficulties that low income earners encounter paying dispensing fees of, on average, $60 per fortnight, the Australian Pharmacy Guild argues that this amount is insufficient to cover the administrative and practical costs of dispensing pharmacotherapies to those on maintenance programs.

Research participants readily acknowledged that their financial difficulties are often the cause of disagreements and sometimes verbal arguments with their pharmacists. However, as noted above, some pharmacists believe that clients lack commitment, as opposed to money, and that this is the central cause of their failure to pay dispensing fees and the
resulting disagreements. This is given some credence by the continued drug use of some of those on maintenance programs.

However, pharmacists, as health professionals, should not confuse dependent drug use with simple choice. In any event, the cost of withholding treatment – to both the individual and the community, of which pharmacists are part – is far greater than the cost of subsidising the dispensing of opioid maintenance pharmacotherapies in the interests of increasing retention in the program. Of course, the benefits of retention to client and community do not negate the right of pharmacists to receive recompense for carrying out their professional duties. If fees are not paid, then pharmacists are caught in the middle by the inability of policy makers to address a very apparent problem affecting many individuals’ retention in what may be a potentially successful treatment program. It is pharmacists who must discontinue treatment whilst aware of the likely consequences. This awareness sees many pharmacists allowing a debt to be accrued before they deny further dosing.

The position of the dispensing pharmacist is unenviable – they are entitled to be paid for their professional services. However, dispensing fees for opioid maintenance medications are not incorporated into PBS subsidies (unlike the majority of medications listed under the Scheme). Therefore, pharmacists have no choice but to have the client pay the fee, given such fees comprise a significant proportion of a pharmacist’s income. The extreme hardship of many low-income clients means many cannot do so – treatment will inevitably be discontinued, the pharmacist in question writes off the amount owed as ‘bad debt’ and the client returns to illicit sources to meet the ongoing needs of an opioid dependency. ‘Bad debt’ costs individual pharmacists several hundreds, if not thousands, of dollars each year. It makes the recruitment of additional pharmacists to share the burgeoning load of pharmacotherapy clients even more difficult and is a significant obstacle to the success of the community pharmacy model that operates in Victoria. Some pharmacies have even had to close their maintenance programs because they have run them at a loss – providing treatments to clients who simply cannot pay. This is a helpful reminder that the stereotyping of pharmacists by some of those on opioid maintenance programs as ‘scavengers’ is just as inaccurate as stereotypes of those dependent on opioids as ‘junkies’.

This demonstrates the quandary facing pharmacists – an approach with no flexibility will likely see a client return to the street. Too much flexibility will lead to a service that costs the pharmacist and is ultimately unsustainable. The key is finding a balance, and pharmacists who achieve this balance enjoy a mutually respectful relationship with their patients. An empathetic understanding is crucial to a pharmacist helping patients manage their treatment so as to gain the greatest benefit possible.

Understandably, given the cost of bad debt to pharmacists, most will not take an existing client who is transferring from another pharmacist without a letter of reference from the latter. If a client is transferring due to issues of debt or a poor relationship, the tone of such a letter can be safely assumed to be negative. Further, many pharmacists will not accept a client unless they pay for their first week’s dispensing fees in advance – an obvious obstacle to those transferred due to their debts at another pharmacy. Such circumstances may block access to a recognised ‘gold standard’ treatment for opioid dependent individuals due to debts or fees that are minimal when considered alongside the costs of heroin dependence. Given the disproportionate consequences of a clients’ failure to meet
their financial obligations, empathetic medical practitioners and clients whose treatment has been involuntarily discontinued may use methods to circumvent the regulations that govern opioid maintenance treatment in Victoria. This greatly compromises those involved. The fact that individuals do so reflects both the desperation of the drug dependent individual seeking treatment and the concern of the health practitioner who knows such treatment will be of great benefit.

Clients of maintenance programs express further dissatisfaction regarding the required payment of dispensing fees for days on which they do not actually present (i.e. having been dispensed takeaway doses in one exchange). Many research participants question the practice of charging a client for seven days of dispensing fees, despite being dispensed medication of a significantly lesser number of days. Guidelines for the dispensing of buprenorphine / naloxone allows up to 28 days of medication to be taken away from a pharmacist once stringent conditions are met. However, the dispensing of 28 days worth of medication in one actual exchange will very likely be accompanied by a request for the payment of dispensing fees to cover a four week period – approximately $120. This is not only an issue raised by clients. Practitioners in drug and alcohol agencies had also hoped an increase in takeaway doses may lead to a reduction in the costs of treatment as pharmacists would charge dispensing fees in accordance with the number of times the medication was dispensed. There is no evidence to suggest this has occurred.

Respect

One of the intended benefits of dispensing opioid pharmacotherapies from community pharmacies was the regular contact of clients with qualified and professional health practitioners. Of course, the degree to which this interaction is used in the interests of client health is dependent upon the pharmacist and whether they see their opioid maintenance clients as patients in need of health care or a potentially troublesome source of income. It also depends on the manner in which a client initially presents at their pharmacy. However, those pharmacists spoken to during the course of research note that ‘troublesome’ clients form a significant minority of those ‘on their books’.

Certainly, research participants spoke of pharmacists who brought a pragmatic and empathetic approach to their practice. The main feature of positive relationships with clients is that the latter are treated no differently from any other paying customer. Apart from their discriminatory treatment under the Schedule of Pharmaceutical Benefits, this is precisely what clients of opioid maintenance programs are – paying customers receiving prescribed medication to treat what is acknowledged by every tier of government in Australia as a health problem and not an issue for the criminal law (despite the reluctance to reform legislation to reflect this acknowledgement).

While there is no evidence to suggest that the majority of pharmacists involved with opioid maintenance programs are discriminatory, the greater majority of participants spoke with considerable antipathy about several pharmacists, past and present, who had dispensed their medication. Certainly, the notion of providing any counselling was the exception to the rule:
It is of great concern when a pharmacist, instead of realising their potential value as a source of health advice to clients, treats those on maintenance programs as somehow inferior to other customers. For many clients, such circumstances see their relationship with their health provider deteriorate to a point at which they are told to find a new pharmacy if they wish to continue treatment. Contractual agreements that communicate explicit discriminatory attitudes towards opioid maintenance clients, only add further weight to the burden endured by financially impoverished and vulnerable participants in opioid maintenance programs.

Respect is obviously a two-way street and a number of clients do display the very characteristics upon which stereotypical assumptions rest. However, this cannot excuse the discriminatory treatment that some practitioners extend to all clients of opioid maintenance programs. For some pharmacists, judgmental attitudes may develop as a consequence of debt and non-payment of fees as well as having to deal with that minority who may be obnoxious, demanding and even, in isolated incidents, physically threatening – potentially encouraging a perception that opioid dependent individuals, as a group, are people who do not fulfill their treatment obligations and are not consequently worthy of pharmacists’ respect. For other pharmacists, the PBS regulations that determine that recipients of opioid pharmacotherapies must pay their own dispensing fees, as opposed to having them subsidised like ‘normal’ pharmacy customers, may also act to distinguish them as an unworthy ‘other.’

A most frustrating aspect of clashes between clients and pharmacists is that effective treatment is rendered impossible. The stability afforded by the maintenance program is lost often, followed by a rapid return to a chaos of heroin dependency and the associated costs.

The Need for Subsidisation

There is little in the way of a rational argument against subsidising dispensing fees paid by low-income earners to receive opioid maintenance pharmacotherapies that offer their best chance of escaping the sickness and criminality of heroin dependence. An inability to pay these fees is the frequent cause of maintenance treatment being discontinued involuntarily and immediately. Unfortunately, opiate dependency cannot be similarly discontinued and, for the lack of $30 a week, the dependent individual must now face a stark choice.

In instances, crimes are committed or illicit sex work engaged in solely to pay dispensing fees to receive medication prescribed to prevent the need for such behaviour. Consider the loss of self-esteem for those who ‘choose’ sex work to fund their medically prescribed treatment. The idiocy of a health program in which financial need comes before well-being cannot be better communicated than by this reality. Alternately, those who cannot pay may resort to heroin use. While many a pharmacist won’t give credit, many a dealer will. If they don’t, again, illicit activity may suffice. Those who prioritise their dispensing fees over all else often find themselves without sufficient money to buy food, a situation often resolved by shoplifting or extensive reliance upon emergency services and charitable organisations. The costs to community service agencies (and the governments that fund them) are
considerable. Many thousands of people donate to these charitable organisations. In this respect, the charity of individual Australians and their families is, at least in part, paying for the government’s failure to provide universal health care.

There are a number of options through which subsidisation of fees could occur. The Victorian State Government could follow the lead of the ACT and directly fund dispensing fees charged to clients of maintenance programs. A second option is for Commonwealth policy makers to amend relevant legislation and the Pharmaceutical Benefits Scheme to include methadone, buprenorphine and buprenorphine / naloxone alongside other medications in Section 85 of the *National Health Act 1953*. This option simply entails the extension of a system that is already in place and understood by pharmacists and clients alike. Using the PBS and associated safety net provisions would also have the advantage of providing equity to clients given that different pharmacies charge different rates for dispensing pharmacotherapies. It would also address the problems that dispensing fees create in other States and Territories. Throughout Australia, financially vulnerable individuals are ill-equipped or unable to pay dispensing fees and the costs that result are far higher than those of subsidising the dispensing fees associated with opioid maintenance programs.

The viability of reform must be considered alongside the costs of individuals having treatment discontinued before satisfactory completion. There is the immediate cost of crime committed to pay for opioids to stave off withdrawal. This encompasses the tangible loss of property, the indirect costs of increasing insurance premiums and the intangible loss of trust and security. Indeed, the thousands of dollars required to meet the needs of the dependent user cannot be acquired through legitimate sources, meaning their return to an existence revolving around a perpetual cycle of ‘rorts’, ‘earns’ and ‘getting on’ or, alternately, raising such monies through debasing involvement in illicit sex work – whether in illegal brothels or on in a street ‘occupation’ characterised by ongoing physical and / or sexual assault. The return to criminality (and associated vulnerability) alone arguably costs far more in total than the subsidisation of dispensing fees. The fact remains that these fees are the greatest single obstacle to participating in a treatment regime designed to remove individuals from the circumstances of chaos and crime. Further, if they are not removed from (or return to) these circumstances, the financial costs of addressing the inevitable damage to the health – mental and physical – of the dependent user will fall to the public health system.

The cost of subsidisation in dollar figures is addressed in the conclusion of this report. It makes clear the fact that subsidisation represents a substantial saving to government (and to the community via reduced costs associated with law enforcement and criminal justice and public health systems). However, it must be recognised that there is another cost that retention in treatment programs would remove. Successfully retaining the dependent opioid user in maintenance treatment would be a very great reduction in the chances of the family and friends suffering the intangible, immeasurable sense of loss that accompanies each, sadly avoidable, fatal heroin overdose. When the reality of the situation is laid bare, the lack of subsidisation for opioid maintenance programs defies rational thought.

There are human rights implications that are integral to the argument for subsidising the dispensing for opioid maintenance pharmacotherapies. Why do opioid dependent individuals not deserve the same health care as the rest of the population? Moral
judgements and perceptions of the type that underlie discrimination have no place in any answer to such a question. Governments are explicit, in Australia and the broader Western world, in naming drug dependence as a health issue and not an issue of criminality. Those whose health has been affected by dependent opioid use deserve the same access to health care resources that the rest of the population enjoy.
This research was undertaken to answer a single question: do the costs of opioid maintenance treatment have a social and health impact upon vulnerable clients of these programs?

This question encompasses many varied and complex issues. The use of pharmacotherapies to treat heroin-dependent individuals incorporates a multifaceted approach. In Victoria, where this research was conducted, the Federal Government pays the full cost of the medication taken by those in opioid maintenance treatment. However, clients are required to pay pharmacists’ dispensing fees. The impact that these fees have on certain clients is the subject of this research.

Clients of pharmacotherapy treatment may be vulnerable for any number of reasons, including, but not limited to, ill-health (physiological and/or psychological), unemployment and/or limited education opportunities and low-income status. In this research, we examine whether the cost of dispensing fees has a negative impact on those who are especially vulnerable to financial burdens because they are already living on a low income.

The impact of dispensing fees on low-income individuals, to the extent that it exists, is considered from a variety of perspectives, including the individuals’ social functioning, mental and physical health and, perhaps most importantly, their ability to remain in treatment. Obviously, an inability to continue treatment, if treatment is desired and considered of benefit by the individual, will have a further impact upon the aforementioned aspects of an individual’s life. Despite the importance of retention in treatment, as noted in a recent issues paper, ‘there has been surprisingly little research that quantifies the impact of fees on patients’ (Chalmers et al. 2007).

Consequently, the research was designed to meet three interrelated aims:

- To examine the extent to which pharmacotherapy dispensing fees negatively affect the social well-being and mental and physical health of clients;
- To examine the effect of dispensing fees on the retention of clients in opioid maintenance pharmacotherapy treatment;
- To examine the impact of the involuntary discontinuance of opioid maintenance treatment.

In meeting these aims, we provide findings that require urgent attention from policy-makers at both Federal and State levels of government. There is a critical need to address what is an increasingly desperate and inequitable situation for the tens of thousands of financially
vulnerable individuals in Victoria, and throughout Australia, who are in, or seeking to enter into, opioid maintenance programs. The research presented herein provides an explicit case for policy reform.

- It provides evidence to support the introduction of subsidised dispensing fees for the low-income clients of opioid maintenance pharmacotherapy programs;
- It demonstrates the cost-effectiveness of a subsidised program; and
- It demonstrates the need for reform of the National Health Act 1953 to subsidise dispensing fees and, in doing so, to address the unjustifiable distinction made between these opioid maintenance pharmacotherapies and other medications and pharmaceuticals covered by the PBS.

There remains a strong demand for opioid maintenance treatment in the community and governments have a responsibility to ensure this demand is met. Certainly, opioid users are encouraged to enter pharmacotherapy treatment as an outcome of public policy (Brogan 2004). It is important to note that opioid maintenance treatment is of benefit not only to the individual client but to the broader community of which they are part. This report addresses problematic opioid users whose opportunities and social well-being are further constrained by a limited income. Nonetheless, they remain equal members of society and should be afforded the same respect as any other member of society. Consequently, the abrupt suspension and / or termination of an individual's receipt of a prescribed opioid drug upon which they have become dependent during the course of politically supported treatment should not be tolerated. Typically, entry into treatment leads to an escalation in levels of opioid dependency to counter their capacity and / or willingness to use illicit drugs. The policy that gives rise to this treatment should thus confer a responsibility to protect consumers against the potentially devastating withdrawal effects that will accompany having their treatment involuntarily and unexpectedly discontinued (Brogan 2004).

As is documented within this report, the costs of an illicit heroin addiction are high, and they are not restricted to the user alone. Heroin dependence is costly to ‘society’ as a whole. Costs are incurred through acquisitive crimes committed to pay the inflated prices of illicit drugs. The publicly funded health system must meet the costs of drug-related health concerns ranging from abscesses resulting from poor injecting techniques to mental ill-health, while addressing the potential public health threat posed by the spread of blood-borne viruses. There is also the intangible cost that is the death of a mother, father, son or daughter, sister or brother who is lost to accidental heroin overdose. These are costs that opioid maintenance programs are designed to ameliorate. The evidence presented within this report demonstrates that they do so to a significant extent. Consequently, in the instance of individuals being removed, involuntarily, from such treatment, significant costs are revisited upon the individual and broader community alike. These costs significantly outstrip the cost of subsidising the dispensing fees paid by low-income earners in opioid maintenance programs.
Methodology

Ethics approval was obtained from RMIT Human Research Ethics Sub-Committee on 23 April 2007. Research was conducted between mid-April 2007 and January 2008.

First Stage

Prior to the submission of an ethics application to the aforementioned RMIT body, agreement to allow the clients of the Access Health and Next Door primary health care centres was received from Sue White (Manager of Access Health) and Vera Boston, CEO of North Yarra Community Health, under whose auspices the Next Door clinic operates.

A Reference Group was formed to assist the conduct of the proposed research by providing expert advice as to the operation and direction of Victoria’s opioid maintenance treatment program. The Reference Group advised the author as to potential research participants and valuable sources of information. The revision of quantitative data collection, noted below, was one such decision taken with advice from the Reference Group. In the latter stages, the Reference Group provided feedback on draft copies of the report and potential policy implications of the recommendations contained within. The reference group comprised:

- Major Michael Coleman (Salvation Army Territorial Consultant D&A Services);
- Major Doug Thomas (Salvation Army Assistant Divisional Commander – Social);
- Jenny Plant (Salvation Army Crisis Services Research & Advocacy);
- Chris Hardy & Danny Jeffcote (Next Door Clinic);
- Sue White (Access Health);
- Sarah Lord (Pharmaceutical Therapy Advice & Mediation Service (VIVAIDS));
- James Rowe (RMIT);
- John Ryan (CEO Anex) (from June 2007);
- Amy Kirwan (Anex) (from September 2007);
- Maurice Sheehan (Pharmacy Guild of Victoria) (from September 2007);
- Pauline Wright (Clinical Services, Turning Point) (until September 2007);
- Peter Muhleisen (Turning Point pharmacist) (until September 2007);
- Mark Stoove (Turning Point) (until September 2007).
Initial research involved the collection and collation of existing reports, academic and scientific papers and other relevant written materials in a literature review. This provides the background and context within which to consider the research question and the aims of the project.

During the course of Reference Group meetings in the early stages of the research, discussions were held to determine methods of recruitment and interviewing of participants at Access Health and Next Door.

Second Stage

Qualitative Research

Field research commenced at Access Health in Grey St, St Kilda, on 1 June. It was decided to complete the first 30 interviews in St Kilda and the second 30 interviews at Next Door, located in Smith St, Collingwood. There has been a considerable amount of research conducted to demonstrate the efficacy of opioid maintenance programs, as is discussed below. However, there has been little work conducted into factors that affect retention rates – such as whether the financial obligations of treatment dissuade entry or lead to debt, disagreement and eventual involuntary discontinuance of treatment. Further, there is little, if any, research available that documents the impact of having to pay for a medication, upon which one is physically and psychologically dependent, in the context of such payments representing a substantial proportion of an already limited income.

One of the reasons for the dearth of research into the costs of pharmacotherapy dispensing fees is the difficulty inherent in trying to quantify the often complex and intangible characteristics of disadvantage and discomfort that may result from the obligation to pay them. Further, every individual within opioid maintenance programs will have their own unique experiences that define, for them, the success or otherwise of their treatment and at what cost this success (or otherwise) has come. The subjective realities of life as lived by others do not avail themselves to quantitative research techniques such as survey. This has prompted calls for more qualitative social research to be conducted in this area (e.g. Frazer et al. 2007) and informed the decision to employ unstructured interviews.
The first 30 interviews were completed at Access Health between 1 June and 2 July. Thirty interviews were subsequently conducted at the Melbourne Inner City AIDS Prevention Centre (MINE). The Next Door clinic is located adjacent to MINE and is responsible for the administration and management of the latter. It was also a more suitable site for interviews given the availability of a private room in which to conduct them. Interviews at MINE were completed between 9 July and 30 August. The only criteria for participating were that individuals had to be aged over 18 years, active or recent clients of an opioid maintenance program and in receipt of government income support.

Given the illegal nature of participants’ past drug use, they may have been wary of providing information, despite assurances of confidentiality. Interviews were unstructured and conversational in nature. A list of questions posed formally from a researcher brandishing a tape recorder is unlikely to elicit a calm, contemplative and truly honest response. In contrast, the establishment of a rapport, in which the similarities between researcher and participant were appreciated, allowed for the sharing of experiences during the course of friendly conversation. Further, disclosing the aims of the research, which was to document the hardships endured by participants as a consequence of paying approximately $30 a week to access medical treatment, established a mutual sense of purpose for many participants.

Interviews ranged in length from between 10 to 45 minutes and were tape recorded and transcribed verbatim using professional transcription services. Transcripts were analysed (by reading and re-reading) for content and the identification of emerging themes. Participants have been assigned pseudonyms and identifying comments (place of residence, schooling history, family etc) have been altered. The quotes reproduced in the report are done so in the very words of the participant with the exception of editing out repetitive phrases some speakers used (e.g. “do you know what I mean?”). This has been done to assist the reader in appreciating the message or experience of the participant, while limiting phrases that hinder the flow of the language.

It was initially envisaged that 120 interviews would be completed – 60 at each site. However, following transcription, analysis of the first 60 interviews provided a portrait, rich in detail and varied in the experiences it communicated. Conducting a further 60 interviews would very likely have led to ‘information saturation’ given that the interviews conducted to date were more than sufficient to meet the aims of the research and provide authoritative answers to central questions underpinning the project.

Quantitative Research

In addition to participating in interviews, the 60 participants completed structured surveys designed to compile demographic data, as well as broader information about participants’ health (physical and psychological) and the potentially adverse effects of the financial burden of dispensing fees on physical and mental health.

Initially, it was proposed that clinical survey instruments be used to assess elements of participants’ health. In the case of mental health, the Kessler-10 (K10), an instrument designed to measure levels of psychological distress, was used. This would allow for a comparison with rates of psychological distress in the general community given the use of
the test in National Health Surveys. The K10 was trialled with the first three interviewees and each had great difficulty understanding and responding to the questionnaire. This prompted questions about the accuracy of the data collected - when too much assistance was provided to participants, it seemed to influence their answers. Too little assistance left participants seeking to fill out the questionnaire from a sense of obligation as opposed to understanding the relevance of the questions and responding accordingly. Consequently, the decision was made to replace the K10 with a more appropriate survey instrument that would record demographic data, including information about participants’ accommodation and income, self-perception of physical and mental health and information about their history in opioid maintenance programs. The survey was designed by the author and is attached as Appendix 1. Survey information was quantified using SPSS.

Third Stage

Following the completion of the initial 60 interviews and surveys, it was decided to divert resources committed to the conduct of a further 60 interviews to broaden the quantitative research base. As noted above, there was sufficient qualitative data collected for the purposes of the report. However, it was thought an expanded survey designed with greater emphasis upon the negative experiences associated with poverty and the related influence of dispensing fees could provide for a more authoritative quantitative component.

While not able to capture the rich experience communicated in the process of conversational interviews, the data collected by surveys could provide a broader indication of the effects of dispensing fees on low-income earners. The revised and expanded survey is contained in Appendix 2. Thirty surveys were completed in Frankston at the Southern HIV / HEP Prevention Service with the ethics approval of Peninsula Health, under whose auspices the service operates. The final 30 surveys were completed at the Foster Street Clinic in Dandenong, an Needle and Syringe Program operating as a primary health facility run as part of South East Alcohol & Drugs Services (SEADS), a program of Southern Health.

Finally, it was thought that the research would benefit from including the perspectives of some dispensing pharmacists. The Pharmacy Guild of Australia and its Victorian Branch have made their support for subsidised dispensing fees clear in recommendations to federal inquiries (e.g. the 2003 Standing Committee on Family and Community Affairs Inquiry into Substance Abuse in Australian Communities). More recently, Health Management Australia (HMA) conducted a study, on behalf of the Pharmacy Guild, to investigate best practice models for the dispensing of pharmacotherapies to those in opioid maintenance treatment. The resulting report, Funding Model Options for Dispensing of Pharmacotherapies for Opioid Dependence in Community Pharmacy, reported:

The project established considerable support that subsidised dosing of methadone and buprenorphine leads to improved satisfaction with service and improved social, health and economic outcomes for clients and improved service and economic outcomes for pharmacies and their staff (HMA 2007, 104).
Three dispensing pharmacists ‘on the ground’ were interviewed. These pharmacists were chosen on the basis that they dispensed pharmacotherapies to many of the participants who contributed to this research. Their perception of the role that dispensing fees play in retention (or otherwise) of clients in treatment, as well as their influence on client-pharmacist relationships, provided a different perspective to that of their clients. Of the pharmacists interviewed, two dispensed to a significant number of participants recruited at Access Health, and one dispensed to participants recruited via the Next Door Clinic.
The Costs and Benefits of Opioid Pharmacotherapy Treatment: A Literature Review

Introduction

The use of illicit opioids and the associated harms remain a social and public health issue that continues to demand new and innovative means of redress. Although accurately measuring the numbers of heroin users in the community is complicated by the illicit (and consequently concealed) nature of heroin use, the most recent population surveys at the time of writing estimated that there were approximately 74,000 dependent heroin users in Australia (Drugs & Poisons Regulations Unit 2006). There are significantly greater numbers of users who are not considered ‘dependent’ and who use heroin intermittently (e.g. Premier’s Drug Advisory Council 1996).2 The cost of heroin, in terms of lives lost, however, is a stark reality. In Victoria alone, there were 2,141 heroin-related deaths from 1991–2005, and whilst the annual number of fatalities has, on average, declined since the late 1990s,3 the human and economic costs continue to exact a heavy toll.

For the individual heroin user, the risk of fatal overdose remains an ever-present reality that underscores the dangers of intravenous heroin use with grim finality. Far more common, but no less significant, is the risk of infectious disease, including blood-borne viruses such as HIV and hepatitis C, spread through unsafe injecting practices. Further, the financial cost of drug dependency can divert the dependent user’s often limited income from living expenses, including food and shelter, with potentially devastating effects on their health and housing security.

The broader costs to the general community include the cost of heroin-related crime, particularly property crime – estimated at between $550 million–$1.6 billion per year – as well as social costs such as the loss of individual fulfillment, the accompanying loss of productive members of society to unemployment (and government-funded income support), increased health costs and the often neglected cost of an individual’s drug use upon their immediate family members, including children (Drugs & Poisons Unit 2006). The loss of a son or daughter, father or mother, brother or sister is a cost that cannot be measured in any tangible sense, despite the devastation.

2 In the report, Drugs and our Community, the Premier’s Drug Advisory Council drew on the Commonwealth Department of Human Services and Health publication, Review of Methadone Treatment in Australia to estimate the number of dependent users of heroin in 1990 at 59,000 as compared to 113,000 occasional / infrequent heroin users (PDAC, 1996, 16).

3 According to the most recent figures released by the Victorian Institute of Forensic Medicine (VIFM), there were 37 fatal heroin-related overdoses in Victoria in 2006 – the lowest number since the VIFM began releasing reports (VIFM 2007). However, as opposed to a continuing tendency to measure the State’s ‘heroin problem’ in accordance with fatalities, declining rates of fatal overdose should not be read as a decline in opioid dependency and related problems.
While many dependent and/or long-term heroin users seek to address their drug use in abstinence-based rehabilitation and treatment programs, subsequent relapse is relatively common (Drugs & Poisons Unit 2006). For those individuals for whom abstinence-based treatments have not proven successful, opioid maintenance programs may present the most viable treatment option. This is based on the view that, for those individuals who at any one time may be unable or unwilling to stop using drugs, opioid maintenance programs can greatly reduce the death, morbidity, disability and other associated harms caused by illicit opioid dependence (WHO et al. 2004).

Extensive research from different countries and with varying client groups has consistently shown substantially greater long-term benefits, in terms of reduced illicit opioid use and improved social functioning, than those achieved by detoxification, drug-free outpatient counselling and residential rehabilitation (e.g. Mattick 1994). In 2005, in recognition of their benefits, the World Health Organisation (WHO) placed methadone and buprenorphine on the WHO Model (Complementary) list of Essential Medicines. The WHO Model List of Essential Medicines also included a new section on medicines used for the treatment of substance dependence (IHRA 2005). In 2008, in a discussion paper, the United Nations Office on Drugs and Crime (UNODC), a body committed to a prohibitionist approach to illicit drug use, noted the ‘false dichotomy’ of harm reduction and the prevention of drug use. The UNODC paper recommended that ‘services provide non-discriminatory facilities that can reduce the harmful consequences of substance abuse to drug users’ including:

- Low-threshold pharmacological interventions (for example, opioid-agonists and antagonist drugs), not directly related to drug-free oriented programmes, but to immediate health protection (UNODC 2008, 5).

This is not to undervalue abstinence as a goal of drug treatment or the validity of rehabilitation programs as treatment interventions – achieving abstinence remains the first preference of policy makers, treatment specialists and many illicit drug users. Indeed, therapeutic rehabilitation communities sometimes receive referrals of the most dependent and disruptive users who have tried, and failed, to achieve some measure of stability via maintenance treatments before entering rehabilitation. Such factors inform the necessity of a range of treatment options that are available and accessible for dependent drug users. However, this report is focused upon the use of pharmacotherapies in opioid maintenance treatment and, more specifically, the means by which the program could be made more accessible and the retention rates in opioid maintenance treatment improved.
The aims of opioid maintenance treatment are, as stated above, to reduce the harms associated with illicit opioid use by:

- Reducing illicit heroin (and other opioid) use;
- Reducing ill-health and death from illicit drug use;
- Decreasing criminal activity on the part of heroin users;
- Stabilising the lives of opioid-dependent individuals and allowing their participation in regular community activities (e.g., employment, educational opportunities);
- Decreasing high-risk activities such as needle sharing (Drugs & Poisons Unit 2006).

There is substantial evidence that maintenance programs have gone some way to achieving these aims. Methadone and buprenorphine\(^4\) are the two drugs used in opioid maintenance programs in Victoria. Methadone is a synthetic opioid agonist in the same category as other synthetic and naturally occurring opioids (e.g., heroin, morphine, pethidine). It shares cross-tolerance and cross-dependence with these other substances, meaning that one becomes dependent on opioids in general as opposed to any one in particular. Consequently, if a sufficient dosage of methadone is prescribed, it is possible to establish tolerance to opioids and preclude the euphoric effects of heroin. However, given that methadone is a full agonist, using heroin in addition to methadone (“doubling up”) can increase the risk of respiratory depression (the primary cause of death in an opioid overdose).

In contrast, buprenorphine is a partial agonist that also contains antagonist properties. Partial agonists exhibit ceiling opioid effects, meaning that agonist properties dominate at lower doses while antagonist properties dominate at higher doses. This was demonstrated in an Australian case where a heroin user consumed 88 mg of buprenorphine in less than 24 hours (the standard maintenance dose is in the range of 12-24 mg). Rather than respiratory depression, the individual suffered severe opioid withdrawal as the antagonist properties dominated, binding to the individual’s receptors and displacing the agonist properties of both the buprenorphine and illicit heroin consumed (Clark et al. 2002). Although the pharmacological composition of buprenorphine increases its safety profile, it can still cause death.

The properties of methadone and buprenorphine mean that the use of legal pharmacotherapies can be substituted for illicit opioids (e.g., heroin). In this way, an individual’s dependency can be maintained to prevent physical withdrawal and the related psychological compulsion to use heroin. For those unable or unwilling to reduce their use of illicit opioid drugs, maintenance programs reduce the aforementioned related harms. Many participants in pharmacotherapy programs express a desire to gradually lower their dose of methadone or buprenorphine so as to withdraw from all drug use (Lenne et al. 2000).

A study by Digiusto et al. (2006) conducted a cross-sectional analysis of data collected across 11 Australian pharmacotherapy trials. It reported the outcomes of 282 actively dependent heroin users entering into methadone treatment. Three months later, 174 (62%)...
were still in treatment. Their mean monthly expenditure on heroin had dropped from $2345 to $230. Involvement in crime dropped from 39 per cent of participants to 20 per cent. Such findings emphasise the reduced illicit drug use and reduced harms to the individual and the broader community, even in the event that an individual has not achieved a point in their recovery where able to completely discontinue the use of illegal drugs.

A separate study of 300 methadone maintenance patients at three Sydney clinics concentrated on criminal activities committed by former illicit heroin users participating in methadone maintenance treatment (MMT). This study found:

- Patients reporting selling drugs declined from 40 to 12 per cent;
- Patients engaging in property crime declined from 35 to 9 per cent; and
- Patients engaging in any income generating crime in the previous 30 days declined from 59 to 20 per cent (Graycar et al. 2002, 8).

These findings are consistent across all age groups and for both men and women, and add to the findings and the existing body of evidence established by earlier studies (e.g. Lind et al. 2005; Ezard et al. 1998). One of the key factors shared by the aforementioned reports is the importance they attach to retention in treatment if participants are to benefit to the fullest degree. In presenting the findings from the ‘Sydney study’ at a South Australian Drug Summit in 2002, Adam Graycar, Director of the Australian Institute of Criminology, noted:

An important finding from MMT studies has been that the benefits only continue as long as the patient remains in treatment (Graycar et al. 2002, 9).

In respect of fatal overdoses, Degenhardt (2001) suggests that increased access to maintenance programs is at least partially responsible for the aforementioned decline in overdoses in Victoria and across Australia. While acknowledging a dramatic decline in heroin supplies as the primary reason for a 58 per cent decline in the rate of fatal overdose from 2000 to 2001, the author noted:

The secondary reason is likely to be the continued expansion of access to an increasing array of treatments for opioid dependence. These treatments include methadone maintenance treatment, other opioid replacement treatments (such as buprenorphine), as well as detoxification and inpatient treatment programs. In 2001, just over 30,000 people were enrolled in methadone maintenance treatment across Australia, with a further 2,000 in buprenorphine treatment. This was an 8% increase relative to the number in 2000. Such treatments are known to reduce the risk of overdosing by a factor of four (Degenhardt 2001).

Methadone and buprenorphine are taken orally. Consequently, their use as a substitute for illicit opioids reduces high-risk activities such as injecting drug use (and the potential sharing of injecting equipment). This also reduces the reinforcing effects of injecting, such as the

---

5 Despite the positive tone of the evaluation, the question needs to be asked as to why such a significant number of clients (38%) were not retained in treatment. The effects of dispensing fees on retention rates may have been a contributing factor, one of the questions that this research seeks to address.
‘rush’ that accompanies the rapid onset of drugs taken intravenously (e.g. see McBride et al. 2001; Topp 2007). Reduced injecting behaviour lessens the potential spread of blood-borne viruses. Wodak and Lurie (1996) cite evidence from behavioural, seroprevalence and sero-incidence studies to show that accessibility to methadone maintenance programs has played a significant role in reducing the spread of HIV in Australia. Such has been the outcome that a US study noted:

An important benefit of the expansion of methadone treatment capacity is a reduction in the transmission of HIV, an outcome that benefits the general population. This benefit is so substantial that expansion of methadone treatment is cost-effective regardless of what assumptions are made about the effect of opiate dependence or methadone prescription on quality of life (Barnett & Hui 2000, 371).

The longer action of both methadone and buprenorphine means that just a single dose is required each day (for many buprenorphine patients, one dose every second day may be sufficient). Takeaway doses may also be prescribed for stable clients under certain conditions. Consequently, maintenance programs allow for participation in occupational or educational activities with a lesser degree of disruption than afforded by daily dosing regimes with the potential to disrupt such productive activities given the business hours of dispensing pharmacies. In this context, the provision of ‘takeaway’ doses may enhance clients’ abilities to obtain and retain paid employment as well as to travel for work and leisure and exert a degree of autonomy over their treatment (Frazer et al. 2007). The issue of takeaways, given the potential for these doses to be diverted, is addressed in greater detail below. An obvious accompaniment to entry into maintenance programs is reduced involvement in a drug subculture and the lifestyle of the heavily dependent heroin user whose repeated use of heroin throughout the day requires sums of money that legitimate sources of income are unlikely to provide.

In July 2001, the National Drug and Alcohol Research Centre (NDARC) published the findings of the National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD). The NEPOD evaluation was carried out over three years, consisting of 13 separate studies in six jurisdictions with the participation of 1,425 pharmacotherapy clients (NDARC 2003). Although the evaluation of any drug treatment intervention rests on many factors in addition to cost, among the evaluation’s findings was that methadone maintenance was the most cost-effective treatment for opioid dependence in Australia. The NEPOD report estimated that, for every dollar spent on the program, the community benefits by $4-$5 in reduced health care, crime and other associated costs (NDARC 2003).

As stated above, the numerous studies conducted emphasise that retention in opioid maintenance programs is a key aspect of the program’s success – clients need to be retained for as long as is necessary to make the often significant lifestyle change from what may have been a chaotic but continued need to meet the demands of an expensive and debilitating opiate addiction (e.g. Corsi et al. 2002). It is continued maintenance treatment that provides the stability required to reduce illicit intravenous heroin use and, as a consequence, involvement in criminal activity and imprisonment and risky drug use practices with potentially negative impacts on personal and public health (National Drug & Alcohol Research Centre 2001). In the House of Representatives Standing Committee on Family & Communities Affairs’ Report on the Inquiry into Substance Abuse in Australian
Communities, Committee members were presented with evidence for the efficacy of MMT by Professor Richard Mattick, Director of NDARC. Professor Mattick drew the Committee’s attention to ‘a number of trials internationally at different times, in different settings, with different investigators, that demonstrated the effectiveness of methadone as a maintenance treatment for opioid dependence.’ The review of MMT concluded:

- [MMT] has been one of the best researched treatments for opioid dependence;
- [MMT] is the only treatment for opioid dependence which has been clearly demonstrated to reduce illicit opiate use more than either no treatment, drug-free treatment, placebo medication, or detoxification in controlled trials; and is the most frequently prescribed pharmacotherapy in use globally for heroin dependence (House of Representatives Standing Committee on Family & Community Affairs 2003, 154).

One of the more recent research papers into policy options for the treatment of heroin dependent individuals demonstrated the cost effectiveness of MMT relative to other pharmacological treatments (Moore et al. 2007). Another recent study by the National Centre for HIV Social Research at the University of New South Wales similarly concluded ‘methadone maintenance treatment is widely recognised as the most effective treatment for heroin dependence’ (Frazer et al. 2007, 1).

A brief history of pharmacotherapy in Victoria

Methadone has a relatively short history as a treatment for opioid dependence. In 1964 US biochemist Vincent Dole, with psychologist Michael Nyswander, discovered that the oral consumption of methadone blocked heroin withdrawal. The synthetic opioid was subsequently employed as a treatment for heroin dependence in New York. As opposed to prioritising abstinence as the goal of treatment, the provision of the relatively inexpensive and legal substitute was seen as facilitating an improved quality of life. This aim was not shared by many policy makers and practitioners monitoring its initial use in Australia.

The history of pharmacotherapy treatment in Australia is brief. The first methadone clinic was established in Sydney in 1969. The use of methadone as a treatment for opioid dependence began in Victoria in 1972, and its use was initially confined to a small number of specialist drug and alcohol treatment clinics (Kutin et al. 1996). Restrictions on the numbers of clients both nationally and in Victoria meant that, by 1985, there were only 150 individuals receiving methadone treatment in Victoria. Of these, only 10 were receiving methadone outside of public, institutional methadone clinics (Department of Health & Community Services 1993).

The limited availability of methadone treatment in Australia owed much to the reticence of policy-makers to endorse the use of a drug that, while legally dispensed, was a habit-forming opioid. In 1985, then federal Attorney-General Lionel Bowen noted that the goal of drug policy was to motivate addicts to ‘kick’ the habit, not maintain their addictions (The Age 2 January 1985). Given the prioritisation afforded abstinence as the treatment goal, evaluative studies that reported a stabilisation of clients’ previously chaotic lifestyles, as well as a reduction in heroin-related mortality, had little influence (Caplehorn et al. 1993).
In January 1985 there were over 5,000 people enrolled in abstinence-based rehabilitation programs in NSW as compared to 842 in methadone programs throughout the state (The National Times). In February 1985, there were only 2,203 registered methadone clients across the whole of Australia, reflecting the continued dominance of abstinence based treatment (Mattick & Hall 1993, 21). To politicians and medicos preaching prohibition and abstinence, methadone was, first and foremost, an opioid with addictive properties. Any moves to facilitate its use constituted the abandonment of long held drug treatment goals informed by the dominant prohibitionist approach to drug policy.

In April 1985, however, recommendations emerged from a Special Premiers’ Conference on Drugs that reflected a significant shift in policy-makers’ attitudes. The major initiative of the Conference was the establishment of the National Campaign Against Drug Abuse (NCADA), the first comprehensive national response to the use of illicit drugs in Australia. The NCADA adopted ‘harm minimisation’ as the underlying principle of drug policy in Australia. Although still a contested term, harm minimisation is widely taken to refer to policies and programs that are designed to prevent and / or minimise drug-related harm through the use of three ‘balanced’ strategies: supply reduction strategies seek to disrupt the illicit drug supply through the use of law enforcement; demand reduction strategies attempt to prevent the initiation of drug use, primarily through education; and harm reduction strategies are designed to reduce all manner of harm related to drug use, whether suffered by drug users or the broader community (Green 2002). It was the addition of the harm reduction component that marked the departure of the NCADA from past drug policy. In the early language of the NCADA, this was referred to as ‘the problem prevention approach’:

This approach acknowledges that the use of both legal and illegal drugs is entrenched in most societies, and will never be completely eradicated … The problem prevention approach points to a range of strategies which, while not necessarily doing anything to decrease drug use, do decrease the likelihood of harm resulting from use (National Campaign Against Drug Abuse 1989, 37).

The NCADA sought to place as great an emphasis on treatment and education as upon law enforcement. The inclusion of the latter is informative as it illustrates that harm minimisation does not represent a departure from the enforcement of prohibitive drug laws. Rather, it is a policy approach that is located along a continuum of potential responses to illicit drug issues. These range from a zero tolerance ‘drug war’ at one extreme through to the wholesale legalisation of drugs at the other. What the adoption of harm minimisation represented (and continues to represent) in Australia was a shift in drug strategy from an affiliation with a ‘drug war’ mentality towards an approach located towards the centre of the aforementioned continuum. Despite this shift, the possibility of reforming prohibitive (and punitive) laws has received little attention and, although raised at the aforementioned Premiers’ Conference, proposals to prescribe heroin to dependent users were dismissed without serious consideration (Blewett 1987).6

---

6 This is a treatment option that continues to be discussed in Australian policy circles. In 1997, following four years of rigorous feasibility research conducted by the Australian National University, a limited trial of heroin prescription was proposed by the ACT government. Following further consultation, the trial was supported by a majority of the Ministerial Council on Drug Strategy – the central advisory body of national drug strategy that consists of the health ministers and attorneys-general of the states and territories as well as their federal counterparts. Despite his initial support for the trial, Prime Minister John Howard,
In contrast, and despite the continued reservations of policy-makers, the use of methadone as a maintenance treatment for opioid dependence became a prominent component of harm reduction strategies. A review of the national methadone guidelines shortly thereafter recommended an increase in treatment numbers given its demonstrated efficacy. The number of individuals in MMT has consistently increased in the years since. The following table shows the dramatic growth in numbers in Victoria from 1985, the year of the launch of the NCADA, to 1999.

**Figure 1: Growth of Victorian Methadone Program 1985 to 30 June 1999**

![Graph showing the growth of Victorian Methadone Program from 1985 to 1999](http://www.dhs.vic.gov.au/ar9899/rscs/ppbd6b.htm)

The impetus for the significant reform of Australian drug policy was the emergence of HIV/AIDS in the mid-1980s. The nature of the virus meant that the potential health threats of intravenous drug use were no longer confined to drug users. The comparative ease with which HIV and, in particular, hepatitis C, could be transmitted meant that the sharing of injecting equipment had the very real potential to spread these blood-borne viruses. A ‘pool’ of infection amongst injecting drug users posed a significant public health threat given the potential for the spread of HIV to the wider community through sexual contact. This public health threat compelled policy-makers to re-evaluate the goals of illicit drug policy and hastened the acceptance of harm reduction as an integral element of illicit drug strategy. Whilst abstinence remained the preferred goal of drug treatment, policy-makers acknowledged the need to prioritise a reduction in HIV risk-taking behaviour and a hierarchy of desirable treatment outcomes was established. Abstinence, the most preferred outcome, is followed by a number of ‘less desirable’ outcomes that each involve a reduction in risky behaviour: reduction of drug use; reduction of injecting; reduction of sharing of injecting equipment; and sterilisation of shared injecting equipment. Whilst methadone maintenance treatment, quite obviously, does not achieve the ultimate goal of abstinence from drugs, it does potentially remove the many potential harms associated with injecting drug use.

amidst a barrage of tabloid and talkback criticism, retreated from his earlier position and declared that the federal government would not pass the amendments to federal legislation that were required for the trial to proceed (See Rowe & Mendes 2005).

The prescription of pharmaceutical heroin (diacetylmorphine) is a treatment intervention that has been employed internationally. Following scientific trials, Switzerland authorised the prescription of heroin for opiate dependence. Heroin has been prescribed for scientific purposes in the Netherlands since 1998 and trials have been planned or are taking place in Germany, Spain, France, Belgium and Canada (see Stimson & Metrebian 2003).
The incorporation of harm minimisation into Australian drug policy allowed for a more considered treatment approach to problematic and dependent drug use. The unique circumstances and complex needs of drug dependent individuals necessitate a broad range of treatment options sufficiently flexible to respond to these needs. Despite a popular tendency towards the homogenous categorisation of drug dependent persons as addicts (if not ‘junkies’), such persons are, in reality, ‘individuals, with specific, stunningly different, and uniformly impossible-to-fill needs’ in the sense that all clients need individually tailored treatment programs (Shavelson 2001, 12). Not only should treatment options be varied and responsive, but, most importantly, they must be accessible. As noted, many opioid dependent individuals express a strong desire to be abstinent. However, the failure to achieve this goal, despite what may be repeated (and expensive) engagement with rehabilitation programs, may induce ambivalence in these individuals about the potential benefits of treatment interventions. This ambivalence means that it is frequently a crisis (whether financial, health-related or a relationship breakdown) that provides the impetus for the decision to re-engage with treatment. Consequently, treatment must be readily available to capitalise on (what might be a short-lived) motivation to seek help (WHO et al. 2004, 9). If a period of time elapses before access to treatment is available, then the crisis that provided the impetus to seek treatment, or indeed, the motivation to address issues of problematic drug use, may no longer be accorded any priority as the following demonstrates:

Would you be able to estimate the time between when you finally decided to get back onto methadone and picking up the first dose?

I first saw a doctor, my timing could be out, but about six months ago, to try and get on the methadone but I haven’t actually been able to actually get onto it until now.

Is that because of difficulties in terms of doctors not being able to find a chemist with a vacancy?

One of the things that some doctors may not understand, especially the doctor I was seeing in Prahran, is that there are other things that affect these decisions – not just finding a chemist, but, you know, dealing with the addiction of using, the financial situation and stuff like that.

It is just not [simply a case of] going to the doctor and finding a chemist with a vacancy, you have also got to be able to afford it. You have got to have the money on the day, for the first dose. A lot of the time, I would have no money and come pay day … I would end up using [heroin] again. The idea of methadone would go out the window, you know (Dennis 40 years).7

As Dennis notes, there may be a place available for treatment, but this availability is contingent upon the individual’s ability to meet the requirements of the program. The most pressing issue for those on income support payments is obviously the financial costs that restrict access to such programs to those able to make payments.

All quotes assigned to individuals are drawn from the 60 participants who were interviewed for this project.

---

7 All quotes assigned to individuals are drawn from the 60 participants who were interviewed for this project.
The comparative success of methadone programs in attracting and retaining clients led to their continued expansion from the late 1980s (Norberry 1992). Further, it was found that the longer an individual remained in MMT, the lesser was their likelihood of HIV infection in comparison to heroin users not in treatment (Wodak 1989). This finding underscores the necessity of ensuring that the requirements, financial and otherwise, of MMT and other maintenance programs do not exclude potential clients or lead to their involuntary removal. In 1988, according to the then federal Department of Community Services and Health, the methadone program was achieving, among other aims, its objective ‘to decrease the spread of infection associated with intravenous opioid use’, a goal made explicit in the 1985 National Methadone Guidelines (Commonwealth Department of Community Services and Health 1988, 6). This decrease had much to do with reduced intravenous heroin use, a reduction confirmed by numerous studies (e.g. Digiusto et al 2006). By 1989, there were approximately 6,500 persons enrolled in methadone programs across Australia, (Commonwealth Department of Human Services & Health 1995). The figure increased by approximately 15 per cent per annum until the late 1990s when the demand for placements increased dramatically (Kutin et al 1996).

Much of the impetus for increased demand for maintenance treatment can be attributed to dramatic fluctuations in illicit heroin supplies in Australia. In the mid-1990s, a heroin glut led to a significant decrease in price and a simultaneous increase in the drug’s purity. When coupled with the highly visible street trade that characterised heroin sales in Melbourne in the mid-1990s (see Fitzgerald et al. 1999, Mercer 1999), the affordability and accessibility of relatively pure heroin led to a considerable increase in its use. Inevitably, increased rates of heroin use were followed by increased rates of heroin dependence and related health problems – not least being fatal overdose. In Victoria alone, heroin-related deaths reached an unprecedented high of 359 in 1999. However, this period of oversupply was followed by a similarly dramatic reduction in heroin availability. By 2001, the number of heroin overdose fatalities had declined to 50 across Victoria (Woods et al. 2006).

The combination of the increased availability of cheap and pure heroin, followed by a sudden lack of availability (evidenced by the rising price and diminishing quality of available heroin), was doubtless instrumental in the demand for placement in treatment programs. Both the increase and the subsequent lack of access to heroin conceivably played a role in increasing demand for treatment. As rates of heroin use increased dramatically, it would be expected that the numbers of individuals seeking treatment would increase as the financial, social and health costs became progressively more unmanageable for many users. Alternately, when the availability of heroin suddenly diminished, many users facing withdrawal found themselves experiencing the crisis that often serves as motivation to engage with treatment options. Entry to an opioid maintenance program is one of few means of addressing the crisis posed by the onset of opioid withdrawal – and the number of individuals seeking entry to pharmacotherapy programs increased accordingly.

In November 2000, following extensive clinical trials, the Australian Therapeutic Goods Administration approved the registration and use of buprenorphine alongside methadone for opioid maintenance treatment and assisting withdrawal from opioid dependency. Prescription of buprenorphine began in April 2001 and in August 2001 it became available under the Pharmaceutical Benefits Scheme (PBS), greatly reducing the cost to consumers.8

8 Prior to the registration and prescription of Subutex®, low dose buprenorphine was available as a prescribed analgesic, marketed under the name Temgesic®. However, the amount of buprenorphine in Temgesic® is insufficient for the treatment of opioid dependent persons.
By the end of 2001, there were more than 1,500 individuals prescribed buprenorphine in Victoria, a number that rapidly increased to more than 3,800 in early 2003. In financial year 2005/06, there were 10,736 pharmacotherapy patients in Victoria (a 50 per cent increase over five years) (HMA 2007). Of these patients, 6,395 (59.6%) received methadone and 4,341 (40.4%) were prescribed buprenorphine (HMA 2007).^9

Each state and territory government has responsibility for managing pharmacotherapy programs within their respective jurisdiction. This includes determining the manner in which the service will be delivered. The rapid expansion of the methadone program in Victoria was partially facilitated by the engagement of community pharmacies as the primary dispensers of opioid maintenance pharmacotherapies. Approximately 70 per cent of clients nationally receive treatment through community pharmacies with the remainder receiving treatment through clinics (the standout is NSW where, as of 30 June 2005, less than 50 per cent of clients received doses through community pharmacies) (Pharmacy Guild of Australia 2004).^10

The move towards a community pharmacy model in Victoria – after initially confining methadone treatment to a limited number of specialist clinics – was made to counter some of the problems associated with specialist clinics. In particular, clinics raised issues of public amenity due to the large numbers of identified drug users congregating at their location, which were evidenced by the opposition and alarm of neighbouring residents (Muhleisen 2002). The concentration of former heroin users at these venues also worked against those seeking to leave the drug subculture given that the common reason for their coming together, as well as a likely subject of discussion, was illicit heroin use. In this context, the more pharmacies that participate in the program, the less likely are problems that accompany such large groups of ex- and current users congregating in the one place. Dispensing pharmacotherapies from community pharmacies also allowed individuals to be treated in ‘normal’ treatment regimes, as opposed to being clients of specialist state-sponsored clinics for dependent opioid users (Hotham 2005).

In Victoria, the number of pharmacies participating in the program has played a key role in decentralising opioid maintenance treatment and establishing it as a community health service. In June 2006, there were 459 pharmacies throughout Victoria participating in the program representing 39 per cent of all pharmacies in Victoria (HMA 2007, 9). The emphasis on community-based pharmacies distinguishes Victoria’s pharmacotherapy programme from those of other states (Ezard et al. 1999). However, the issue of dispensing fees – or, more specifically, the difficulties collecting dispensing fees – has been acknowledged as a major disincentive to pharmacists’ involvement in maintenance programs (Clark et al. 2004). This issue is discussed in greater depth below.

---

^9 Of those prescribed buprenorphine, 1,460 were receiving the Suboxone®, a new combination of buprenorphine and naloxone. The introduction and rationale for this combination pharmaceutical is discussed below.

^10 In 2006, the NSW Health Minister, John Hatzistergos, outlined a plan to open no more private clinics and to pass responsibility for the prescription and dispensing of pharmacotherapies to community-based GPs and pharmacies. A spokeswoman for the Health Minister noted a community-based model provided users with a better chance of ‘normalising’ their treatment (Sikora 2006).
Questioning opioid maintenance programs

Disadvantages associated with opioid maintenance treatment

As with any medication, methadone has side effects – many of which are unpleasant if the consumer is unfortunate enough to experience them. High doses of methadone can cause severe constipation, excessive perspiring, dehydration and poor libido. It can cause lethargy among consumers (Byrne 2004). A number of perceived side-effects are addressed by participants in this research.

Many of the disadvantages associated with methadone are a consequence of having to present every day (or frequently, if a client qualifies for ‘takeaway’ doses) at their dispensing pharmacist in order to receive their medication. This can place significant restrictions on the life of the pharmacotherapy client – indeed, methadone is known by many consumers as ‘liquid handcuffs’. As one consumer has written:

> At times over the past ten years, I feel I have improved my life despite the methadone program rather than because of it. I have managed to keep my job for the past seven years even though I have trouble juggling the hours I have to work with the hours that I can get dosed at the chemist. I have managed to keep the fact that I am on ‘done from my kids even though this is really hard to do when you have to go pick up four days every week. Not being able to get a bunch of takeaways at short notice or even with notice has sometimes meant that our family just can’t take off for the weekend or go on long holidays like ‘normal’ families do (Walker 2003, 25).

Some, such as Herkt (1995) and Zajdow (2004), argue that requirements such as daily dosing act as a state sanctioned means of controlling problematic drug users. This view has also been expressed by clients. As one health worker noted:

> I remember one former heroin user forcefully arguing that methadone was just a form of social control – the state sanctioning replacement of one highly addictive drug with another. He felt that this policy of ‘harm reduction’ was more concerned with preventing crimes committed by drug users, rather than in helping individuals or tackling the underlying problems that led people to turn to drugs in the first place (Rushforth 2004, 131).

It is to be hoped that prescribing doctors undertake a treatment approach that incorporates underlying problems that may lead people to misuse (i.e. self-medicate with) drugs. Having been stabilised on opioid maintenance programs, these people may now be in a position to begin to address these problems. Nonetheless, the requirements of opioid maintenance programmes do render a client’s basic rights subject to the approval of prescriber and dispenser. This includes such rights as the ability to travel, to freely organise their own time and, in some respects, the right to privacy. This issue was raised by a number of the research participants. However, the restrictions on clients’ movements and use of time could be considered relatively manageable when compared to the constraints placed upon a ‘normal’ life by the 24-hour demands of a heavy opioid dependency.
The introduction of a 4:1 combination of buprenorphine and naloxone in April 2006 added a pharmacotherapy that potentially increases the possibility of increased takeaway doses and even unsupervised dosing for those who have remained stable on their pharmacotherapy programs and need to travel for such reasons as work or family. When the medication is taken sublingually, as is intended with buprenorphine, the naloxone has less than 10 per cent bioavailability and a plasma half-life of less than one hour – with the consequence of the drug’s actions being indistinguishable from that of buprenorphine (Bell et al. 2004). However, when injected, the naloxone is highly bioactive and can precipitate moderate to severe withdrawal in someone with opioid dependence. Consequently, the introduction of a buprenorphine/naloxone combination has permitted revision of takeaway guidelines and has introduced the possibility of unsupervised treatment (Winstock et al. 2007). This may go some way to addressing the constraints inherent in presenting for daily dosing.

A commonly reported grievance of individuals on opioid maintenance programs is that they are treated in a manner that is both unfriendly and discriminatory. It must be emphasised that this is not necessarily the norm – many if not most pharmacists and consumers develop friendly working relationships – however, the power dynamics of the relationship, along with ‘junkie’ stereotypes that continue to dominate perceptions about heroin users, can lead to insulting and humiliating treatment by pharmacists influenced by such perceptions. As one example, numerous pharmacies have potential clients sign contracts as a condition of treatment. Some of these contracts are demeaning to say the least, with clauses including11:

- You should attend the pharmacy alone except for your partner or children;
- Any type of abusive behaviour towards any staff member will NOT BE TOLERATED and will result in IMMEDIATE DISMISSAL FROM THE PROGRAM. Any abusive or disruptive behaviour towards any customer in the shop will also result in IMMEDIATE DISMISSAL.
- As a mark of respect to other customers we ask that appropriate clothing be worn at all times and that you present in a clean, tidy and respectable manner;
- Any SUSPICION of drug dealing or any other criminal activity on the premises or within the vicinity of the pharmacy will result in the police being called and IMMEDIATE DISMISSAL;
- You should wait on the chairs in the waiting room for the pharmacist to call your name;
- For purchases, please ask the staff for assistance. Please do not wander around in the pharmacy.

The tone of such contracts make clear that the pharmacotherapy client is not a ‘normal’ customer, despite the fact that the client is a customer entitled to the same service as any other, as opposed to an object of suspicion whose custom is tolerated (and only under strict conditions). This issue of whether such attitudes affect retention rates is addressed by drawing on clients’ own perceptions below.

11 These examples have been reproduced from four ‘contracts’ used by inner and suburban pharmacies in Melbourne.
The issue of diversion

The diversion and illicit sale and / or use of pharmacotherapies are primary concerns associated with opioid maintenance programs. In Australia, a number of accidental deaths have occurred due to methadone toxicity, often in combination with other drugs that depress the central nervous system (CNS) (Zador & Sunic 2002; Caplehorn et al. 1999). Although the pharmacological composition of buprenorphine increases its safety profile, it can also cause death. Respiratory depression has been associated with the misuse of buprenorphine, especially when used in combination with benzodiazepines and other drugs that depress the CNS (Boatwright 2001). However, the number of accidental deaths is lower than those associated with a full agonist such as methadone. In France, where buprenorphine has been used in opioid maintenance treatment since 1996, the rate of death associated with methadone is three times that associated with buprenorphine (Auriacombe 2001).

The dangers associated with the misuse of pharmacotherapies have been widely reported in the popular media – particularly when children and infants have consumed methadone stored by their opioid dependent parents or guardians (e.g. Masters 2006). Opioid ‘takeaway’ doses are stored in the home of clients who have demonstrated a willingness to comply with the stringent requirements of opioid maintenance programs. This allows clients to live a less regimented lifestyle with obvious benefits for their employment and education opportunities given that takeaways reduce the need to present at a dispensing pharmacist during business hours on a daily basis. However, it should be made clear that the danger is not created by ‘takeaways’ but by inadequate storage. For example, similar dangers are presented by insecure storage of legally possessed firearms and laws are in place to enforce the safe and secure storage of these. That said, whilst emphasis must be placed on the secure storage of takeaway doses of opioid pharmacotherapies, they are in no way more threatening to children placed at danger by inadequate storage of numerous pharmaceutical medications as well as everyday cleaning products.

A greater danger is presented by the diversion of prescribed opioids from their intended recipient to a third party or the intravenous use of buprenorphine and methadone doses produced for oral consumption by the legal recipient. A number of strategies seek to prevent diversion and subsequent non-prescribed use of opioids. In Victoria, the responsibility is placed on both the prescriber and the dispenser of the pharmacotherapy to adopt their practices to minimise the risk of diversion (Drugs & Poisons Unit 2006). The primary means of addressing illicit methadone diversion is the dilution of doses with liquid (e.g. cordial) to a total of 200ml. This volume makes injection very unlikely. In comparison, a dose of buprenorphine in tablet form is easier to divert and anti-injection strategies such as dilution are not possible without affecting the active properties of the drug. The main anti-diversion strategy is supervision of dosing by the dispensing pharmacist. A combination of factors, including the time taken for a sublingually administered dose of buprenorphine to dissolve and competing demands for the pharmacist’s attention, make it relatively easy for the consumer to leave the pharmacist with their buprenorphine dose reasonably intact. Consequently, crushing the pill into a powder administered sublingually has become a practice of pharmacists unable to supervise clients and attend to other demands in often busy pharmacies. However, it should be noted that the Victorian Drugs Poisons Unit policy...
on maintenance pharmacotherapies states ‘crushing tablets into a fine powder may cause pasting in the mouth and actually slow absorption’ and instructs dispensing pharmacists to ‘aim to administer as small granules’ (Drugs & Poisons Unit 2006, 35).

The illegal diversion of large amounts of buprenorphine also presents the potential for precipitated withdrawal in an opioid dependent individual. Buprenorphine, a partial opioid agonist, has sufficient properties to bind to the opiate receptors. However, at a certain point in dosage, the agonist effects do not increase further, even with increased dosage – a ceiling effect. In this situation, the antagonist properties of the drug take over, displacing the full agonist effects without providing for the equivalent degree of receptor activation, leading to precipitated withdrawal in opioid-dependent persons. As opposed to spontaneous withdrawal, which begins approximately 6–12 hours after last opioid use and peaks at approximately 36–72 hours after last use, precipitated withdrawal is immediate and far more severe. In a case study in Melbourne, a male in treatment began diverting his buprenorphine doses whilst recommencing heroin use (Clark et al. 2002). The individual initially took 40 mg of buprenorphine after several weeks of regular heroin use and immediately experienced uncomfortable withdrawal effects. Throughout the day, in a bid to relieve these painful effects, he consumed a further 48 mg and continued to experience persistent agitation, severe abdominal cramps, diarrhoea, nausea and sweating. While this example demonstrates the relative safety of buprenorphine in relatively high doses – 88 mg being three times the recommended daily maximum – higher doses of the drug caused the antagonist effects to displace all agonists, whether as components of buprenorphine or as illegally administered heroin or morphine.

There is considerable evidence of diversion and intravenous use of diverted buprenorphine either by the intended consumer or by a third party. Analysis of data collected as part of the 2002 Illicit Drug Reporting System (IDRS) confirmed significant rates of diversion and injecting of diverted doses by third parties. Interviews with a convenience sample of 156 intravenous drug users in Melbourne found that a third had injected buprenorphine in the 6 months prior to interview. Of these, almost half (47%) reported obtaining the drug via means other than by having it dispensed on prescription (i.e. using buprenorphine diverted by the intended recipient) (Jenkinson et al. 2005). In 2005, a cross-sectional survey was conducted with 282 pharmacies participating in methadone and buprenorphine programmes across Victoria. This revealed concern from the majority of pharmacists that buprenorphine was being diverted by clients at a rate of 33 suspected cases for every 100 clients (Neilsen et al. 2007). In 81 cases, treatment was discontinued by the pharmacy as a consequence of the client diverting their dose. Some pharmacists called for the discontinuation of buprenorphine treatment and, indeed, in some countries (e.g. Scotland) buprenorphine has been withdrawn from the market due to the rates of illegal diversion of doses (Jenkinson et al. 2005).

There is a danger that buprenorphine tablets that have been placed in an individual’s mouth will attract bacteria that may then enter the bloodstream if the tablet is subsequently crushed, dissolved and injected. Of great concern has been the association of this practice with fungal eye infection (endogenous fungal endophthalmitis) (Aboltins et al. 2005). Due to the dangers associated with injecting diverted buprenorphine, the buprenorphine/naloxone combination was added as a further pharmacotherapy for opioid maintenance treatment, primarily as a means of addressing the illegal diversion of buprenorphine. However, there is also anecdotal evidence of individuals injecting takeaway doses of the new combination pharmacotherapy. A number of participants in this research
acknowledged having done so in the hope of experiencing the ‘rush’ from the intravenous use of the drug (i.e. the rapid delivery of the psychoactive properties to the brain as opposed to the comparatively slow process of absorption via sublingual administration). However, this practice was soon discontinued by these participants given that injecting the dose did not have the desired effect. The intravenous use of a drug designed to be taken sublingually led to the dissipation of its opioid properties at a rate that left them in withdrawal some time before being able to present for their next dose. Further, the ‘rush’ was reportedly minor and not worth the time-consuming process of obtaining and employing wheel filters to remove insoluble components of crushed pills.

The increasing prescription of the buprenorphine / naloxone combination in place of buprenorphine alone, alongside anecdotal evidence of discontinuing experimental intravenous use gives reason to believe the problems associated with diversion and inappropriate administration will decline. Further, due weight should be accorded to the value of takeaways in allowing those on maintenance programs to return to a productive and fulfilling lifestyle. The availability of takeaways for those who comply with the requirements of treatment in accordance with the guidelines established by the Victorian health authorities gives rise to a greatly enhanced ability to enter into employment or educational opportunities that might be compromised by the necessity to present to a dispensing pharmacist, seven days a week, during business hours.

Abstinence pharmacotherapies and maintenance pharmacotherapies

Policy makers committed to abstinence-based approaches continue to search for alternatives to opioid maintenance treatments. In December 2005, for example, then federal Health Minister, Tony Abbott, speaking of methadone, noted ‘… in the end, it’s just a substitution of a legal for an illegal product’ (Robotham 2005, 2). The Health Minister was speaking of his desire to see naltrexone used more widely as an intervention for heroin dependence.

Naltrexone is a drug that binds to the opioid receptors and, consequently, blocks the effects of opioids introduced to the body. Advocates for its use argue that blocking the euphoric effects of opioids counters the positive reinforcement experienced upon injecting opioids and that the drug-seeking behaviour and craving of the aforementioned euphoria will subsequently diminish (Tucker & Ritter 2000, 73). However, given its capacity to block the euphoric effects of opioids, research has generally reported the acceptability of naltrexone as a treatment as poor (Tucker & Ritter 2000; Bell et al. 1999). Reports detailing the NEPOD project coordinated by the National Drug and Alcohol Research Centre noted:

Although naltrexone treatment following detoxification is effective, only 4% of heroin users remained in naltrexone treatment at six months. As a comparison, the retention rate of those in methadone, buprenorphine or LAAM treatments was 44% at six months. Of the 4% still in naltrexone treatment at six months, none had used any heroin in the past month. Naltrexone is suitable for the highly motivated patient with good social supports and much to lose from continuing with opiates (Parsons 2002, 4).
The greater efficacy of opioid maintenance has not stopped policy makers calling for the prioritisation of naltrexone for ideological reasons. Self described social conservative and National Party Senator Barnaby Joyce called for the funding of naltrexone in preference to methadone in a press release in the lead up to the 2007 federal election. His view is shared by Salvation Army Major Brian Watters, one time Chair of the Australian National Council on Drugs (ANCD) – the principal advisory body to the Commonwealth Government on drug policy. Major Watters has been publicly critical of methadone, arguing that substituting one opioid for another is simply continuing the addict’s opioid dependence. His criticism that ‘we have tended to take a mechanical or pharmacological approach’ to drug treatment rests on an oft stated conviction that more effort should be directed towards moving the dependent individual towards abstinence (Commonwealth Standing Committee on Family and Community Affairs 2003, 156).

In 2003, the Commonwealth Standing Committee on Family and Community Affairs released *Road to Recovery: Report on the Inquiry into Substance Abuse in Australian Communities*. Although supportive of methadone as a (short term) treatment, the preference for abstinence based approaches was clear:

> In the committee’s view, the need to help people on MMT to move beyond it and on to abstinence is one of the most important issues to be addressed in relation to heroin addiction … When providing methadone maintenance treatment to save lives and prevent harm to people dependent on heroin, the ultimate objective [should] be to assist them to become abstinent from all opiates, including methadone (Commonwealth Standing Committee on Family and Community Affairs 2003, 158).

Of naltrexone, the report stated:

> The committee strongly recommends as a matter of urgency that the Commonwealth Government fund a trial of naltrexone implants, coupled with support services required for efficacy (Commonwealth Standing Committee on Family and Community Affairs 2003, 161).

The support for naltrexone and criticism of maintenance programs was repeated in a separate inquiry by the same committee in 2007. If anything, the subsequent report, *The Winnable War on Drugs*, was even more critical of maintenance treatment, recommending:

> The Commonwealth Government amend the National Pharmacotherapy Policy for People Dependent on Opioids to specify that the primary objective of pharmacotherapy treatment is to end an individual’s opioid use (Commonwealth Standing Committee on Family and Community Affairs 2007, 128).

Criticisms of maintenance programmes ignores the unanimity of research findings that demonstrate how the benefits of these programs increase with the length of time a client is retained in treatment. In one confronting passage, the Committee on Family and Community Affairs suggested that opposition to alternatives such as naltrexone ‘may come from those with a financial interest in prescribing methadone’ (Commonwealth Standing Committee on Family and Community Affairs 2007, 131). There was no mention made of private and profitable naltrexone clinics operating in Australia. The committee’s support for the abstinence based naltrexone treatment was made clear in its recommendation that:
The Costs and Benefits of Opioid Pharmacotherapy Treatment: A Literature Review

The Commonwealth Government lists naltrexone implants on the Pharmaceutical Benefits Scheme for the treatment of opioid dependence (Commonwealth Standing Committee on Family and Community Affairs 2007, 131). Abstinence-based treatment and rehabilitation using naltrexone has been found to be successful. However, success is typically enjoyed by ‘highly motivated’ clients who may have employment and/or a strong social support system – factors that provide motivation to address problematic opioid use. However, a majority of individuals with issues related to dependent opioid use are income-poor, isolated, and unemployed. Addressing such individuals’ physical dependency on heroin may not address the circumstances and social environment that contributed to their drug use in the first instance. If one’s life begins to revolve around the use of a drug – if the day is spent acquiring it and acquaintances are limited to other drug users who engage in similar activities – then removing the drug may remove one’s only social network and sense of purpose, with predictable results. NSW Health guidelines prepared for medical practitioners who practice rapid opioid detoxification using naltrexone note:

In general terms, patients with good social supports (employment, relationship, family) and with fewer psychological difficulties (less comorbidity) appear to be most likely to benefit from naltrexone treatment (Bell et al. 2001, 24).

They also note that ‘the majority of subjects undergoing rapid detoxification will relapse within 6 months’ (Bell et al. 2001, 12). The risk of relapse should not be underestimated in these circumstances. A period of naltrexone-induced abstinence will greatly reduce an individual’s tolerance to opioids and place them at considerably greater risk of overdose if they relapse (Bell et al. 1999; Ritter 2002). A study by Digiusto and colleagues (2004) as part of the NEPOD, focused on serious adverse effects13 (SAEs) occurring among participants entering drug maintenance treatment using opioid agonist/partial agonists pharmacotherapies (methadone, buprenorphine) as compared to those treated with an opioid antagonist (naltrexone). Of most interest to this report was the finding that

---

12 The report of the Standing Committee on Family & Community Affairs has been received with a unanimous response of incredulity by those experienced and expert in the field. The absence of evidence and a suite of recommendations that directly contradict the thoroughly documented evidence of researchers and practitioners with decades of practical experience have been ably demonstrated in subsequent critiques of the report. This is not the place to add to the criticism other than to observe the continuing manner in which ideology continues to overwhelm evidence in policy areas that are seen as incorporating a moral dimension. It is, however, illustrative to quote from the dissenting report of the committee:

Four years ago, in August 2003 the House of Representatives Standing Committee on Family and Community Affairs finalised a report into substance abuse in the Australian community … It is difficult to justify the cost of another inquiry covering similar subject matter within such a short space of time … In fact, the Government’s response to [the report] Road to Recovery was not tabled in Parliament until August 2006; some three calendar years after the committee completed its work and just six months prior to the initiation of this Inquiry … It is important to also record Federal Labor Member’s concerns at the conduct of the present inquiry. While many witnesses to the earlier inquiry were asked to present their views again, not all who did this were treated with respect by individual committee members. Some experienced outright hostility because their expert views did not accord with the personal beliefs or political aims of those questioning them (Commonwealth Standing Committee on Family and Community Affairs 2007, 313-14).

13 These are defined by the Australian Therapeutic Goods Administration – they include heroin overdose, general illness accidents/injuries, other drug reactions, psychiatric events, pregnancy-related events or admission for inpatient detoxification.
people taking naltrexone had eight times the rate of overdose after leaving treatment than participants treated with methadone and buprenorphine. Further, 44 per cent of these overdoses occurred within two weeks of leaving treatment. Given that heroin dependency is recognised as a chronic, relapsing condition, the risk is significant. These findings inform warnings that accompany guidelines on the use of naltrexone (e.g. Australian National Council on Drugs 2002, Family Drug Support 2002, Fitzroy Legal Service 2007). In summarising the findings of the NEPOD evaluation of naltrexone to the Standing Committee on Family and Community Affairs, Professor Richard Mattick stated that orally administered naltrexone is safe and effective as long as patients remain in treatment. He went on to note:

It is not well accepted by many who try it. Compared with the other pharmacotherapies evaluated, the study found that it is harder to retain patients in treatment with naltrexone, compliance is poorer and the risk of death and overdose is higher when treatment is ceased or intermittent (Commonwealth Standing Committee on Family and Community Affairs 2003, 159).

These warnings are pertinent as in March 2008, a number of drug specialists wrote to the Medical Journal of Australia to call for the restriction of widespread and unregulated use of naltrexone implants. This followed a retrospective case file audit, revealing the hospitalisation of 12 naltrexone implant recipients to two Sydney public hospitals with eight cases directly related to implant recipients suffering severe adverse events. Six patients were suffering severe opioid withdrawal and dehydration (Lintzeris et al. 2008). An earlier editorial in the same journal noted that, whilst an intuitively attractive option for the treatment of opioid dependence, empirical research support for orally administered naltrexone was unimpressive given poor adherence to treatment. While patients who did adhere to treatment did well, only 2 per cent were still taking the drug three months after conventional inpatient detoxification (in Wodak et al. 2008).

Rather than ‘enforcing’ abstinence, opioid maintenance treatment seeks to stabilise an individual to the degree that factors such as isolation, homelessness and poor health, that may be contributing to their drug use (or vice versa), can be addressed. If these factors are successfully addressed, then an individual may choose to gradually reduce their pharmacotherapy dose and enter a lifestyle of abstinence with a much stronger foundation upon which to base their recovery. This stability, in addition to the reduced morbidity and mortality associated with reduced illicit opioid use, is one of the most notable benefits of maintenance programs that use opioids such as methadone. Perhaps the final word should go to a research paper commissioned by the Parliament of Australia and compiled by the Parliamentary Library. This noted:

For the majority of opioid-dependent individuals, naltrexone has been consistently linked with high rates of non-compliance, a greater risk of mortality and reduced likelihood of long-term success – this indicates the need for further research into its efficacy and safety … The paper concludes that the treatments should be considered on their individual merits, rather than on the basis of characteristics of their relevance to particular policy approaches such as ‘zero tolerance’ and ‘harm minimisation’ (Thomas & Buckmaster 2007, 1).

14 My emphasis.
Such a conclusion is apt – given that the views expressed in favour of naltrexone, while contrary to the evidence, are accurately representative of the supporters’ publicly stated preference for zero tolerance policies.

The above makes clear the fact that the use of the aforementioned pharmacotherapies in opioid maintenance treatment is not without complications. However, when these problems are balanced against the benefits of opioid maintenance treatment, they are easily outweighed. Further, there is always room to address these complications. The concerns expressed about discrimination, and discussed further by participants in Section 9 of this report, can be remedied by education. Diversion also remains a concern. It is notable that there is far less reported diversion of the buprenorphine / naloxone combination than of buprenorphine alone. Finally, the evidence in support for abstinence based treatments compares miserably with that for opioid based pharmacotherapies – exposing the underlying ideological views that sustain the continued support for naltrexone.

The costs of opioid maintenance treatment – the client

In Victoria, an estimated two-thirds of pharmacotherapy clients are unemployed. Almost half have not completed education beyond Year 10, and over a quarter are subject to correctional orders. Consequently, the majority of clients rely on income support payments as their primary source of income (HMA 2007).

The actual cost of pharmacotherapies is fully subsidised by the Commonwealth government under the Pharmaceutical Benefits Scheme (PBS). In 2008, the cost of methadone to the government was approximately 36 cents per 50mg dose (or $36 per litre). The cost of buprenorphine is significantly higher. A 12mg dose of buprenorphine – alone or in a combination with naloxone – costs the government $7.30 (Australian Government Department of Health and Aging 2008a). The cost to the pharmacotherapy client is incurred as a dispensing fee charged by the pharmacist. The manner in which this fee is charged differs from other medications dispensed by pharmacists in accordance with the National Health Act 1953.

The majority of medical preparations used by Australians are subsidised by the Commonwealth Government under Section 85 of the National Health Act. For medications listed under Section 85, patients may pay a total co-payment of up to $31.30 (or $5 for those with a concession card) with the remaining monies paid for by the government (Australian Government Department of Health and Aging 2008b). This can run to hundreds, sometimes thousands, of dollars for a single course of medication. Section 85 medicines also have dispensing fees but these are fully subsidised.

15 The government pays $10.50 for a packet of seven 2mg buprenorphine tablets and $30.10 for a packet of 7 8mg tablets. The buprenorphine / naloxone combination is bought in packets of 28, the government paying $42 per packet of 2 mg buprenorphine / 0.5 mg naloxone tablets and $120.40 for every packet of 28 8mg buprenorphine / 2 mg naloxone tablets.
In contrast, methadone and other opioid pharmacotherapies are included under Section 100 of the *National Health Act*, which deals with ‘specialised medications’. In the case of opioid maintenance pharmacotherapies, the drugs are supplied free by the Commonwealth government for dispensing by public institutions. Consequently, methadone was initially dispensed from public hospitals and treatment clinics for free. Section 100 does not address the issue of dispensing fees because it was not envisaged that pharmacists would be dispensing the medication. However, given that the means of dispensing was the responsibility of states and territories; the model for dispensing always had the potential to change. In Victoria, the shift to the community pharmacy model, along with the absence of subsidies for pharmacists’ dispensing fees under the existing PBS arrangements, means pharmacists are compelled to charge the clients of pharmacotherapy programs directly for dispensing fees (Clark et al. 2004). As noted by the Victorian Department of Human Services Drugs & Poisons Unit (2006, 15):

> As with any other professional service, providers of dosing services are entitled to a fee for dispensing pharmacotherapies. At present there are no government subsidies for fees for preparation and supervision of doses and the costs are usually borne by the patient. Individual service providers are free to set their own fees.

In 2004, the costs of dispensing pharmacotherapies in Victoria are borne by the client at an average cost of $5 per day. However, a majority of pharmacists prefer weekly or fortnightly payment to minimise the time taken to dispense opioid pharmacotherapies and offer inducements in the form of cheaper rates for weekly, fortnightly or monthly payment of dispensing fees (e.g. $60 per fortnight or $100 per monthly payment). Nonetheless, at a discounted weekly rate of $30, a consumer will pay $1,560 per annum. A client survey conducted in 1999 as part of an evaluation of community methadone services informed the finding that:

> Taking into consideration travelling costs as well as dispensing fees, the average cost per client per year was approximately A$1800. The mean proportion of weekly income spent on methadone was 19% with three-quarters of clients reporting that they experienced problems in paying for their methadone treatment (Ezard et al. 1999, 420).

An average weekly dispensing fee of $30 is seen to be a comparatively modest amount of money when considered alongside the costs associated with maintaining a heroin dependency. However, to view the issue in terms of simplistic comparisons is to ignore the

---

16 There seems little rationale for the inclusion of opioid dependence pharmacotherapies in Section 100. This section is concerned with ‘a number of drugs [that] are also available as pharmaceutical benefits but are distributed under alternative arrangements where these are considered more appropriate’ (http://www.pbs.gov.au/html/healthpro/browseby/section100). However, in Victoria, distribution arrangements for opioid pharmacotherapies are the same as for other drugs available as pharmaceutical benefits.

17 The government-funded agencies in Victoria that continue to dispense pharmacotherapies to that minority of clients for whom community pharmacies are inappropriate also charge fees. This is, in part, to ease transition to a community pharmacy if a successful transition can be managed at a later date (Clark et al. 2004).

17 This figure is based on the fortnightly rates charged to the majority of participants in the research of $60 or $70. Those paying $60 tended to pay weekly or fortnightly and, consequently, received one day’s dispensing free as an incentive to pay in this manner.
complexities that define (and complicate) individual cases of drug-dependence. As noted by the Victorian Drug Policy Expert Committee in its 2000 report:

People moving into the methadone program are generally trying to establish a non-drug using lifestyle and this usually involves a range of costs that are commonly funded from limited income security payments. The Committee is aware that many alcohol and drug agencies are trying to fund the cost of methadone for users, sometimes by providing ‘loans’. This is an indication that, for some, the burden of paying for dispensing is onerous.

This position is supported by the Financial and Consumer Rights Council which, in 2000, reported:

Those on methadone are some of the most disadvantaged and socially excluded people in our communities. They often have long-term substance abuse histories, coupled with offending histories, which makes reintegration into mainstream culture difficult. Many are on Disability Support Pensions, recognising other issues they face or the crippling effect of substance abuse. We are very concerned that the consequences of methadone dispensing costs places a further barrier for these people being able to manage financially and emotionally, and constitutes a further block to them being able to participate fully in society (Goldsworthy 2000, 1).

In a report of methadone dispensing costs, the Council listed six consequences that arise due to the problems that such costs pose for low-income earners. These are paraphrased and expanded upon below:

1. Strained family relations due to asking for financial assistance – regularly seeking financial assistance from family and friends who may themselves be struggling is a reported cause of relationship strain. There is the additional complication that requests for money will be met with suspicion if there is a past history of such requests being made to support illegal drug use;

2. Committing crime to pay for dispensing costs – if legitimate sources of income are inadequate to cover pharmacotherapy dispensing costs, then the only lifestyle change individuals may make is that they are now buying their drugs from a legal source (i.e. while financing their use via illegal activity);

3. Not being able to afford living expenses – given the level of discomfort associated with opioid withdrawal, meeting the cost of opioid maintenance fees will often be an individual’s first priority. They may, as a consequence, have difficulty meeting living expenses and go without food, medication and, in some cases, secure accommodation;

4. Seeking emergency relief – this is a major problem acknowledged by community service agencies such as Salvation Army Crisis Services. However, many agencies refuse to provide money for pharmacotherapies, and those that do have limited funds to devote to assisting with pharmacotherapy costs. The inability to access such assistance only further prioritises the need to meet pharmacotherapy costs above other expenses. Government funded community services invariably end up absorbing the cost of the dispensing fees as they are funded (and, in cases,
not philosophically opposed) to respond to client need in respect of food and accommodation. This is effectively a form of cost shifting – agencies won’t pay for pharmacotherapies, so clients divert money from living expenses to pay these costs and then seek accommodation and food assistance through the same agencies. At the end of the day, the government funds are meeting the costs of dispensing fees;

5. Missing doses and ceasing treatment – if unable to pay dispensing fees, individuals may have their treatment terminated. If a client does not present for their methadone dose for three consecutive days (or five in the case of buprenorphine), pharmacists are instructed not to administer further doses until being re-authorised by the relevant individual’s prescribing medical practitioner (Drugs & Poisons Unit 2006). Involuntary discontinuance of treatment often leads individuals affected back to illicit opiate use – even missing a single day can lead to severe withdrawal symptoms and, as related in this report, many individuals will seek out illicit opiates if denied their dosage. Of more concern is that being refused dosing may be seen as a window for a temporary return to the heroin-using cycle before crisis again motivates engagement with treatment services. If they do recommence a program at a later date, they must often do so at a higher dose than when treatment was terminated given their increased tolerance. This may waste weeks of gradually reducing dosage with the aim of becoming abstinent. Retention is fundamental to seeing an opiate maintenance program completed successfully;

6. Impact on relationship with dispensing pharmacy – Difficulty making payments, accrued debt, and disagreements over payment issues decreases trust and rapport between client and pharmacist, compromising the latter’s ability to assist with broader treatment issues. Pharmacists (and doctors) have a significant opportunity to influence the course of an individual’s life through the delivery of services to illicit drug users. However, as is shown in this report, the accumulation of debt and the inability to pay it is responsible for many clients leaving, or being involuntarily removed from, maintenance programs.

At the heart of the issue is the question of whether illicit drug users – or more specifically, heroin users – are considered deserving of the same health care as other Australians. The structure of the program is such that cost is prioritised over health. It is the ability to meet the cost, as opposed to health needs, that determines whether an individual will begin pharmacotherapy treatment. Irvine Newton, member of the Pharmaceutical Society of Australia and a community pharmacist in Melbourne’s western suburbs has noted:

The PBS unfairly discriminates against these clients and it’s high time that situation was remedied. The PBS exists to provide subsidised medicines at an affordable price to all Australians. Subsidies contribute to both dispensing fees and ingredient costs. Many people simply can’t afford the daily fees and as we predicted … pharmacists are now starting to withdraw services because, at the present rate of return, they can no longer justify providing them … (Newton 2005).
In the opinion of many people, heroin addiction is self-inflicted. The complexities of drug dependence are reduced to a simple matter of ‘choice’ on the part of the affected individual; ‘they chose to use heroin – what did they expect?’ Passing judgement on lives that most have had the good fortune not to have lived should be condemned for the simplistic view of humanity it engenders. Such judgements are based on a world that is seen in terms that are as black and white as the tabloid newsprint from which they are so often derived. To ignore the ‘grey’ that comprises the complexities of individual lives and circumstances, betrays laziness, hypocrisy or an inability to accept that they are part of a society that gives rise to circumstances in which individuals seek refuge in the use of dangerous and potentially deadly drugs. In any case, were it an issue of choice, could the same criticism not be applied to the other medications that are subsidised under the PBS for conditions that could be similarly described as self-inflicted? Acamprosate (Campral) and naltrexone (Revia) are prescribed to alcoholics to control cravings for the purposes of relapse prevention. The dispensing of these drugs is subsidised under the PBS. Similarly, Olanzapine (Zyprexa) a medication prescribed to control the symptoms associated with schizophrenia, is subsidised at the cost of $20 per month for a 10mg dose, regardless of whether an individual’s schizophrenia is associated with the use of amphetamines or cannabis (Muhleisen 2002).

Given the overwhelming evidence that the effectiveness of pharmacotherapy treatments increases the longer a client is retained in treatment, the greatest cost is that the inability to meet dispensing fees may lead to the withholding of dosage and, more concerning, for treatment to be ended – often abruptly and without alternate arrangements to address the resulting withdrawal. The likelihood of a return to illicit heroin use, as reported by participants in this project, is almost inevitable. This report draws attention to several cases in which clients have had treatment discontinued by pharmacists responsible for dispensing their medication, due to their inability to pay fees.

The Pharmacotherapy Advocacy, Mediation and Support Service (PAMS) is funded by the Victorian Department of Human Services to provide support, advocacy and referral information for pharmacotherapy clients in Victoria. It also mediates between clients and pharmacists in the event that payment of dispensing fees has compromised the relationship between the parties and the continued treatment of the client. A total of 464 cases were recorded via PAMS’ telephone service in the 2006–07 financial year (Lord 2007). This represents approximately 100 more calls than the service has dealt with in any preceding year, indicating a strong and potentially growing need for the service within the Victorian pharmacotherapy program. Approximately 78 per cent (n=311) of the calls were from pharmacotherapy consumers. Of the consumers who contacted PAM during the relevant period, 77 per cent were receiving government income support. The PAMS service documents the issues raised by callers according to 18 different categories. Although up to three issues are recorded per caller, the primary issue or ‘main reason for calling’ is also recorded. The single most frequently reported issue to the PAMS service in 2006–07 was that of dispensing fees and / or debt management, which was broached by 31.5 per cent of callers (Lord 2007). Given the high proportion of callers were living on government income support, it was noted that ‘this finding was not surprising’ (Lord 2007, 9).
With a brief to mediate between pharmacotherapy dispensers and clients, PAMS is not funded to provide financial assistance to clients in need of assistance in avoiding having their treatment withheld. The PAMS Annual Report (2006) notes:

PAMS has, on occasions of dire crises, drawn very small amounts of money from general petty cash to pay for 1-2 doses for some consumers. This is unfunded and unsustainable.

Historically, there have been some Victorian financial and welfare based agencies which have been able to meet this need. However, sadly, over the last 2-5 years, the capacity of these services to provide this form of assistance has dramatically reduced. Financial assistance is only available to consumers who live in the areas of St Kilda, Fitzroy / Collingwood and in some cases Footscray and the CBD (usually only homeless persons who are the clients of a specific service). This situation continues to be worrying. The cost of remaining on a program is approximately one-third of a fortnightly Centrelink cheque which becomes detrimental to the consumer’s general health and standard of living, especially in a time of crisis.

Frequently, when consumers are unable to access further credit with their pharmacist or access any form of financial assistance, they face program termination. In such cases, the chance of obtaining an alternative service provider is almost negligible when there is a debt outstanding with a former pharmacy … If a consumer cannot afford to pay for his / her medication, there are few other options than suffering withdrawal sickness (leaving every facet of one’s life unmanageable for a certain period) or returning to heroin use and an illicit lifestyle … (Lord 2006).

While the cost of dispensing fees may seem relatively minimal to many members of the public, those surviving on government income support are devoting a significant proportion of their income to a medical treatment that removes them from the chaotic, unhealthy and often criminal lifestyle of the dependent heroin addict. Furthermore, dispensing fees are not the only costs incurred by clients on opioid maintenance programs. Travel costs are often required to visit one’s dispensing pharmacist on a daily, or at least frequent, basis and impact upon the financial well-being of the low-income earning pharmacotherapy client, whilst the commitment of time to regularly attend one’s pharmacist can compromise educational or employment opportunities (HMA 2007).

The sceptical question often posed in response to the financial difficulties of clients is: how can an individual, who was able to pay the costs of a heroin dependency that may have demanded hundreds of dollars each day, now say they cannot afford $30 per week? Such a question misses the very basis of opiate maintenance programs and their aim to replace the chaos and criminality of dependent heroin use with a stable lifestyle that does not involve criminal behaviour. A lifestyle of dependent heroin use is often characterised by a continuous cycle of illegal activity enabling the financial demands of the dependency to be met. Making the decision to begin opiate maintenance treatment, for most, represents a decision to remove oneself from such chaos and criminality in a search for the stability afforded by the treatment program. Individuals no longer require hundreds of dollars each day – and the activities that have provided such an income are often a large part of the desire to confine dependent heroin use to the past. Individuals can access a legitimate
The Costs and Benefits of Opioid Pharmacotherapy Treatment: A Literature Review

income provided by government income support in the form of Newstart, a Disability Support Pension or another form of income support. For those who took part in this research, even with income support, living expenses left them with very little. The tenuous nature of the financial situation is ably demonstrated by the following:

I am on Newstart … I get approximately $480 a fortnight … My rent is $150 a week, so when you add the $50 [per fortnight for dispensing fees] on top of that, you’ve got $300 for rent and $50 for methadone. On top of that methadone, I am on Valium and Serapax, so I need to fill, in total, four scripts a week, eight a fortnight, which is approximately $35 to $40. So I am looking at spending about $100 per fortnight at the chemist. So when you have $300 worth of rent, $100 at the chemist … you can do the maths.

You have $40 a week to live on.

And that is before … you know, you buy a packet of cigarettes and you are broke. Let alone shopped or [paid for] transport. I have to catch two trams to the chemist, even though it is a short distance. I could walk, but it would take half an hour. So I am already in the red, as you say - every week, every fortnight. It does make it very difficult (Cain 20 years).

Such struggles are the norm for financially vulnerable individuals on income support programs and a small number of the many experiences of poverty shared by participants are collected in Section 6 of this report. Such experiences illustrate the misguided basis of questions as to participants’ ability to afford illicit and considerably more expensive drugs. They fail to appreciate the transition of an individual between living two different lives, and the support required for the decision to ‘go straight’. The consequences of the involuntary discontinuance of opiate maintenance treatment are discussed at length within this report. If they are to be avoided, the burden upon those individuals who struggle to pay their dispensing fees, and thus risk not being retained in treatment, must be alleviated.

The costs of opioid maintenance treatment – the community pharmacy

Community pharmacies also experience problems as a direct consequence of the failure to subsidise the dispensing of opioid maintenance pharmacotherapies. The aforementioned difficulties regarding the collection of fees are a major disincentive to pharmacists’ participation in opioid maintenance programs. Pharmacists report writing off an average of 20 per cent bad debt (Clark et al. 2004). Further, the average dispensing fee of approximately $5 per day has remained unchanged since 1985 and many pharmacists argue that this is insufficient reimbursement for the time required to dispense to clients on pharmacotherapy programs. While free to set their own fees, a pharmacist who chose

---

to raise their costs by just a few dollars would soon lose the bulk of their clients to a pharmacist who realised that even existing fees represent a significant cost for those on low incomes. There is, of course, the opportunity for isolated pharmacists (e.g. in rural areas) to exploit their monopoly over opioid maintenance treatment in a particular region. Still, the argument of sufficient remuneration remains unresolved amongst the Pharmacy Guild. One pharmacist offered the following perspective:

Only a relatively small proportion of [methadone maintenance treatment] clients cause significant problems, but that small proportion does seem capable of consuming a lot of a pharmacist’s time. Unfortunately, most community pharmacies can expect to experience minor disruptions or disturbances at some time with methadone clients. Often these will involve verbal abuse, theft or arguments related to payment problems. Reimbursement for pharmacists’ participation in harm reduction programs is clearly inadequate and presents a major barrier to recruiting new pharmacies. Almost all community pharmacies experience difficulty in collecting fees from patients and the fees do not adequately reimburse them for their effort (Petersen 1999, 167).

By contrast, in an admittedly limited study conducted by the Pharmacy Guild of Australia (and reported in Chalmers et al. 2007), based on reports of ten pharmacies, the average cost of dispensing a daily dose of methadone was calculated at $3.27 and a daily dose of buprenorphine at $3.29. The disparity of opinion as to a fair rate of remuneration was represented by the stipulated costs of dispensing methadone ranging from $1.61–$7.37 and the costs of dispensing buprenorphine ranging from $1.03–$8.18. Despite the obvious inconsistencies in individual pharmacists’ estimates, eight of the ten pharmacies involved reported a positive financial return at an average of $15,424. Despite positive returns, many pharmacists maintain the current level of dispensing fees is insufficient to reimburse the time and effort required to administer opioid maintenance programs.

A mid-1990s survey of 144 Victorian pharmacies dispensing methadone found that, while the greater majority of participating pharmacists (92%) enjoyed a sound relationship with their clients, 60 per cent had experienced a ‘disturbance’ or disruption during the course of dispensing pharmacotherapies. This included events such as verbal abuse (29%), theft (22%) and disturbances relating to payment difficulties (18%) (Muhleisen et al. 1998). Slightly more than two per cent of those surveyed had terminated a client’s treatment in the three months preceding the survey. This included 63 clients for non-payment of dispensing fees and a further 190 clients for failing to attend treatment.22 As the experiences of research participants demonstrate below, it is reasonable to assume that many clients failed to attend because they had insufficient money to pay for their medication to be dispensed. Ninety-four per cent of pharmacies surveyed had experienced difficulties

---

22 According to guidelines issued by the State health authorities, if a methadone client does not present to collect their dose for three consecutive days, then the pharmacist is required to withhold further doses until the client returns to their GP and presents with a new script. A similar arrangement exists for those prescribed buprenorphine although, given that many buprenorphine clients ‘double dose’ – taking two days doses at one time – and that buprenorphine has a longer duration of action than methadone, pharmacists are not required to withhold medication unless a client does not present for five consecutive days. Of course, the dangers of precipitated withdrawal rule out double dosing for clients on doses at the higher end of the buprenorphine scale.
collecting dispensing fees – with 70 per cent writing off debt of between $5 and $1,000 each month (Muhleisen et al. 1998). This was the equivalent of approximately 7 per cent of all dispensing fees being written off as bad debt. The loss of such income contributed to over half (53%) of surveyed pharmacists’ belief that current levels of remuneration for their services was inadequate. The research team concluded:

A key requirement for the enhancement of methadone services is the development of a system of payment of pharmacists that adequately reimburses them for labour associated with daily dispensing, and does not place inordinate financial strains upon methadone clients (Muhleisen 1998, 12).

The lack of adequate remuneration for their role in opioid maintenance programs has led, as predicted by Newton (2005), to pharmacists withdrawing their services because they can no longer justify the cost of providing them. One example occurred in late 2005 when the Fitzroy branch of pharmacy chain My Chemist closed its program. This was one of few pharmacies dispensing pharmacotherapies for opioid dependent clients in the immediate area – leaving prescribers and service agencies desperately attempting to relocate 80-100 clients. The reason for the closure was the inability to justify providing pharmacotherapies given the associated costs:

Owner and pharmacist Mario Tascone said [the pharmacy] was losing money through the program because many clients were unemployed and could not afford to pay. The pharmacy was covering the cost instead. ‘The majority of people live from week to week, they’re unemployed … to scrape together $5 a day is pretty hard’ (Nader 2005, 7).

Far from frustrated with the difficulties inherent in the community pharmacy model, however, the Pharmaceutical Society of Victoria has proposed the State Government subsidise dispensing fees to encourage retention of clients of maintenance programs (Drug Policy Expert Committee 2000, 112). More recently, the Pharmacy Guild of Australia recommended to the Inquiry into Substance Abuse in Australian Communities that the Australian Government pay a subsidy to pharmacies for dispensing and supervising pharmacotherapy treatment (HMA 2007). This recommendation recognises the importance of retention in treatment for positive outcomes and that dispensing fees are a significant obstacle to retention for many clients. In 2004, the Pharmaceutical Guild of Australia released a tender to develop and evaluate funding model options for the dispensing of pharmacotherapies in the search for ‘best practice funding options’. The final report observed:

There is a need to ensure that future service delivery and funding model options include strategies that facilitate retention in the program. Research has shown that longer retention in treatment is associated with improved post-treatment outcomes. In addition, many studies confirmed that a longer length of time in treatment reduces criminal behaviour and also increases socially productive behaviour (such as employment) (HMA 2007, 59).
The value of long-term pharmacotherapy treatment for opioid dependence is recognised by Victoria’s public health authorities. Retention is prioritised to the degree that a relapse of illicit heroin use is not sufficient to terminate treatment, particularly given the potential consequences of termination. As the Victorian Policy for Maintenance Pharmacotherapy states:

Given the risk of relapse to illicit opioid use following cessation, pharmacotherapy is usually long term; patients should be encouraged to remain in treatment for as long as they benefit from it. The continued use of heroin, while it should be discussed, is not necessarily a reason to terminate treatment … Evidence suggests the benefits are maximised when the patient remains in treatment for at least twelve months23 (Drugs & Poisons Unit 2006, 32).

Such views are now accepted internationally – as represented by such organisations as the World Health Organisation and the United Nations Office of Drug Control who jointly released a discussion paper stating:

For those individuals who are currently unable or unwilling to stop using drugs, treatment interventions should be directed at reduction of morbidity, disability and death caused by, or associated with, substance use. Reduction in risk behaviours associated with drug dependence is a credible goal (WHO et al. 2004, 9).

Addressing costs for clients and pharmacists – An argument for subsidisation

The use of methadone and buprenorphine in pharmacotherapy maintenance programs is internationally recognised as one of the most effective treatments for opioid dependence. Methadone has often been referred to as the ‘gold standard’ of opioid dependence treatment (Drugs & Poisons Unit 2006). Cost, it is here emphasised, should not be the foremost consideration when addressing issues of individual and public health. Nonetheless, given the noted cost savings associated with pharmacotherapy programs, MMT is also the most cost-effective treatment for opioid dependence. As the Standing Committee on Family & Community Affairs summarised:

A review of the effectiveness of MMT showed that, for every dollar spent on methadone maintenance, the community benefits by $4-$5 in reduced health care, crime and other costs … studies demonstrated that MMT reduced involvement in criminal activity and rates of imprisonment, and protected against HIV infection (but not against hepatitis B and C). NEPOD found that MMT halved rates of property crime, drug dealing, fraud and violent crime (2003, 154).

23 My emphasis.
The Costs and Benefits of Opioid Pharmacotherapy Treatment: A Literature Review

Studies that have examined the links between reduced criminal activity and involvement in treatment have found such links to be dependent on many factors, including the proportion of users who enter treatment and the length of time for which they are retained in treatment (Digiusto et al. 2006). The issue of retention is emphasised in numerous Australian and international studies. Gaughin and Solomon, for example, note that, while the efficacy of MMT has been widely demonstrated:

Its success in assisting opiate users to stop or reduce their use of illicit opiates, including heroin, by injection is contingent on continuing to take methadone. Unfortunately, many individuals remain for short times after enrolment … factors associated with retention of methadone programs in Australia have been comprehensively examined [although] there is less information about participant behaviour while on programs and associated program variables which, in turn, may influence retention (1998, 771).

A primary finding of this report is that one of the most influential ‘program variables’ is the dispensing fees clients are obliged to pay. As has been illustrated, there are numerous costs for those seeking to escape the cycle of illicit opioid addiction that are directly and indirectly linked to the spending of limited finances on dispensing fees. The greatest cost to pharmacotherapy clients is undoubtedly the loss of their place in a maintenance program and a return to problematic drug use and the chaotic lifestyle that typically characterises it.

It was estimated in 2003 that 65 per cent of clients are retained annually in maintenance programs (Clark et al. 2004). Given the negative impact of dispensing fees upon retention in programs, subsidisation would ideally go some way to addressing the financial burdens that negatively influence the retention of clients in maintenance treatment. The estimates of Clark and colleagues suggest subsidising opioid maintenance treatments for this reason alone. For example, if there was a 5 per cent increase in initiation of treatment, it is estimated that there would need to be an 8 per cent increase in retention for the related savings to match the cost of a $3 government subsidisation. Digiusto and colleagues reached a similar conclusion when discussing their findings in respect of the aforementioned links between a reduction in criminal activity and retention in pharmacotherapy maintenance treatment:

Given the increasing incidence of illicit drug use in Australia and New Zealand, the findings of the present study, along with the findings of other studies, suggest that the expansion of preventative interventions and treatment services for illicit drug use would represent a good social investment. The obvious question is, ‘Why, then, do our governments continue to limit public funding for these interventions?’ (2006, 186)

This question is given further emphasis by the reported satisfactory relationships between clients and dispensers in those jurisdictions that have been prepared to subsidise the cost of dispensing fees. In the Australian Capital Territory (ACT), pharmacotherapies are dispensed according to a tiered system. Clients on tier 1 (i.e. those to whom pharmacotherapies are prescribed and dispensed at ACT Health public clinics) receive their first 6 months free and then pay $15 per week (with the remainder subsidised by the government). Clients on tiers 2 and 3 pay $15 per week to a community pharmacist and the remaining cost is subsidised. The ACT Health Department makes the relevant
payments directly to the dispensing pharmacist. The satisfaction of participating pharmacists is reflected by the fact that 21 of the 23 pharmacies that were dispensing at the time data was published indicated a willingness to take additional clients (ACT Health 2005). In its request for tenderers for the development of best practice funding options for pharmacotherapies, the Pharmacy Guild of Australia noted of the ACT scheme:

> The client satisfaction survey conducted by the Pharmacy Guild of Australia in 2002 confirmed the belief that the arrangement in place in the ACT is beneficial to clients. It was found to assist them in the management of personal finances, having a positive impact on their treatment. The results of this survey also indicated that the conditions of payment were clearly understood and adhered to by the client group. Additionally, a high level of client satisfaction in relation to financial problem resolution was reported, increasing the overall satisfaction level for the provision of the services (Pharmacy Guild of Australia 2004, 6).

Such factors doubtless assist retention – particularly in light of the financial difficulties that dispensing fees present to clients who are reliant upon government income support. A small number of studies in the US have found that the elimination of fees substantially increased retention. Maddux et al. (1994) randomly allocated 152 illicit opioid users to a fee or no-fee status, the latter paying nothing for treatment, as compared to US$2.50 per day for the fee paying participants. It was found that retention was significantly increased when fees were eliminated. Of the fee and no-fee cohorts, 34 per cent and 54 per cent respectively remained in treatment after one year. Des Jarlais reported similar findings when comparing publicly funded and private methadone clinics in New York City in the 1975-76. The publicly funded clinics recorded retention rates of 58 and 59 per cent over the two years as compared to figures of 37 and 38 per cent in the private clinics (Des Jarlais 1982). In countries such as Canada, the United Kingdom and New Zealand, no such comparisons have been made given that government funding of pharmacotherapy programs incorporates dispensing fees (HMA 2007).

In Victoria, the notion of subsidising opioid dependent clients dispensing fees has attracted some attention for groups considered at high risk of discontinuing treatment and relapsing into illicit heroin use. In 2004, as part of the Victorian Government’s Drug Initiative, funding of $453,500 was allocated to subsidising the dispensing fees of those aged 18 years and under and of those Juvenile Justice clients covered by a community-based order.

In June 2007, Healthcare Management Advisors (HMA), who successfully tendered for the aforementioned Pharmacy Guild of Australia project to examine funding options for dispensing of pharmacotherapies in community pharmacies, released its final report. Three potential funding models were trialled to investigate the hypothesis ‘that the cost of treatment affects the client treatment outcomes’:

- Model 1 was trialled in two pharmacies in Victoria. A subsidy of $2.50 was paid and normal service delivery continued;
- Model 2 was trialled in two pharmacies in South Australia and involved the subsidisation of the full dispensing fee to specifically assess the impact of eliminating the client payment;
Model 3 included a $2.50 subsidy and the two participating pharmacists in NSW received a $50 incentive payment to provide an enhanced care component developed in consultation with a representative of the Australian Injecting and Illicit Drug Users League (HMA 2007).24

Unfortunately, the trial involved only six pharmacies across three states and ran for only three months. Further, just 92 consumers chose to participate given the rigorous procedures that required completion prior to participation (see HMA 2007). Thirty consumers from Victoria participated with 26 completing the trial (84 clients in total completed the trial). Of the 84 participants who completed the trial, 62 (73.9%) received a pension or ‘temporary’ benefit as their main source of income (HMA 2007, 72).

Despite the short time frame of the trial and limited numbers of participants that comprised the trials, the findings do indicate positive outcomes as a consequence of subsidising dispensing fees. There was a high, statistically significant improvement in perceived health status across the three groups. It was suggested that this could be attributed to the availability of more money to spend. Indeed, 95 per cent of clients indicated that the trial had a positive impact upon their finances, including the ability to ‘save money’, ‘spend more money on food’, ‘pay off their debt’ and buy clothes (HMA 2007, 82). Respondents in post-trial interviews also indicated less conflict with partners or spouses as well as with relatives during the period of the trial – a factor doubtless linked to the reduced need for financial assistance from those close to them. Overall, participants indicated that the trial had no impact upon their overall quality of life, but it had a positive impact upon their social life due to the availability of more money (HMA 2007). In respect of the hypothesis ‘that the cost of treatment affects the client treatment outcomes’ it was reported that there was improvement in clients’ health, well-being, social, treatment and economic outcomes. The greatest improvements were evident in the client group trialing the fully subsidised funding model.

In respect of the impact of the trial on participating pharmacists and their staff, the findings were also positive. Relationships were stated to have improved between staff and clients (33%) with 22 per cent indicating that staff “didn’t have to deal with payment issues with clients’ which aided relationships, enabling a focus on clinical care and improved time management (HMA 2007, 86). The trial had a statistically significant effect on decreasing levels of bad debt for all participating pharmacies. All funding models trialled resulted in greater financial returns for the pharmacies. The only negatives were the increased paperwork (which was, nonetheless, considered less time-consuming than arguing with clients).

It was apparent that both clients and pharmacists viewed some form of subsidy as effective in improving health and financial outcomes for clients and improving effectiveness and financial viability for pharmacists. The HMA project established considerable support for the

---

24 The enhanced care component aimed to develop a process to deliver client and pharmacy focused support. It involved greater sharing of information and discussion of issues between dispenser and consumer. There is a distinct lack of information about this model in the Final Report other than to note that it was not perceived as beneficial to those who took part (HMA 2007). The evaluation of this model included this statement: “The impact of the enhanced care component in NSW appears to have been minimal. It should be noted, however, that only 14 of a possible 19 clients had the enhanced care form completed and, for most of these, it was not completed until late in the trial thus eliminating the opportunity to fully trial this option. Participating clients did not believe they had received an improved level of service (HMA 2007, 102)."
contention that the subsidising of pharmacotherapy dispensing improves outcomes as well as improved service for clients, and economic outcomes for pharmacists and their staff. The HMA report therefore recommended that:

Clients participating in pharmacotherapy treatment through community pharmacies be subsidised according to the following:

Option 1 to be full subsidisation based on an agreed maximum; or
Option 2 to be partial subsidisation based on an agreed maximum (HMA 2007, 104).

Examining the latter option, the HMA report stated that there was no definitive rationale for determining the level of subsidy but noted that most clients were comfortable making some contribution to their treatment (HMA 2007). Pharmacists supported the idea of some client payment as a means of ensuring the treatment was valued by the clients who were making some financial investment. As such, a subsidy of approximately 50 per cent ($2.50) of the dispensing fee was thought appropriate. Based on national pharmacotherapy figures, this was estimated to have a financial implication for federal health funds of $21 million (HMA 2007). Several stakeholders highlighted the option of utilising the PBS structure to provide clients with the dispensing subsidy in the same manner as utilised for other medications. The advantage of using this option is that it is already in place and understood by pharmacists and clients alike. Using the PBS and associated safety net provisions would also have the advantage of providing equity to clients given that different pharmacies charge different rates for dispensing pharmacotherapies – a variation of which many clients are aware and critical.25

The relatively short time span of the trial and the limited number of participants prevent authoritative conclusions being made as to the effect of subsidies on retention rates. However, given the improved outcomes for clients, not least financial outcomes, and the improved relations between pharmacy staff and clients, it is not unreasonable to expect positive improvements in retention rates as a result of such subsidies. Certainly, this rationale is accepted by the Victorian Government which, when reporting on the subsidisation of dispensing pharmacotherapies for all those aged 18 years and under, as well as those subject to Juvenile Justice Orders, noted:

This enables clients with limited income to commence and remain on the pharmacotherapy program, improving treatment outcomes (Victorian Government Department of Human Services 2002, 17)

The issue of pharmacy debt – and the possibility of involuntary removal from opioid maintenance treatment – is a serious problem. With the majority of pharmacotherapy clients being individuals with limited incomes, many clients are forced to seek emergency assistance or simply ‘go without’ in order to ensure continued treatment. However, while this reality should seem apparent, it has not translated into health policy reform.

25 According to one ‘Methadone Agreement’ clients were compelled to sign in order to receive methadone from a pharmacist in Melbourne’s eastern suburbs, the daily dispensing fee was $10 (as compared to a weekly payment of $35).
Consequently, the remainder of this report addresses the issue of dispensing fees and their impact on the lives of clients with limited income, as well as their dependents, as related by those so affected. It does so to draw attention to the urgent need for an alternative payment scheme to be introduced – in the interests of clients, dispensers and, ultimately, the broader society. While detractors may bemoan the cost, whether to State Government through Health Department subsidies to dispensing pharmacies, or to Commonwealth Government through reform of the PBS guidelines, either strategy would in fact represent a cost-effective approach. There is overwhelming evidence as to the success of maintenance programs in reducing the social and health cost of illicit drug use as well as lessening demand for emergency relief in areas such as housing and nutrition – relief is often sought by those on limited incomes who must prioritise their medical treatment over basic necessities. Of course, such savings are only achievable if those in need of opioid maintenance treatment can access them for the period required.

In the following sections, we turn to those who participated in this research, for theirs is the most compelling evidence for subsidisation that exists. The next section of the report provides background information about those who participated – it demonstrates the circumstances of hardship that defined the lives of the great majority of those in need of opioid maintenance programs. While much of the following section comprises statistical information from the surveys distributed during the second and third stages of the research, these statistics are placed in proper context by drawing on the words of those 60 participants who took part in unstructured discussions about their experiences as low-income earners engaged with opioid maintenance programs. These discussions, and the statistics they illuminate, dramatically illustrate a way of life, or a ‘lifestyle’ if you will, that no one should be compelled to live.
The 60 participants who were interviewed during the second stage of the research completed surveys as an interrelated component of the interviewing process. These surveys complement the interview data by ensuring that certain demographic and health characteristics, along with the types of pharmacotherapies used and at what cost, were provided, allowing these characteristics to be compiled as quantitative data. At the same time, interview data has been used to illustrate some of the findings of the collated survey data. Finally, the surveys provided some guidance for the interviewer who could refer to the survey data to note the type of pharmacotherapy a participant was taking and at what cost, whether their housing and nutrition were less than adequate and ask relevant questions around these issues rather than starting from a base of no knowledge of the participant.

A further 60 surveys were completed in the third stage of the research project – 30 in Frankston and 30 in Dandenong respectively. This survey was expanded, to include questions about participants’ experiences of opioid maintenance programs, questions about relationships with prescribers and dispensers, and questions about costs (e.g. additional medications, travel costs). Consequently, at times, survey data has been presented as a whole to represent the demographics, income and housing circumstances of all participants. At other times, the additional information gleaned from expanded surveys is presented separately. Further, some data from specific locations has been presented so as to highlight differences between the different areas in which surveys were conducted. However, caution should be taken when comparing the localised data given the small numbers of participants surveyed in each locality.

Methodological Issues

There were a number of methodological issues related to the collection of data. Participants who willingly take part in research activities may harbour suspicion as to the motives of researchers which may influence the accuracy of answers and, consequently, of research findings. Throughout the course of the research, a small number of participants expressed concerns about the confidentiality of responses. Although reassured about the confidential nature of the data and of guarantees of anonymity, such concerns may have had some influence on the manner in which they answered questions.
The validity and reliability of data may also have been affected by false reporting and/or the misinterpretation of questions. I sought to minimise this issue by working through surveys with participants when it was perceived as necessary. However, this assistance took into account the need to balance supervision with privacy given what were, in some cases, deeply personal questions.

Finally, it is important to recognise that both surveys and interviews capture aspects of a research participant’s life at a certain point in time (i.e. the time of survey or interview). Many participants live a transient lifestyle that involves constant changes to personal circumstances. In acknowledgement of this, surveys and interviews incorporated information about life history. Researchers are not in a position to predict future developments in participants’ lives. In this respect, it is necessary to keep in mind that the only perspective that can be obtained throughout the course of interview or survey is that of the present. The very process of sharing experiences about the past, particularly in the context of an interview, will impact upon the interviewee’s organisation and understanding of their experience. There is no fixed meaning in the past. With each new telling of an individual’s story, the context varies, the audience differs and, consequently, the story is modified.

Demographics

Gender

A greater proportion of males participated in the research project. Although in St Kilda, recruitment was roughly equal in terms of gender representation, only seven of the 30 participants in Collingwood were women (approx 23%), and nine of the 30 in Frankston were women (approx 30%). Following the completion of the second stage of research, women represented a third of the research participants. Participants in Dandenong, recruited opportunistically as they were in each location, were roughly equal (16 men / 14 women), resulting in a final gender balance that is a reasonable reflection of the gender balance of those on opioid maintenance programs in Victoria (67% men and 33% women).²⁶

Table 1: Gender

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>76</td>
<td>63.3</td>
</tr>
<tr>
<td>Female</td>
<td>44</td>
<td>36.7</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100</td>
</tr>
</tbody>
</table>

²⁶ Personal communication – Dr Malcolm Dobbin, Senior Policy Adviser, Drugs & Poisons Services, Department of Human Services (29 January 2008).
Age

Participants’ ages ranged from 18 to 62 years with a mean age of 34.7 years. Participants’ average age varied from locality to locality, from a mean age of 38 years in St Kilda, to 34.5 years in Collingwood, 32.9 years in Frankston and 33 years in Dandenong. Following the stage two surveys, approximately 20 per cent of participants were less than 30 years old. This rose to more than 30 per cent following the completion of stage three surveys. More than half (52.1%) of participants were in the 30-40 age range. For many illicit heroin users, it takes some years of experimentation before their use becomes problematic. As Dr Sherman, a general practitioner specialising in addiction medicine in St Kilda has observed, those who present for treatment at his St Kilda clinic do so after an average of seven years drug use (Drugs & Crime Prevention Committee 1998). While for many a crisis will prompt the search for treatment, for others gradual but increasingly problematic drug use or growing frustration with the chaotic lifestyle of dependent heroin use may prompt this search.

Initiation into injecting drug use occurs at a relatively young age. The mean average age of first injection reported by the 914 participants in the 2006 Illicit Drug Reporting System (IDRS) survey was 19.1 years of age, reflecting the findings of the previous year (NDARC 2007, NDARC 2006). In Australia, heroin or amphetamines are typically the first drug that the first time injector uses (e.g. Day et al., 2005; Crofts et al. 1995). That less than five per cent of participants were aged less than 25 (despite the eligibility of all those clients of opioid maintenance programs on income support aged 18 years and above), is indicative of a general trend to use heroin for some years before engaging in treatment programs.

---

27 One participant declined to provide their age.
<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>1</td>
<td>.8</td>
<td>.8</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>.8</td>
<td>1.7</td>
</tr>
<tr>
<td>23</td>
<td>1</td>
<td>.8</td>
<td>2.5</td>
</tr>
<tr>
<td>24</td>
<td>2</td>
<td>1.7</td>
<td>4.2</td>
</tr>
<tr>
<td>25</td>
<td>7</td>
<td>5.8</td>
<td>10.1</td>
</tr>
<tr>
<td>26</td>
<td>8</td>
<td>6.7</td>
<td>16.8</td>
</tr>
<tr>
<td>27</td>
<td>4</td>
<td>3.3</td>
<td>20.2</td>
</tr>
<tr>
<td>28</td>
<td>5</td>
<td>4.2</td>
<td>24.4</td>
</tr>
<tr>
<td>29</td>
<td>4</td>
<td>3.3</td>
<td>27.7</td>
</tr>
<tr>
<td>30</td>
<td>4</td>
<td>3.3</td>
<td>31.1</td>
</tr>
<tr>
<td>31</td>
<td>8</td>
<td>6.7</td>
<td>37.8</td>
</tr>
<tr>
<td>32</td>
<td>8</td>
<td>6.7</td>
<td>44.5</td>
</tr>
<tr>
<td>33</td>
<td>8</td>
<td>6.7</td>
<td>51.3</td>
</tr>
<tr>
<td>34</td>
<td>3</td>
<td>2.5</td>
<td>53.8</td>
</tr>
<tr>
<td>35</td>
<td>6</td>
<td>5.0</td>
<td>58.8</td>
</tr>
<tr>
<td>36</td>
<td>3</td>
<td>2.5</td>
<td>61.3</td>
</tr>
<tr>
<td>37</td>
<td>3</td>
<td>2.5</td>
<td>63.9</td>
</tr>
<tr>
<td>38</td>
<td>5</td>
<td>4.2</td>
<td>68.1</td>
</tr>
<tr>
<td>39</td>
<td>8</td>
<td>6.7</td>
<td>74.8</td>
</tr>
<tr>
<td>40</td>
<td>6</td>
<td>5.0</td>
<td>79.8</td>
</tr>
<tr>
<td>41</td>
<td>3</td>
<td>2.5</td>
<td>82.4</td>
</tr>
<tr>
<td>42</td>
<td>3</td>
<td>2.5</td>
<td>84.9</td>
</tr>
<tr>
<td>44</td>
<td>4</td>
<td>3.3</td>
<td>88.2</td>
</tr>
<tr>
<td>45</td>
<td>1</td>
<td>.8</td>
<td>89.1</td>
</tr>
<tr>
<td>46</td>
<td>3</td>
<td>2.5</td>
<td>91.6</td>
</tr>
<tr>
<td>47</td>
<td>2</td>
<td>1.7</td>
<td>93.3</td>
</tr>
<tr>
<td>48</td>
<td>2</td>
<td>1.7</td>
<td>95.0</td>
</tr>
<tr>
<td>50</td>
<td>2</td>
<td>1.7</td>
<td>96.6</td>
</tr>
<tr>
<td>51</td>
<td>1</td>
<td>.8</td>
<td>97.5</td>
</tr>
<tr>
<td>54</td>
<td>1</td>
<td>.8</td>
<td>98.3</td>
</tr>
<tr>
<td>56</td>
<td>1</td>
<td>.8</td>
<td>99.2</td>
</tr>
<tr>
<td>62</td>
<td>1</td>
<td>.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>99.2</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>.8</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
Education, Income and Accommodation

Over half (58.3%) of the survey respondents had not completed secondary school, although approximately 10 per cent had tertiary degrees and another 22 per cent had some tertiary study and/or had undertaken training in a trade or received a TAFE qualification.

Table 3: Highest level of education attained.

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>7</td>
<td>5.8</td>
<td>5.8</td>
</tr>
<tr>
<td>Some secondary</td>
<td>63</td>
<td>52.5</td>
<td>58.3</td>
</tr>
<tr>
<td>Completed secondary</td>
<td>13</td>
<td>10.8</td>
<td>69.2</td>
</tr>
<tr>
<td>Post secondary trade / TAFE</td>
<td>15</td>
<td>12.5</td>
<td>81.7</td>
</tr>
<tr>
<td>Some tertiary education</td>
<td>11</td>
<td>9.2</td>
<td>90.8</td>
</tr>
<tr>
<td>Completed tertiary education</td>
<td>11</td>
<td>9.2</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Three-quarters of participants listed government income support as their main source of income. However, 15 per cent of participants stated their main source of income was some form of employment. While employment was the primary source of income, the majority of these individuals continued to draw income support payments. Students and those six participants (all female) who nominated home duties were dependent upon the income of others (parents and partners) for living expenses (including payment of dispensing fees).

Table 4: What represents your main source of income?

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed full time</td>
<td>5</td>
<td>4.3</td>
</tr>
<tr>
<td>Employed part time</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>Casual / Occasional work</td>
<td>10</td>
<td>8.3</td>
</tr>
<tr>
<td>Income Support</td>
<td>91</td>
<td>75.8</td>
</tr>
<tr>
<td>Student</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Home duties</td>
<td>6</td>
<td>5.0</td>
</tr>
<tr>
<td>Other28</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

28 The single respondent who nominated ‘other’ specified involvement in sex work as her main source of income.
When the survey was revised to specify the type of income support in the third stage of the research (surveys conducted in Frankston and Dandenong), Newstart payments were shown to comprise nearly half of income support payments, while Disability Support Pensions were paid to 20 per cent of participants in these localities and approximately 12 per cent received Parenting Payments. A number were on Personal Support Programs that ensured a more intensive level of support for clients with special needs or who had been on income support for a lengthy period of time. For people on income support payments, the level of income received greatly restricts their ability to do any more than survive – and for those on opioid maintenance programs, even this becomes questionable.

I am on the PSP program which is Personal Support Program; it is the same as Newstart. I think after rent it is $280, $285 [per fortnight] I’ve been getting after rent.

Do methadone payments eat up a fair bit of your remaining money?

Sixty bucks a fortnight? I worked it out on my calculator that I only get about $4 something for a day, I have $4 a day to live on...

What other costs have to come out of your pay?

Everything, toilet paper, food, whatever the house needs. Like my kitchen is really dirty at the moment because I haven’t gone out and done a big cleaning equipment shop for a while, I need to go out and get the right chemicals and stuff like that. And electricity bills, gas bills, I recently cleared my gas bill but I still owe my electricity company a lot of money. (Neddy 30 years)

Trends in accommodation differ in each research location. Nearly 45 per cent of respondents in St Kilda live in rooming or boarding houses, reflecting the relative availability of this form of accommodation as the ‘least expensive’ alternative available to those on limited incomes.

| Table 5: What best describes your current living arrangements? (St Kilda) |
|--------------------|----------|-----------|
| Private rental (own) | 1        | 3.4       |
| Private rental (shared) | 3   | 10.3      |
| Public housing        | 4        | 13.8      |
| Friend’s house / flat | 1       | 3.4       |
| Rooming / boarding house | 13    | 44.8      |
| Refuge / shelter      | 2        | 6.9       |
| No fixed address      | 5        | 17.2      |
| **Total**             | **29**   | **100.0** |

Unlike public housing, many rooming and boarding houses charge rent that is, in some cases, not greatly dissimilar to rental prices on the private rental market – at least before the latter experienced its own recent increase as demand for rental properties continues to outstrip supply (e.g. Petty 2008). This obviously exerts significant pressure on the budget of low-income earners.
My boarding house rent is $223 [per fortnight].

That’s a fair chunk of your fortnightly payment – nearly half of it.

Yeah, well, I’ve never got behind … I did get behind at one time. I’ve dreaded that. Once you get behind, it’s so difficult to catch up. Once, I got a fortnight behind and I got time [to repay it], but had to pay the money, the $223 … and then keep $200, or try and keep the best part of it, for the next [rent] because they still dig in [for their money] … They like direct debit. It took me about … three payments to catch, but I had to scrimp, do you know what I mean? Virtually live on bread for that period, like, and that was just one [fortnight’s] payment, do you know what I mean? (Terry, 62 years)

| Table 6: What best describes your current living arrangements? (Collingwood) |
|-----------------|-------|-----|
|                | Number | Percent |
| Private rental (shared) | 5 | 16.7 |
| Public housing | 10 | 33.3 |
| Transitional housing | 2 | 6.7 |
| Friend’s house / flat | 3 | 10.0 |
| Rooming / boarding house | 2 | 6.7 |
| Squat | 4 | 13.3 |
| No fixed address | 2 | 6.7 |
| **Total** | **30** | **100.0** |

In contrast, a significant proportion (one-third) of those recruited in Collingwood live in public housing. As with rooming houses in St Kilda, public housing is one of the few available means of accommodation accessible for those receiving government income support payments. The different housing trends in different areas are a direct reflection of the ‘cheapest’ accommodation available. The greater proportion of Collingwood participants living in squats, transitional housing or with friends may reflect the fact that, while access to boarding houses is relatively immediate, the reliance on, and subsequent wait for, limited public housing in Fitzroy / Collingwood compels those waiting for a vacancy to live ‘rough’ or in temporary circumstances until a property becomes available.

Frankston shows less of a trend for accommodation, with a scattering of individual participants in private rental, boarding houses and living in situations of primary homelessness. At the same time, one-third of participants live in private accommodation, the largest proportion of any locality. The most represented accommodation type was public housing with, as in St Kilda, a third of participants living in government subsidised housing.
Table 7: What best describes your current living arrangements? (Frankston)

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private owner</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Private rental (own)</td>
<td>5</td>
<td>16.7</td>
</tr>
<tr>
<td>Private rental (shared)</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Public housing</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td>Transitional housing</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td>Parents’ house / flat</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>Rooming / boarding house</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>No fixed address</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Accommodation arrangements in Dandenong, as with Frankston, showed less of a trend, having a lesser concentration of boarding houses or public housing than either St Kilda or Collingwood respectively. Responses from Dandenong participants are notable for the fact that no participants reported having ‘no fixed address’. However, 30 per cent of respondents were living with parents (including a number of ‘older’ participants) or friends, suggesting a greater degree of reliance on informal support structures than in the other areas. Public housing and the private rental markets were the other main forms of accommodation among participants recruited in this area. It would be assumed that those in the private rental market were using a significant proportion of their income to pay rent.

Table 8: What best describes your current living arrangements? (Dandenong)

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private rental (own)</td>
<td>5</td>
<td>16.7</td>
</tr>
<tr>
<td>Private rental (shared)</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td>Public housing</td>
<td>8</td>
<td>26.7</td>
</tr>
<tr>
<td>Transitional housing</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Parents’ house / flat</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Friend’s house / flat</td>
<td>5</td>
<td>16.7</td>
</tr>
<tr>
<td>Rooming / boarding house</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Combined, the responses from all areas showed that approximately 50 per cent of participants were living in states of homelessness as defined by Chamberlain and McKenzie.29

29 Chamberlain and Mackenzie (in House of Representatives Standing Committee on Community Affairs, 1995) distinguish three levels of homelessness:

- **Primary homelessness** – People without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, or using cars for temporary shelter;
- **Secondary homelessness** – People who move frequently from one temporary shelter to another. Those experiencing such a degree of homelessness would include hostels and night shelters, refuges, and those staying temporarily with friends or family, or those using boarding houses on an intermittent basis;
- **Tertiary homelessness** – People who live in boarding houses on a medium to long-term basis. Such residents are often without kitchen and bathroom facilities of their own; their accommodation is not self-contained; and they do not have the security of tenure provided by a lease.
Table 9: What best describes your current living arrangements? (Combined)

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private owner</td>
<td>1</td>
<td>.8</td>
<td>.8</td>
</tr>
<tr>
<td>Private rental (own)</td>
<td>13</td>
<td>10.8</td>
<td>11.7</td>
</tr>
<tr>
<td>Private rental (shared)</td>
<td>15</td>
<td>12.5</td>
<td>24.2</td>
</tr>
<tr>
<td>Public housing</td>
<td>32</td>
<td>26.7</td>
<td>50.8</td>
</tr>
<tr>
<td>Transitional housing</td>
<td>6</td>
<td>5.0</td>
<td>55.8</td>
</tr>
<tr>
<td>Parents' house / flat</td>
<td>6</td>
<td>5.0</td>
<td>60.8</td>
</tr>
<tr>
<td>Friend's house / flat</td>
<td>9</td>
<td>7.5</td>
<td>68.3</td>
</tr>
<tr>
<td>Rooming / boarding house</td>
<td>21</td>
<td>17.5</td>
<td>85.8</td>
</tr>
<tr>
<td>Refuge / shelter</td>
<td>2</td>
<td>1.7</td>
<td>87.5</td>
</tr>
<tr>
<td>Squat</td>
<td>4</td>
<td>3.3</td>
<td>90.8</td>
</tr>
<tr>
<td>No fixed address</td>
<td>11</td>
<td>9.2</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

When explored from a gender perspective, a greater proportion of female participants have obtained public housing (36.4%) than men (21%). This reflects the greater vulnerability, and the consequent prioritisation, of women living in circumstances of primary homelessness – particularly if the women had children living with them.

Fifty-seven (47.5%) participants were parents. However, of those 57 parents, only 21 had their children living with them (29 per cent of male parents and 46 per cent of female parents). In the case of men, children were more likely to live with their other parent (the mother from whom the father had become separated). In the case of women, the overwhelming majority of those who had children living with them lived in public housing; this underscores the understandable prioritisation accorded to vulnerable families.

Table 10: Do your children live with you?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do your children live with you?</td>
<td>9</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>No</td>
<td>22</td>
<td>14</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
<td><strong>26</strong></td>
<td><strong>57</strong></td>
</tr>
</tbody>
</table>

Consequently, men were represented in greater rates in almost every other housing category. More than 20 per cent (21.6%) of male participants lived in circumstances of primary homelessness (as did 13% of women).
Table 11: Accommodation by gender

<table>
<thead>
<tr>
<th>Category</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private owner</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Private rental (own)</td>
<td>8</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Private rental (shared)</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Public housing</td>
<td>16</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Transitional housing</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Parents’ house / flat</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Friend's house / flat</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Rooming / boarding house</td>
<td>14</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Refuge / shelter</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Squat</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>No fixed address</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76</strong></td>
<td><strong>44</strong></td>
<td><strong>120</strong></td>
</tr>
</tbody>
</table>

Those women whose children did not live with them reported their children as living with extended family. Two had children in care while the children of four respondents had grown up and left home. The type of accommodation participants accessed had a direct impact upon their well-being. For some, it was contributing to their growing despair and depression, particularly if their accommodation was such that their children could not stay with them.

I live in a rooming house and I can’t have [my children] overnight and that’s absolutely devastating for them … and for me. It wasn’t so long ago that there was a reunification in place and they were going to live with me but we won’t go down that road … (Sage, 35 years).

The lack of hygiene and exposure to disease of those ‘living rough’ presents constant and significant health threats. Potential health threats that accompany street homelessness only add to the myriad physical and psychological health issues that already compromise the well-being of low-income earners on income support payments and, consequently, place greater financial strain on already limited budgets. Further, they not only inflict costs upon the afflicted individual but the public health system which invariably deals with resulting infection and disease.

I squatted for eight months last year during the winter, through the winter.

That would have been hard.

Yeah it was … when we first started we had to sweep all the pigeon shit away and drag a mattress up and stuff like that, in this little loft and we stayed there for a month and a half before we found a good squat (Perry, 40 years).

The circumstances of lives lived ‘on the street’ can greatly impede the ability to present at one’s dispensing pharmacy on a daily basis. The lack of security exposes squatters to potential (and real) violence, debilitating illness, possible eviction and the search for new accommodation, resulting in a transient existence that can be a substantial obstacle to daily presentation at one’s pharmacy.
Health

Physical Health

The health of participants is of significant importance given that complications may compromise their ongoing involvement in opioid maintenance treatment.

Table 12: In the past 12 months have you suffered any of the following?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>8</td>
<td>7.0%</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>23</td>
<td>20.0%</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>15</td>
<td>13.0%</td>
</tr>
<tr>
<td>Asthma</td>
<td>31</td>
<td>27.0%</td>
</tr>
<tr>
<td>STI</td>
<td>4</td>
<td>3.5%</td>
</tr>
<tr>
<td>No known problems</td>
<td>42</td>
<td>36.5%</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>21.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>148</strong></td>
<td><strong>128.7%</strong></td>
</tr>
</tbody>
</table>

Although over a third of participants reported no significant physical health problems in the preceding 12 months, more than one-quarter had suffered from asthma, whilst one-fifth had suffered from bronchitis in the 12 months preceding the survey. Further, those participants who did report ‘other’ physical health problems listed a broad range of concerns:

- Tooth abscesses and dental problems (x9);
- Pleurisy (x4);
- Flu (x3);
- Post-traumatic stress disorder (x2);
- Epilepsy (x2);
- Hirschsprung’s Disease;
- Facial surgery;
- Broken neck and related problems;
- Acquired brain injury;
- Physical injuries, including broken bones (the consequences of an assault);
- Renal failure / liver damage;
- Chronic gout;
- Chronic arthritis (knees and back);
- Alcoholism (and related ABI – Chronic short term memory loss);
- Bipolar syndrome;
- Nerve palsy;
- Spinal nerve damage;
- Prolapsed disc / sciatica;
- Benign pituitary tumour;
- Diabetes;
- Ovarian cysts;
Heart problems (past attack);
Irritable bowel syndrome;
Insomnia;
Anaemia.

The range of physical health issues reported is varied, ranging from relatively minor ailments to severe and ongoing ailments that require continued and sometimes costly medical care.

I am epileptic so I lose a lot of stuff. I’ve had a lot of fits in places. I have to move around a lot. Any stress and I start fitting. [I’m] bipolar as well [so am on] antidepressants. I have to pay for all my drugs for epilepsy; I had a fit two days ago... I’ve also got Hirschsprung’s disease which is a bowel disease.

I have no bowel and I got stabbed at one point so now I have no large intestine, nothing, so that’s really expensive as well because I get malnourished and stuff, so I have to take drugs for that as well. I’ve got to pay probably an extra 30 bucks a week in other medications.

So that’s $65 a week including methadone and meds?

It makes it worse because then I get more stressed out, more agoraphobic, more panicky and then I get bigger mood swings – even if I’m medicated – and then I have fits because I’m all stressed out about money (Helen, 38 years).

The need to pay for medications other than prescribed opioids consumes a significant proportion of some participants’ incomes. One participant in Dandenong who suffered from asthma and bipolar disorder spent approximately $80 each fortnight on medication. This included the following: Ventolin (salbutamol), Atrovent (ipratropium) nebuliser solution, Bricanyl (terbutaline) and Seretide (salmetrol and fluticasone) Turbuhalers for asthma; Valium (diazepam) (5mg as required), Cipramil (citalopram) (2 per day), Epilim (valproate) (700mg each morning and evening) and Zyprexa (olanzapine) (2.5 mg each evening) for treatment of bipolar syndrome and anxiety.30

Other participants also have to pay for care of dependents such as children. Whilst one sole parent was prescribed and paid for Seroquel, Valium and Panadeine Forte for his own mental ill-health, his son’s respiratory ailments required Ritalin and asthma pumps. The male in question was still waiting for approval for a carer’s payment. Such health needs are the source of further financial demands.

One of the main health concerns to arise from survey data was the inadequate diet that most participants reported with obvious consequences for the nutrition of those affected. Nutrition is a serious issue. Resistance to infection is impaired and recuperation from illness and injury is slowed by inadequate nutrition. When medical professionals talk about the health care needs of street-based injecting drug users there is a tendency to prioritise the

30 It is ironic to consider the moral judgements that accompany the use of illicit and, indeed, licit, opioids such as methadone and buprenorphine when one considers the vast legal pharmacopoeia that is prescribed and subsidised under the Pharmaceutical Benefits Scheme, particularly given that many legally prescribed medications mimic the psychoactive properties of illegal drugs.
issue of nutrition. In discussing these health care needs, Linda Kelly, a nurse with the RDNS Homeless Persons Program based at Access Health noted:

Nutrition is the first thing really because you can’t do anything else until people have got some sort of basic nutrition.

The average number of meals eaten by participants was 1.7 per day. Unsurprisingly, when asked if there were times they could not afford food, nearly 90 per cent of participants responded in the affirmative.

Would 60 bucks a fortnight make a great deal of difference?

Definitely. I can feed myself for a week on $60 … I could probably feed myself for two weeks on $60. it would make a huge difference, of course it would. (Sara, 26 years)

For the majority of individuals who participated in the research, emergency services were the primary source of food. The prioritisation of dispensing fees and the direct debiting of bills and rent meant that, for many participants money was exhausted before sufficient food could be purchased, leaving participants to rely on community services, theft or other measures in order to eat.

For me, it is probably more malnutrition rather than undernutrition – that’s because I’m making the wrong choices about food I suppose. Because my life is a bit hectic it means that I don’t always eat three meals and I often wake up without breakfast and come down here [to MINE] and get something [to eat] and then breakfast will then often last till dinner time. I don’t have the option to just go to a supermarket every day and buy exactly what I’d like.

I often eat a lot more healthily when I’m out of money because I’ll go to the bins at the markets and pick out the vegetables, fruit and vegetables, from the bins. You get a lot of good stuff there (Timmy, 33 years).

The issue of nutrition is discussed in depth below.

Oral Hygiene

One of the major complaints about opioid maintenance treatment – in particular, methadone treatment – is its reported effect on oral hygiene, or more specifically, the patient’s teeth.

My teeth. So the last two years, since I have probably been on a high amount of methadone, the highest I have probably ever been, being up to 80. I first got myself up to 80 and then it has taken so long to get down from 80. So my teeth have had two fillings in the last two years and prior to that, I hadn’t had any fillings in my life. So it really is eating into my teeth. I worry about that, because when I do get off methadone, hopefully in another year, I hope my teeth kind of hold up (Sandy, 37 years).
My teeth, it’s fucking eating my teeth away like nothing. I’ve lost all of them now, I had all them, then all of them broke, they busted in my mouth, but all these ones in the front up here, they just slowly fell apart from the inside … eating food every now and then, boom boom boom, spit out a couple of teeth, they just fall out, no pain, no nothing, they just fall out in big chunks, it’s unbelievable (Angelo, 34 years).

When asked if they were concerned about their teeth, a significant majority of participants replied in the affirmative.

Table 13: Are you concerned about your teeth?

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>88</td>
<td>73.3</td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>26.7</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Methadone, like all opioids, decreases the production of saliva which is important for oral hygiene. This requires extra dental care on the part of those in opioid maintenance programs if they are to avoid these side-effects.

I think if I brushed more often and maybe made sure my mouth didn’t dry out so much, I probably would have slowed down any deterioration or even stopped it, if I paid more attention to it. When you’re using, it’s more important, you know, more important things, nothing in your mind, your teeth aren’t hurting, you just worry about whether you’ve got drugs there. (Simon, 39 years)

However, for many clients, particularly for those struggling to manage drug use or living in situations of homelessness it becomes almost impossible to look after their oral hygiene to the degree required.

It’s easy to forget even though it is something I never forgot all my life and then when I started [methadone]. I just started to forget, that’s when I lost my job for being late to work. Anyway, the methadone definitely accelerated it … Last time I’d been to the dentist was ’94, I started [methadone] in early ’99 and after a couple of years, I started getting problems, toothache and teeth started to break, a couple of fillings I had from when I was younger (Simon, 39 years).

The greatest restriction on oral hygiene, as alluded to by Simon, is limited finances. Waiting times for public dental care are lengthy except in cases of emergency and private dentists are prohibitively expensive or unavailable. Consequently, despite their concerns, 40 per cent of participants had not seen a dentist in the two years prior to completing the survey. A further 22.5 per cent had managed to see the dentist just once – despite recommendations of a visit to a dentist every six months in the interests of good oral hygiene. For those on income support this is simply impossible.
Mental Health

In reading the survey data in respect of mental health, it is important to note that the listed conditions were self-diagnosed and that an individual's self diagnosis of depression and acute anxiety may not be supported by that of a medical professional. However, this is not reason to dismiss participants’ perceptions of their own well-being.

Table 14: Have you experienced the following over the past 12 months?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>11</td>
<td>10.4%</td>
</tr>
<tr>
<td>Depression</td>
<td>93</td>
<td>87.7%</td>
</tr>
<tr>
<td>Paranoia</td>
<td>45</td>
<td>42.5%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>93</td>
<td>87.7%</td>
</tr>
<tr>
<td>Panic Attacks</td>
<td>58</td>
<td>54.7%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>5.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>306</strong></td>
<td></td>
</tr>
</tbody>
</table>

Of the 120 participants, 106 participants reported mental ill-health, recording 306 instances. These participants reported significant (and equal) episodes of anxiety (87.7%) and depression (87.7%). More than half reported experiencing panic attacks. The conditions reported by research participants can affect their participation in opioid maintenance treatment in several ways. Some participants may not present for doses due to the effects of mental (or physical) ill-health as opposed to ‘not taking their treatment seriously’.

Usually my missed doses are about depression, I suffer quite severe bouts of depression and I just simply don’t get out of bed for days on end. Usually what gets me out of bed is the fact that I’m just so sick from not being dosed and that’s usually what budges me. There are other times where I’ve chosen not to dose because I’ve used drugs but usually if I’ve used I will still get my dose later in the day, usually missed doses is about my depression (Sage, 35 years).

Sixty-seven per cent of participants reporting mental ill-health take prescribed medication to alleviate the symptoms of their illness (while more than half (57.5%) acknowledged using non-prescribed medications for this reason). Approximately 26 per cent had been hospitalised for reasons of mental ill-health (e.g. a psychotic episode). For some, their financial situation was a contributing factor for their depression. With their limited income quickly consumed, many individuals are left with little opportunity to spend their time in any meaningful way. Entertainment tends to cost money and the prohibitive cost of public transport makes even a walk in parklands or along the beach a less than affordable option for those not within walking distance of such environments.

When you’re out of money, what does it mean in terms of how you spend your day?

I often do spend a couple of days in a row in bed because it does make me feel very depressed, it means that I can’t really do anything but sit at home or whatever. It does affect me socially. (Sara, 26 years)
Blood-borne viruses

Confirming research into the prevalence of hepatitis C amongst injecting drug users, a significant majority reported testing positive – although a small number had since cleared the virus from their bodies. Two individuals had never been tested.

Table 15: Have you ever tested positive for hepatitis C?

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>85</td>
<td>70.8</td>
</tr>
<tr>
<td>No</td>
<td>33</td>
<td>27.5</td>
</tr>
<tr>
<td>Never been tested</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

More than 20 per cent of participants also reported having tested positive for hepatitis B, whilst a small number had not been tested. Perhaps one of the most worrying aspects in relation to hepatitis B was the fact that many participants (38%) had still not been vaccinated against the virus as evident in Table 17.

Table 16: Have you ever tested positive for hepatitis B?

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>23</td>
<td>19.1</td>
</tr>
<tr>
<td>No</td>
<td>86</td>
<td>71.6</td>
</tr>
<tr>
<td>Never been tested</td>
<td>11</td>
<td>9.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 17: Have you ever been vaccinated against Hep B?

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>63</td>
<td>52.5</td>
<td>53.4</td>
</tr>
<tr>
<td>No</td>
<td>45</td>
<td>37.5</td>
<td>38.1</td>
</tr>
<tr>
<td>Immune after already contracting</td>
<td>10</td>
<td>8.3</td>
<td>8.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>118</strong></td>
<td><strong>98.3</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

HIV infection was not a reported concern of research participants.
Participants’ opioid maintenance programs

A significant number of participants had tried different forms of opioid pharmacotherapies in the past – many moving from buprenorphine to methadone or from methadone to the buprenorphine / naloxone combination and back. Table 18 reveals the extent of variation between pharmacotherapies by the 120 survey respondents. Few participants were comfortable or satisfied with their initial pharmacotherapy experience and several tried alternatives in a bid to find which treatment option best suited their needs.

Table 18: Have you ever been prescribed the following?

<table>
<thead>
<tr>
<th>Pharmacotherapy</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>98</td>
<td>81.7%</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>85</td>
<td>70.8%</td>
</tr>
<tr>
<td>Bupe / Naloxone</td>
<td>45</td>
<td>37.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>228</strong></td>
<td></td>
</tr>
</tbody>
</table>

Whilst a large majority of participants have been prescribed methadone in the past, more than 70 per cent have, at one stage, been prescribed buprenorphine. Given its relatively recent introduction (April 2006), it appears prescription of the buprenorphine / naloxone combination has gained considerable favour among prescribing doctors with in excess of a third of research participants having been prescribed the medication either currently or in the past.

It is important to note a significant discrepancy between the findings of surveys completed in Frankston and those in other locations. Data from locations other than Frankston shows a majority of participants had been prescribed buprenorphine or buprenorphine / naloxone, yet little more than a quarter were prescribed these opioids in their current maintenance program and just 11 per cent continued to receive buprenorphine in its initial pharmaceutical composition (i.e. as buprenorphine alone).

Table 19: Which pharmacotherapy are you currently prescribed? (locations other than Frankston)

<table>
<thead>
<tr>
<th>Pharmacotherapy</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>61</td>
<td>67.7%</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>10</td>
<td>11.1%</td>
</tr>
<tr>
<td>Bupe / Naloxone</td>
<td>18</td>
<td>20.0%</td>
</tr>
<tr>
<td>Completed</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>90</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

In contrast, a majority of respondents (43.3%) in Frankston were being prescribed buprenorphine. A number of participants in St Kilda, Collingwood and Dandenong noted their prescribing doctors removing the option of buprenorphine without added naloxone given the propensity for its diversion. However, some doctors in Frankston were continuing to prescribe buprenorphine in its pure form and a majority of participants in this area acknowledged diverting for later intravenous use.
It is important to note that a majority of participants in the other areas of research were prescribed pharmacotherapies at specialist primary health care services established specifically to treat intravenous drug users and other marginalised members of their local communities. Consequently, their opioid maintenance treatment is overseen by doctors who are specialists in drug and alcohol treatment. Doctors at such services act from a base of specialised knowledge, in consultation with other staff members such as drug and alcohol counsellors and nursing staff. Frankston does not have such a facility – participants were recruited via the area’s primary NSP as opposed to the aforementioned primary health centres in St Kilda, Collingwood and Dandenong. Research participants in Frankston may have been patients of one of the two private GPs who prescribe opioid pharmacotherapies in the area. These GPs may not have the multidisciplinary support and expertise of other drug and alcohol workers to draw upon when writing prescriptions for clients of opioid maintenance programs in Frankston – a number of whom spoke of demanding buprenorphine and refusing to accept any alternatives. Alternately, they may be seen at the Peninsula Drugs and Alcohol Program (PENDAP) where such experience and advice is available. Certainly, the disparities are worthy of further investigation outside of the scope of this report.

| Table 20: Are you currently prescribed? (Frankston) |
|-----------------|-------------|----------|
| Methadone       | 9           | 30.0     |
| Buprenorphine   | 13          | 43.3     |
| Bupe/Naloxone   | 8           | 26.7     |
| Total           | 30          | 100.0    |

Once the figures for Frankston are taken into account, a different picture emerges. Of 21 participants being prescribed buprenorphine at the time of survey, 13 were in Frankston. This may have implications for diversion and related health problems in that location, given that a number of participants in Frankston acknowledged injecting their buprenorphine – a practice with potential health consequences that were addressed in section 5 of this report. Caution, however, is again advised against drawing definitive conclusions given that the numbers of persons surveyed is obviously not sufficient to do so.

When one compares the results of Table 18 to Table 21, which details participants’ current pharmacotherapy treatment, it appears that a majority of those prescribed buprenorphine or a buprenorphine / naloxone combination in the past have commonly returned to methadone treatment (or initiated it for the first time).

| Table 21: Are you currently prescribed? (Total) |
|-----------------|-------------|----------|
| Methadone       | 70          | 58.3     |
| Buprenorphine   | 23          | 19.2     |
| Bupe/Naloxone   | 26          | 21.7     |
| Street bupe     | 1           | .8       |
| Total           | 120         | 100.0    |
When asked about the cost of pharmacotherapies, there were a range of responses that reflected pharmacists’ discretion in charging dispensing fees. The greater majority of participants (72.6%) who were able to pay fortnightly did so at a rate of either $60 or $70 per fortnight. Those paying $50 fortnightly constituted the next largest group. A number of these individuals attended pharmacies offering the option of monthly (in reality, four-weekly) payments of $100. One participant was paying a daily rate of $7, hence paid $98 (listed as $100) per fortnight. The individual paying $160 had been unable to find a pharmacist willing to dispense pharmacotherapies to him given issues of debt. However, he remained addicted and given the greater availability of buprenorphine on the street than heroin in his local area (Frankston) he continued managing his addiction through use of diverted buprenorphine at a greatly escalated cost (that was nonetheless cheaper than heroin).

The disparity in the amounts paid for dispensing fees reflects, in part, the ability of pharmacists to set their fees and the manner in which they prefer to receive payment (i.e. daily, weekly, fortnightly or even monthly with differing levels of discount available). In addition, while some clients pay fees daily and some in respect of blocks of time, still others are paying off accrued dispensing fee debt combined with their regular payments.

<table>
<thead>
<tr>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>.9</td>
</tr>
<tr>
<td>$40</td>
<td>2.6</td>
</tr>
<tr>
<td>$50</td>
<td>15.4</td>
</tr>
<tr>
<td>$55</td>
<td>.9</td>
</tr>
<tr>
<td>$60</td>
<td>41.0</td>
</tr>
<tr>
<td>$65</td>
<td>.9</td>
</tr>
<tr>
<td>$70</td>
<td>31.6</td>
</tr>
<tr>
<td>$72</td>
<td>.9</td>
</tr>
<tr>
<td>$75</td>
<td>.9</td>
</tr>
<tr>
<td>$78</td>
<td>.9</td>
</tr>
<tr>
<td>$80</td>
<td>2.6</td>
</tr>
<tr>
<td>$100</td>
<td>.9</td>
</tr>
<tr>
<td>$160</td>
<td>.9</td>
</tr>
</tbody>
</table>

Total 117 100.0

What is apparent from the responses of those who participated in this research is that low-income earners in opioid maintenance programs are overwhelmingly living lives defined by poverty, poor mental and physical health and insecure (and often unhygienic) accommodation. This greatly compromises the chances of their being retained in treatment. Any move to alleviate the financial pressures they face, such as the subsidisation of dispensing fees for opioid maintenance programs, would go some way to addressing the continued removal of patients from programs due to their inability to pay associated fees. The cost of such an involuntarily removal is, more often than not, substantial as demonstrated in the following sections that draw from the experiences of research participants in their own words.
The Benefits of Opioid Maintenance Treatment

It’s given me time to do me housing ... I’ve got a hot shower, I’ve got a kitchen, I can cook something up, I’ve got a TV. Basic you know ... so [I’m] comfortable on the ‘done – I haven’t hocked anything that’s worth anything for [a long time], you know, it’s just out of the equation (Russell, 39 years).

The following sections of the report use the words of research participants to illustrate, in considerable detail, the costs and benefits of opioid maintenance treatment from the perspective of patients / clients of this treatment. Many of the contributors to this research certainly experienced significant, yet often avoidable, costs – financial and personal – as a consequence of engagement in opioid maintenance treatment. These are discussed in detail in following sections. As was made clear in the overview of research into opioid maintenance, the benefits of treatment are substantial; if there were no perceived benefits, it would be highly unlikely that participants would persist with their treatment when the financial obligations involved have such a detrimental impact on other aspects of their lives. Further, many of the problems associated with opioid maintenance treatment were directly related to difficulties that compromised their retention in treatment as opposed to the actual treatment program itself. This is more than apparent when speaking to those in treatment so as to appreciate their personal perspective, which is the very rationale for engaging with such individuals as contributors and, effectively, co-writers of the remainder of this report.

Stability

Stability is essential if those with chronic or problematic patterns of drug use are to move towards reintegration as a healthy member of society. Certainly, stability allows for a range of concerns to be addressed, such as housing and food security, along with health and family issues. At the least, it allowed participants to finally be in a position from which they

---

31 The respective descriptions of those enrolled in opioid maintenance programs as patients and clients are used interchangeably throughout this report. Much of the research (as apparent in Section 4 of the report) refers to clients of maintenance programs. A number of pharmacists use the word patients. However, it is interesting to note that those who did use this term saw themselves as having a role to play beyond simply dispensing pharmacotherapies – instead they considered their clients’ overall well-being and responded to any other health concerns of these clients as they arose.
could begin to address these issues. It was gratifying to hear that most participants found treatment to have stabilised what was, for many, lives of drug dependency characterised by extreme chaos, criminal activity and poor mental and physical health.

I am pretty positive about [the treatment] … It's kept me stable, it's kept me not using … unless I can't get my dose or something like that, no not interested. So it's worked in that way … (Helen, 38 years)

The overwhelmingly positive response in relation to the benefits of opioid maintenance treatment was the fact that it provided a measure of stability that the use of illicit heroin did not. Indeed, all of the positive aspects associated with opioid maintenance treatment were related to, or contributed to, the greater stability enjoyed by participants.

Methadone has done a lot of good …It gets me stable, I don't hang out, it gives me a purpose to actually get up and get out every day and I find once I'm actually out, I do things and that helps to eliminate the depression a lot – and it is keeping me out of the crime circuit (Cinnamon, 44).

The methadone … yeah it's made me stable, it's given me time to do me housing … I've got a hot shower, I've got a kitchen, I can cook something up, I've got a TV. Basic you know, I live comfortable [but] I'm not living [the high life]. I'm scratching, existing, surviving, like just existing … so I'm comfortable on the 'done – I haven't hocked anything that's worth anything for [a long time], you know, it's just out of the equation (Russell, 39 years).

I've only been on it about a month or so now. And, like, to be honest with you, you hear a lot of people out here dissing out programs and shit, like, this is the best fucking thing that happened to me. I'd only been using [heroin] about two years, and in that two years man, I've gone from fucking working at Crown Casino, living in a really nice rental joint to just lost everything mate. You know, sold all my friends fucking DVD players, sold all my own shit, to now, like for four months, I've been homeless and for two months of that I was using and I thought, 'look, now I've fucking lost everything. Fuck it, I think I might just try a program, and within two days I was like this is the best fucking thing I've ever done man. One, because I'm not spending all that money and two, I'm not looking for the dodgy, 'what can I fucking scam today?' and stuff. A lot of anxiety and stress has just been lifted off me fucking head, man (Damo, 26 years).

[Methadone] just makes me feel normal, I've gone back to school, doing me VCE. I used to be really, really, really anti-methadone, but when you use it properly it works well. (Dave, 56 years)

[Methadone] has obviously stabilised your life.

It has. It has enabled me [to work] – I had quite a large habit, especially with the methadone. Like a lot of rapid detox places won't even touch you. It is too much
methadone in your system. It is okay for people who have had a high heroin habit, but I think when you have got methadone in your system (it’s not an option). So, my only option, I think, was methadone and it has stabilised my life in a lot of ways, it has been a really godsend.

As soon as I got onto the methadone, I stopped using, because I knew if I was going to do it – I had tried before and this time, I thought ‘no’, so I pretty much stopped the first day I started and that was two years ago. (Sandy, 37 years)

Sandy was working in a part time job, evidence of her new-found ability to address issues like housing, education and employment. This stability is integral to the rationale of maintenance treatment. An individual cannot even contemplate entering employment or education, let alone addressing the underlying issues that may drive them to ‘self-medicate’ with drugs, when in the midst of a dependency that consumes their waking hours. If pharmacotherapy removes the need to spend one’s day doing ‘earns’ and ‘rorting’, the ensuing stability provides the basis to move forward as opposed to constantly repeating the endless cycle of acquiring money and scoring.

I was losing the plot … You have always got something on. It is a stress. So I said I’d better get out of here before I go silly, you know. I was using heaps and heaps of drugs because of this [stress] and I needed help. I couldn’t get help [in St Kilda], ‘cause a lot of my friends used to bump into me and say, ‘do you want to get on?’ I couldn’t handle it ’cause my life was going downhill, I was in the gutter, I had to pick meself up and that is when I went to Sydney. I was fine in Sydney. I was doing a little bit of casual work, now and then. I was pretty happy and content with my life and after three years I come back to Melbourne and got on the program. Buprenorphine … that has stabilised me health. I am now sane, I am sane and I am happy about everything within meself. I think I am doing progress and I would rather be on the program than using stuff (Nick, 46 years).

[Recommencing methadone treatment last week was due to] a combination of things … I can’t afford it anymore and, oh … I don’t want to do it anymore. I am getting sick of it, being a pin cushion. Yeah, I just felt I had to do something and methadone was really the only thing that would help me, you know. I knew it would help me to stop using, that is the main thing, to stop using. And do other things … I will be forty soon and I have got to start thinking about the fact that I can’t run around like a young man anymore and … I have got to start thinking about doing other things in my life instead of using all the time (Dennis, 39 years)

---

A dependency on heroin – the most powerful physical and psychological painkiller – may grow out of its use to provide relief (albeit temporary) from depression, poverty and a life characterised by limitations and a lack of opportunities. The use of illicit drugs in this way is commonly referred to as self-medicating.
So there’s no compulsion or physical need to use? Methadone holds you?

Yeah, that holds me fine, and I’m busy doing school. I don’t really have time to whinge and go, ‘oh, me pain’, like it’s healthy. If you keep busy, you’re sort of not focused on, you know, rorting around town, working out ways to make money (Jamie, 41 years).

Ceasing illegal drug use

For many individuals, engaging in an opioid maintenance program effectively ends their use of heroin. A number of participants who reported remaining abstinent from further heroin use were on self-described ‘blockade’ doses of methadone, that is, a dose sufficient to bind to the brain’s opioid receptors to the degree that any additional opioids (i.e. heroin) have little if any of the desired effect.34

Methadone’s about five times stronger than heroin … that’s why it can be used as it is as a block. That’s why you can’t get stoned, unless you wanna go and buy yourself a weight [gram], you know? Who’s got four hundred bucks for one shot? You’re only wasting your money if you use heroin, because you can’t feel it. The methadone blocks it. If you’re on anything over eighty it’s called blockade. I had a shot just out of habit - when you get paid, you just go and score just to have it right? And I thought, what a waste of fucking money, you know what I mean? (Kristie, 50 years)

I’ve probably had two, three tastes in twelve months which I haven’t gone out [looking for]. I’ve had stuff in front of me which I’ve knocked back … I’m on a high dose, I’m on ninety [milligrams], I’ve been stable on ninety for probably twelve months. I was on a hundred and twenty five. But using is pretty much out of the picture … (Russell, 39 years)

I was probably anywhere from half a gram to a gram a day … or more. It was anywhere from about $250 to $600 a day. Which is why I needed that methadone backup [on a prior program when still intermittently using heroin] … [This time] I am not using anymore. I haven’t used for, almost, all the time I have been on methadone, I haven’t used and I suppose my expenditure for methadone, because I pay $100 a month, which means it is only $25 a week (Sandy, 37 years).

Some participants elected to be prescribed buprenorphine or buprenorphine / naloxone for the reason that the antagonist properties of these pharmacotherapies would place an additional obstacle to continuing heroin use. For some participants, this decision was based on their past experiences of using heroin on top of methadone.

33 Jamie suffered from continued pain as a consequence of a recent operation.
34 Although such doses are generally perceived to be anything above 80-90 milligrams of methadone, individual metabolisms determine the quantity of a blockade dose.
The Benefits of Opioid Maintenance Treatment

To be honest the last taste I had was about 10 days ago. The only reason I had it was because it was shouted [free]. I won’t go out and buy a taste, no way because I’d have to spend $200 anyway and I’m not going to go and spend $200 just to try to feel alright. I feel alright now so I don’t need to spend 200 bucks.

So the taste, did you feel anything of it on top of the Suboxone?

I missed [picking up my dose] that day. I didn’t pick up that day. I’d had it the night before and this was the next afternoon and I specifically waited for a bit [for the Suboxone] to come out of my system. Yeah I got something out of [the “taste” of heroin] alright, a headache and I felt shitty and a little bit depressed actually. I don’t know, I just thought that it wasn’t a good thing and it sort of turned me even further against it. Not so much the time or the money – like I said, it didn’t cost me anything – but it still does cost because I was sticking something in my arm [and defeating my intention not to use heroin]. If you think about it like that, it wasn’t worth it ... So yeah I don’t see the sense in [using heroin]. This [buprenorphine] is my dose, if you know what I mean, that’s how I work it out now. That’s my nudge for the day, so to speak, and since I’ve been thinking like that, I’ve been alright. I’ve got smokes in my pocket, a tram ticket, so there are differences. Usually I’d have nothing. I’d be coming here [to the Next Door clinic] to have a feed, a shower, [to] get a [transport] ticket so [heroin use] really doesn’t make any sense to me any more (Perry, 40 years).

I haven’t been feeling any of the hits I’ve been having which is only … since I’ve been on the program, like two months, [I’ve had] maybe two or three hits. I really haven’t felt either one, and I’ve kinda liked that. I’ve thought, ‘shit gear, why do I fucking bother?’ You know? It’s probably good stuff I just don’t even feel it, you know. (Damo, 26 years)

While these experiences of opioid maintenance treatment contribute to the relevant individuals’ commitment to maintenance programs, for others, opioid maintenance treatment does not mean ceasing all illicit opioid use. However, engagement in an opioid maintenance program ensures that those who, for a variety of reasons, are unable to achieve abstinence during the early stages of treatment almost invariably ‘use’ significantly less than prior to their engagement with the program – therefore, their engagement with an opioid maintenance program most often means an end to criminal activity and / or sex work given that one’s legitimate income, while low, can be sufficient to pay for occasional use. It is also important to acknowledge that any decrease in the use of illicit drugs is accompanied by a decrease in risky drug use practices.
Decreasing illicit drug use

As emphasised at numerous stages of this report, the longer an individual is retained in treatment, the greater the benefit derived. It is for this reason that knowledge of continued instances of illicit drug use is not considered sufficient reason to cease treatment (Drugs & Poisons Unit 2006). The fact that participants had reduced their use significantly despite acknowledging they are not willing, ready or able to ‘give up’ illegal drugs entirely illustrates a key factor in the support of opioid maintenance programs by organisations such as the World Health Organisation. Such an approach reflects a pragmatic acceptance that many of those on maintenance treatment programs, particularly methadone maintenance programs, may continue to use heroin – including participants in this research. This acceptance arises because, despite the ‘doubling-up’ of licit and illicit opioids, those who continue to use heroin considerably reduce their use. This allows those whose drug use patterns have changed from chaotic, constant and in some cases relatively frequent to intermittent use, to achieve a degree of previously unattainable stability. Thirty per cent of research participants were now completely free of heroin use. However, the remaining 70 per cent, while still using heroin, had all significantly decreased this use. This was of great benefit to their health and well-being, their stability and gradual reintegration into society. Given the accompanying cessation of acquisitive crime and / or illicit sex work needed to support an illicit opioid dependency, it was also of real benefit to the broader community.

For those who continued frequent heroin use, opioid maintenance programs reduce the costs of their heroin dependency by providing a ‘safety net’ in the form of access to legal opioids. Such individuals may use intermittently or frequently, while secure in the knowledge that the treatment remains available to them if they are unable to ‘get on’.

While I was with this other chemist, on my ‘done, I was still using so much and I guess I didn’t see the importance of picking up every day and not using … I’d only go like one day out of 3 just so I don’t get cut off … so that I still had it. I was the typical junkie, thinking, ‘oh, what about the days I can’t score?’ I need something to make me feel better. That used to be my frame of mind, you know what I mean? (Azure, 28 years)

My life has pretty much been crime involved and that so [I’ve] always had habits. You know, so [the methadone program] is sort of just go pick every three days, whatever, just so you can sort of keep on it in case you can’t [score] so you don’t [hang out]. In case you can’t get an earn or whatever and so you’re not sick … (Kristy, 50 years)

Without this ‘safety net’, those who continue to use heroin frequently may well resort to increasingly desperate crimes given their inability to acquire sufficient monies to meet the needs of their dependency through usual means.

I used to have a raging habit, hundreds and hundreds and hundreds of dollars a day. I was doing armed robberies, I got done for that. My co-accused went to jail for four and a half years. I fortunately got bail and while I was on bail I got myself into Odyssey House, I spent two years and two months there and got the maximum suspended sentence that you could get (Sara, 26 years).
It must be emphasised that those who use maintenance programs in this manner (i.e. as a ‘safety net’ to be accessed only when illicit heroin is unavailable or unaffordable) represent a minority of those on maintenance programs – certainly in the case of the 120 individuals who participated in this research. Even for those whose heroin use remains relatively frequent, maintenance programs afford a measure of stability; the user no longer awakes worrying about the need to obtain hundreds of dollars to satiate their dependency. Further, the requirement for clients to present regularly at pharmacies and receive their dose if they are not to be removed from a maintenance program ensures their continued contact with health professionals. Chemists are often aware of, and counsel clients against, continued heroin use if they wish to be retained as participants in the program at their pharmacy. Notification of continued use to prescribing doctors may lead to similar counselling with the intended effect of reducing the individuals’ illicit heroin use.

For the majority of participants in this research, heroin use had already decreased from a pattern of dependent daily use supported through illicit and criminal activities to a pattern of fortnightly use each payday as the following experiences illustrate.

The doctor’s guess was that my usage would have been probably around 30 to 50 milligrams of morphine [pills] roughly [a day] and I was also using [heroin] whenever I could at the time – probably about three or four times a week.

So now it is just once every so often?

Yeah like once a fortnight. But it is still too much; it should be only once a month if that (Neddy, 30 years).

I guess one of my main triggers for using is access to money so my drug use these days revolves around pay day once a fortnight. I have cut down my drug use so I will have a taste once a fortnight. That’s my treat for the fortnight. I guess I don’t prioritise things that well but even if I wasn’t spending that amount on my pay day I know I would still be short. I have a lot of other medication that I pay for as well and I’ve got an animal at home and big electricity bills (Sara, 26 years).

The use of heroin once a fortnight is obviously a far lesser financial burden than a high level heroin dependency. The dramatic decrease in illicit heroin use amongst those on the program was an oft-repeated theme in interviews:

I was using two or three times a day and could have been anywhere between 50 and 100 bucks every time. Half the time I couldn’t even tell you where half the money was coming from let alone the drugs.

Was it raising the money required that led to the jail?

Yeah. Getting out and doing this rort and doing that rort.

Is the methadone holding you? How often would you be using now?

I’ve got it down to once or twice a week. Considering I was using two or three times a day every day … (Will, 28 years).
It must be reiterated that the longer participants are retained in treatment, the less likely they are to use ‘street drugs’. The use of heroin as a fortnightly ‘treat’ admittedly consumed a significant proportion of participants’ low income — but it was obtained without resort to criminal activity. Those who might pass judgement on the use of limited income to buy illicit drugs should reflect on the fact that the amount of money spent is less than that spent by the average individual taking in a movie and a few drinks or a night out for dinner. For many research participants, the use of heroin represented the only means of recreation / relaxation known to them. It might be that gradual re-engagement with ‘mainstream’ society and mixing with networks outside of past associations with other drug users may take time. In this respect, it would be hoped that income support would be sufficient to allow individuals to engage in such activities as dinners out, a film and drinks or even a holiday on rare occasions. However, such is the level of income support that, for many, ‘payday’ use of heroin remains the only known form of relaxation and time outside of lives characterised by difficulty and disadvantage, if not the frequent discrimination that must be endured by injecting drug users. At a later point in this report, participants speak of the depression that accompanies an isolated and sometimes empty life when one does not have the finances to engage in any form of social activity beyond conversation. Recipients of income support are largely unable to engage in meaningful or enjoyable leisure activities of their choosing. The many without employment opportunities due to disabilities or ill-health are all too often compelled to spend their lives indoors staring at television screens / or walking aimlessly until night provided a cost-free purpose in the form of sleep.

When the issue of subsidising dispensing fees has been raised in the past, many individuals argue that those who can spend $50 of their meagre income to buy heroin cannot justifiably complain about dispensing fees in the range of $50-$70 per fortnight. This is to effectively argue that recipients of income support, who must pay for a health service that other members of the community receive for free, should refrain from any leisure activities that cost money — and there are few that don’t. Opponents of subsiding maintenance programs are obviously not aware of the individual circumstances of many of those in these programs. For example, they may be, understandably, unaware of the existence and value of supportive social networks that have developed alongside an opioid dependency of many years. This ‘positive’ aspect of one’s life as a dependent heroin user may not be easily dismissed and / or forgotten once opioid maintenance treatment begins. However, these networks also mean continued access to heroin. It should be remembered, nonetheless, that the dependent individual has taken a first step towards abstinence from illicit opioids and the longer the client is retained in treatment and encouraged during the treatment process, the far greater the likelihood will be that they do achieve the desired abstinence of all illicit drugs.

Azure, a mother of two in her late twenties, continued to use heroin each fortnightly payday:

*How much were you spending on gear when you were using.*

I was using at least a gram a day, about 400 bucks a day … I’ve always sold stuff I own to people or to cashiers or jewellers. I’ve never been one to go out and steal a handbag or go to a shop and steal something but like, if I was really desperate I’d go to Myers or something and you know [shoplift, but] rarely, really rarely. I wasn’t much of a rorter. I’ve always amazed myself with how much dope I’ve used.
I started when I was 12. I'm 28 now, where [did] all that money come from you know? I'm sure that's my choice, I've chosen to block out a lot of things I would have done when I was younger to get money you know ... (Azure, 28 years).35

The last line of the above underscores the point that maintenance programs reduce the costs and harm associated with dependent heroin use – particularly if $400 is needed each day to meet the costs. The fact that Azure has ‘chosen to block out a lot of things’ that she had done to make money is made more pertinent by the fact that she was introduced to heroin at the age of 12 by a 15 year old sex worker she befriended at a refuge in Wollongong, approximately 80 kilometres south of Sydney.

… without the methadone I don’t think I’d be able to not use, really. I still do spend a lot of my time thinking, god, I’d love a taste [of heroin] you know, things like that. I’m not ready to do the full yard and get clean, yeah, like, I think it’s a process I’m working towards, but if I can’t afford to pay the dispensing fees [for] my ‘done and [the pharmacist] goes, you know, ‘I can’t dose you’, I’d be back to using but then I can’t afford it. So I don’t know what would come of that. I did stripping once when I was 15 for about 3 months. I hated it but I made a lot of money and had a lot of gear, got myself a little shack for like a week and shared with this chick but yeah man, if I earn money, I’m going to use more gear anyway you know - it’s an evil vicious circle man.

One definite pro [of methadone] is waking up in the morning feeling completely functional, getting the kids to school, things like that (Azure, 28 years.)

Azure’s struggle to achieve abstinence is one that many users in opioid maintenance programs struggle with. Her own words – ‘I’m not ready to do the full yard and get clean …it’s a process I’m working towards’ – best represent the struggle that many face. It is a struggle however, that they can address and a process that they can work towards given the stability afforded them by the treatment program. It is, as noted above, a first step, which requires retention in treatment and encouragement throughout the course of treatment if a client is to go the full distance and leave behind what may have been the only source of peace, serenity and a sense of self-belief (however temporary) that was found in heroin. For many, the main threat to that retention, and a distinctive discouragement to participation in maintenance programs is the prohibitive costs involved in remaining compliant with the treatment process. These obligations threaten the stability that may allow the underlying reasons for problematic drug use to be addressed, particularly if repeated use served as a form of self-medication. As her final comments illustrate so succinctly, despite her continuing struggle with drugs, methadone has afforded Azure (and her children) the stability needed to take care of basic family requirements. Without it, a rapid return to heroin dependency, financed by potentially dangerous income-earning opportunities, may soon come to characterise her subsequent lifestyle. The likelihood of her family – two dependent young boys – experiencing the care and stability of a household in which their needs were prioritised would be unlikely at best.
What is made apparent by the experiences shared in this research, is that the key factor in whether or not an opioid maintenance program is of benefit is the necessity of a commitment and genuine desire on the part of the individual participant to use the opportunity to change their lives. A small minority of those individuals who contributed to the research did not want to stop using heroin, and, for these people, methadone maintenance is still of benefit; it serves as a ‘safety net’ in that it allows access to opioids if they are unable to ‘score’ due to a lack of either money or availability of heroin. To keep this safety net, however, they must not miss presenting at their dispensing pharmacist for three consecutive days and they must continue to see their GP in order to have scripts written. This, at the least, ensures that they remain in contact with health professionals.

It is the individuals who share a genuine desire to discontinue all illicit drug use who have the most chance of success in using opioid maintenance programs to remain abstinent from further illicit heroin use and, potentially, abstinence from all opioids.

Before the methadone, how much money were you spending on smack?

Oh anything from two to four hundred a day. Every day… fuck yeah, through the roof.

How long have you been on methadone for?

About two and a half years, three years now. I got on it, went up to a hundred and twenty mls and, from there, thought, ‘fuck, I don’t wanna get stuck on this.’ I had met a couple of other people that had been on it [for] ten, fifteen years and mate they just looked fucked, fair enough, since then I’ve lost all me teeth and everything else, but I sort of accepted that. When I got on, I got on it [and] fucked up. I wasn’t ready to give up smack, so I basically jumped off and got back on the gear …

I got back on the methadone and this time when I got back on it … I think everybody goes through a phase [when they’ve just had enough], I just told my Dad this morning, you don’t notice it until you’ve gone through it and it’s just … I don’t know why but every night I ask myself, ‘why do I fucking use that shit, why do I fucking use that shit?’ Then one day I woke up and I was just so over it, so against heroin and, yeah, since this day, two and a half years [ago] I haven’t even had a shot on the sly, kidding myself you know saying, ‘oh, I’ll just go and have one for, fuck, old times’ sake, been there done that, don’t want nothing to do with it, I hate it [and] while I stay like that it’s good for me … No heroin – that’s my definite aim (Angelo, 34 years).

Angelo’s comments show the benefits of the continued treatment of individuals such as Azure who struggle to remain abstinent from illicit drugs. As he notes, ‘everybody goes through a phase’ in which they realise a lifestyle defined by the demands of a drug dependency can no longer be endured. Azure notes this is a process she is working towards. While Angelo initially struggled and ‘fucked up’ his first methadone program, he reached the point Azure is working towards. The case for continued opioid maintenance treatment for those individuals struggling with their inability to abstain from illicit drug use could not be any more forcefully made than by the contributions of the participants above.
The Costs of Opioid Maintenance Treatment

So you often have a week or so with no money at all?

Oh absolutely, I have 12 days a fortnight with no money (Sage, 35 years).

[Maintenance treatment] takes up a lot of your day, because you have to worry about it. You are concerned about the money – If you don’t have it you are screwed, so you will often put that above [all else], it is kind of like your highest priority, above rent cause if you are sick, you can’t do nothing.

If you are getting unwell, you can’t do anything. So I will put it above the rent, put it above food, put it above everything else, you know. It is really fucked up, so to speak, and that is where a lot of the problems come in. The time and energy that you put into it, and the priority that you put into it, often stops you from having other opportunities and doing other things with the money. Do you know what I mean? You have so much emphasis and focus on [paying for treatment], it is so stupid (Benji, 25 years).

The dispensing fees for opioid maintenance pharmacotherapies are paid for by clients, while the overwhelming majority of other medications are subsidised by the Federal Pharmaceutical Benefits Scheme (PBS). For those surviving on a relatively low income – such as is represented by rates of government income support provided through Physical Disability Pensions or Newstart – the average dispensing fee of $60[^2] per fortnight represents a considerable proportion of one’s income. Just what proportion of their income this constitutes is contingent upon other costs including those of such necessities as accommodation. Such is the cost of accommodation in the property market that private rental prices have increased beyond the means of low-income earners (e.g. Schubert 2008). This may compel individuals to enter into income-raising activities that may be illegal and / or degrading – activities that they might never have contemplated but for the desperation of their personal circumstances.

[^2]: The mean average extrapolated from the figures in Table 22 was $62.70 per fortnight.
I pay a lot of rent – One hundred and ninety a week – to live in a boarding house [in St Kilda] … It is pretty good, there are good people there, there’s no idiots there. [I’ve been there for] four months … [My partner’s] at Hanover [emergency accommodation] and I’m [in the boarding house] because Hanover won’t have us both there, so we’re looking for somewhere together …

So once your rent is paid you’ve got about 20 bucks. How are you getting by?

[Sex] working, I have to work one night a week just to get an extra hundred bucks so I can get the dose, [my partner] knows all about it. I also can work with my cousin who is a cleaner and I get paid off the books with that so it depends on how I feel because I hate – not street work but I work in a parlour – but I’m not up to it anymore, I’m too old for it. So sometimes I work with her but I have to do like a 13 hour night shift to get enough and health wise I’m not up to it … I sometimes miss [my pharmacotherapy dose] because if I can’t afford it I won’t go. Probably once every two weeks, sometimes more often. I’ve never gone three days but I’ll go a couple of days and just hang out in [withdrawal] (Helen, 38 years).

As Helen notes, one of the reasons many clients fail to show for their medication every day is simply because they don’t have the money to pay for it. This may mean extremely unpleasant withdrawals for clients (as addressed below). For financial reasons, Helen misses approximately one day each week, although she is sure never to miss three days in a row. As noted previously in this report, if a client on methadone doesn’t present at their dispensing pharmacist for three consecutive days (or five consecutive days for buprenorphine clients) then the pharmacist is compelled by the Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence37 to refuse to provide a dose until the client has returned to their prescribing doctor and obtained a new prescription (Drugs and Poisons Unit 2006). The rationale of this requirement is that, given the client hasn’t been receiving their medication, the prescribing medical practitioner may need to reassess their situation and alter a dose accordingly. In reality, the frustrations inherent in repeating this process sees many postpone doing so and use the ‘window of opportunity’ for a return to a period of heroin use, free from the constraints and obligations imposed by the stringent regulations that accompany opioid maintenance programs.

37 In contrast, the National Clinical Guidelines and Procedures for the Use of Buprenorphine in the Treatment of Opioid Dependence (Abbreviated Version) stipulates that patients ‘who have missed more than one week of dosing should be re-inducted’ into treatment (Lintzeris et al. 2006, 9).
For those on limited incomes, financial obligations, including payment of dispensing fees, leave little, if any, disposable income. Some participants supplement their income in the only way they know. Jade, for example, continues to work St Kilda’s streets as a sex worker. As she matter-of-factly states, she simply couldn’t afford to pay for her accommodation if she didn’t.

I’m on Newstart so I get paid every second week on a Friday. It is $460 because I owe them money … I owe all this money [but] I’m not worried about owing Centrelink. I think [they take out] about 50 or 60 bucks. I [also] get rent assistance where I am because I’m paying $170 a week.

So, after the loan repayment comes out and rent is paid, you’re left with $120. Let’s take out the methadone 70 so that leaves you with 50 a fortnight. Are there other costs you’ve got to pay?

Well I smoke, so I buy a packet of cigarettes. Yeah I buy a packet of cigarettes on my payday. I buy a couple of [Vodka] cruisers or something just to have [to relax] and then I’m left with fuck all. So that [pay] day I look forward to, but it’s not a day I can have off [sex working] because if I pay my rent, the two weeks rent, I can’t sustain myself which means I have to get back out there [and work] which highly depresses me. Very occasionally, I’ll use [heroin] and I’ll do the wrong thing but usually I do the right thing because as long as I’ve got a roof over my head [I’m OK] … so you’re right, I’m left with 50 bucks at the end of it … Really how can you survive on that?

Do you use often on top of the methadone?

If I have to go out to work, which is generally twice a week, then of course I am going to use. I am not going to stand out in that fucking cold without having something first. I get my first hundred and I go and see my friend and then work the rest of the night, I usually only want to make 250. I am not out there to make a fucking fortune, I make my 250 and go home.

So basically if you weren’t working you wouldn’t be able to afford the methadone let alone anything else?

Exactly, I couldn’t cover the cost of my rent, I couldn’t cover the cost of anything, I’d be screwed … (Jade, 32 years).

If dispensing fees are not paid, those in treatment risk being denied further doses of maintenance pharmacotherapies. The consequences are potentially devastating; a stable client is ejected from the treatment that is the very basis of their stability and thrown back into a situation in which the needs of their ongoing – and potentially increased – opioid dependence must be met through other means. The costs to participants of opioid maintenance programs, whose financial obligations the majority of participants are ill-equipped to meet, are addressed in some detail at a later point. At present, however, it is important to note that the fear of such an eventuality leads many of those in treatment to prioritise their pharmacotherapy payments over all other living requirements – including food and accommodation.
If you’re stuck paying $6 a day and then if you haven’t got that [on one particular day], it’s like ‘nup, [no dose]’. That’s happened lots of times … and then you just realise you have to pay him and stuff everything else. I’ve gotten seven evictions in the last few years because it’s: do you pay the chemist or do you pay your rent? Being on methadone keeps me stable … at least I know I’ve got that. So to me, I will pay for that before I’ll pay for anything else. Try and explain that to someone – people don’t get it. They say I’d rather have a roof over my head – I can fight the [eviction] thing in court later but its how I am going to be today … (Rebecca, 38 years)

I can’t rest, cannot go to sleep until I know we’ve got the $12 [for my partner and my own dispensing fees] plus $2 each for a [train] ticket because we’ve got [public transport] fines already … So $16 just to get to the chemist and get our methadone (Jacqui, 31 years).

That’s the first thing I pay. Cause if I don’t have it [my methadone] I’m fucking [laughing], you know what I mean, if I don’t get my ‘done I’m ratsht, I can’t move, so I pay for that first before I pay for the rent [laughs]. You know what I mean, I put my priorities like that, where others might not I do, cause it’s something I need (Kristy, 50 years).

---

Food and families

One of the most common findings of the research was that participants rarely had enough money left for food of any kind – let alone an adequate supply of nutritious food. The greater majority of participants, as was observed in Section 6, survived on less than the standard three meals per day.

So money generally runs out?

Oh yeah. On the 2nd week before the next pay day I usually have no money.

So what does that mean in terms of living?

It means that maybe two out of seven days a week I won’t eat anything. I sometimes go to the food vans but that’s not always the most pleasurable experience. It means that I am not at the best health that I could be, I am probably quite underweight, I don’t eat very well at all simply because – it is not that I don’t get hungry – I just cannot afford to buy food most of the time (Sara, 26 years).

Well food is a luxury option that you don’t always get. I think I mentioned that, after a while, you realise that if you are not working, it is remarkable how much you can just get away with not eating (PJ, 35 years).

For some participants, this meant not just food for themselves, but for family members, such as children, dependent on them for the provision of such basic necessities.
We survive by going to the supermarket and, like, I had to knock off cooked chickens before … but that’s survival that’s about getting food to eat not coffee to change for money. That’s how I had to survive. When I had my son’s pram, you’d put stuff down the pram. I got busted with him in the pram and then you have the cops and take the kid and pram and everything up to the office and it’s a great big drama. Even when you’re walking out [without being caught], you’ve got that whole feeling of waiting for that ‘excuse me’ thing to happen, a tap on your shoulder. Now it is harder because you’ve got cameras and stuff. I don’t say it’s a good thing but it is survival and rather than go and rob a house and that … I am not justifying it, its just survival (Rebecca, 38 years).

As Rebecca’s observations show, one of the few means of accessing adequate meals is to steal food. This was a constant theme that arose.

Sometimes I grab 50 bucks off [my flatmate] and go do the shopping and that’s enough to keep us going for a week. I just have to keep my eye out for the specials and knock off a fucking thing of meat. I’ll put a roast down my pants and that’s good because you cook it up and have a nice meal and you have fucking sandwiches for the next week (Ade, 27 years).

As Sage indicates, for many drug use is not about simple choice. While illicit drug use occurs across all sectors of society, there are many reasons for the concentration of problematic and dependent drug use in areas of socio-economic disadvantage where opportunities for advancement are few. Poverty and the limitations it imposes on those who suffer it make escape, however temporary, attractive. It’s an attraction that few find able to articulate. However, the idea of simply being able to stop using something that gives relief from a life defined by hardship and struggle is an idea that rests on moralistic values as opposed to reality.
The Cost of Opioid Maintenance Treatment

…I know for a long time I’d be going alright [and not use heroin] and then I wake up in the morning and just feel that urge, you know, something on me mind. I’ve got bills and I don’t want to open the envelopes because I know if I open the envelopes, it’s going to sort of put pressure on me and start thinking about that [financial pressure] and once that happens and I start thinking about the other [heroin], do you know what I mean? To alleviate that sort of stress or problem or whatever it is. It’s still there anyway, but I do tend to do that. To push aside that problem and to sort of forget it (Terry, 62 years).

The additional burden created by maintenance program dispensing fees only exacerbates the poverty of many. For those with dependent children, further to ensuring the availability of food, they must meet the costs associated with adolescents’ burgeoning social and school lives. The inability to do so can leave parents feeling inadequate and distraught – their love of their children is no less than that of any loving mother or father – and many parents suffer greatly by ensuring their children receive all they need, even if it means going without for themselves.38

The other reason why I am coming off my ‘done is because I can’t afford it. I can’t afford 60 bucks a fortnight, do you know what I mean, that could be going towards food. My daughter needs new school shoes at the moment and yeah you just... it’s fucked. I’ve got to apologise to my kid some nights and say, ‘I’m sorry darling tonight we’re just having toasted sandwiches and an egg’ but she’s great, she goes that’s fine mum, it’s alright. I just say to her things are tight and they’re getting worse, because she’s getting older too. Like school holidays are on ... two of her friends rang her wanting to go out and so I said how much do you need and I know, well, what is it, 12 bucks to get into the pictures, 3.30 for a tram ticket, there’s 15 already, then something to eat and I tell her to go to Coles and buy her drink and that there, don’t buy nothing from the pictures. I said to her, ‘Alright Mia, I haven’t got a lot of money’ I said, ‘but we won’t be having much for tea tonight’. Like tonight we’ve got a bowl of soup and bread and some cheese so we’ll just have toasted cheese sandwiches again. Some nights she might have Special K [cereal] or something.

Yeah, like, my daughter loves cantaloupes … [crying] they’re $5 you know what I mean, we’ve just been living on fucking toasted sandwiches and a bowl of soup, we eat meat about once a week … one day last week I didn’t even send her to school because I didn’t have any lunch [for her] and I rang St Vincent de Paul and they were supposed to come on the Saturday but they didn’t come. I rang them Monday and they apologised and they still didn’t come, they came on the Tuesday. Oh yeah … things have been really tight. (Michaela, 48 years)

38 When the Family and Human Services Committee, chaired by the Hon Bronwyn Bishop, released its report A Winnable War following its inquiry into the impact of illicit drug use on families, accompanying media reports suggested drug addicted mothers ‘were desperate’ to get their children back from foster care ‘to get access to family support payments’ [my emphasis] (Packham 2007). The stereotype of drug dependent parents made explicit in such emotive and unsubstantiated judgments stands in stark contrast to the sacrifices many drug-addicted parents make to ensure their children’s well-being.
I have my son part time. I don’t get any family payment but I am still expected to look after him half the time. Family payment is worth 250 a fortnight, I don’t get any of that but imagine [supporting the two of us] on $85 [which is my disposable income for a fortnight]. If he wants to go to the pictures or something you can’t because that’s $30 … two tickets. I would be ruined. I spend all my money in that one week in school holidays everything’s gone and then the next week I come in here getting help to pay the chemist, if it wasn’t for Access Health, they’re the only people that ever help pay the chemist and before then it was like I would be in tears trying to get help somewhere to pay the chemist (Rebecca, 38 years).

The boys are eating so much food now … they’re both at school this year and the food intake’s gone up and we’ve had to buy lots of clothes this year and shoes and, like I bought both of them two pairs of shoes last month … it was like almost 200 bucks in four weeks on shoes, things like that. Because of the autism [suffered by one of my sons] I get an extra 100 bucks, but it’s only 100 bucks and a lot of that will go on schooling, school lunches. I’ve noticed nowadays – I’d just be happy sending him to school with a sandwich and an apple - but most kids are eating like cooked food and he’s missing out so like I sort of cook up spaghetti bolognaise and send it, then there’s even things like, man, I have to go and find new lunch boxes which cost like 15 bucks and then there’s school bags so yeah, financially, I struggle heaps man.

Kids always want to do things, like you see these ads and I do, I feel real bad, like he’s always asking [for something]. I can only ever get them a hot wheels car each on payday, they’re only like two bucks 60 or something but that’s like their treat because anything more and I’m, like, cutting into food money and shit you know. I try to do things, [but], like, I’d like to be able to lay-by toys but I can’t because I don’t have the money to put on the lay-by so it’s really unrealistic me going, ‘oh, I know you want that, we’ll go lay-by it’ because I’m going to have lost whatever money I do get to put on it anyway … Christmas time I really hate because the kids don’t get that much you know, they get one nice present each and pretty much that’s it. Then you see all these other kids … so like every Christmas for the last couple of years it’s been really hard for me because even the kids, you’d think their parents don’t have that much money, they’re getting really cool stuff and they get spoilt all the time and I’m like, we can’t buy you toys every week but kids don’t get that. Well if he’s got it, why can’t I have it? I always feel bad with stuff like that.

I just sort of go, look, bare necessities, you know, basic essentials to keep everyone happy and stuff like that but I guess because life has always been such a struggle I’ve just learnt to fucking just deal with it and get on with it. (Azure, 28 years).
The role of emergency services

The diversion of money from food and accommodation engenders a heavy reliance on emergency relief services provided by the likes of the Salvation Army Crisis Contact Centre or the St Vincent De Paul Society. Ironically, a number of such organisations have a policy whereby they will provide assistance for food and accommodation but strictly not for opioid maintenance dispensing fees. Invariably, they end up doing so as the money that might otherwise be spent on food or rent is diverted to dispensing fees only to be replaced by the financial outlays of these services for emergency food and accommodation assistance. The philosophical principles of such organisations may prevent them from providing assistance for pharmacotherapies, but the reality is that they do – albeit in an indirect manner which may salve their principles.

I have used [Access Health] and St Vinnies recently. They give you food vouchers and that's it. You get like 30 bucks worth at Safeway or Coles. What do you get for 30 bucks at Coles? Bigger all, yeah, nothing and you just can't get what I need to eat so I have to buy pretty much one day's worth of food maybe two.39

I'll eat, maybe, once every couple of days and I will just have fruit and stuff like that so I get a bit of vitamins in me, lots of fruit juice and that's it, yeah, so it's a bit hard (Helen, 38 years).

---------------------------------

I definitely [use emergency services]. I don't eat for days and, you know, as I said, just hit the services up and just know where the [soup] vans are going to be. You just get to know where they are and what times they roll up and that is the food that you survive on ... I just grab a few sandwiches and put them away for the next day and stuff, save some for brekkie or something. That is why I seen the nurse [at Access Health today] ... cause I tried to get some Sustagen ... some kind of [dietary] supplement (Mick, 42 years).

---------------------------------

How do you manage things like food and clothing?

Well this place, Access Help and the Salvation Army, this jacket I got from them, brand new with the tag on it. I got one for my partner the same, and the kids. All brand new. They give out food and fruit here. An old lady I know gets a lot of garbage bags full of left overs from Brumby's and she makes pots of soup up for my partner 'cause she knows he's sick. But that's on a really good day. I can go without food. I'm more worried about my partner (Jacqui, 31 years).

---------------------------------

... there's the Indian Sisters [St Mary's House of Welcome], there's the food van, and there's a Church up the road as well, Seventh Day Adventists. Yeah, I go to them on a pretty regular basis (Baz, 31 years).

---------------------------------

---

39 Helen has Hirschsprung's disease (a bowel disease) which means there are certain types of food she cannot eat. She also suffers epilepsy and severe, clinically diagnosed depression.
Because I’m homeless I’m really not eating that well at the moment, but it’s something that I hope, once I start renting again, and get a proper fridge and an oven and whatnot, then I’ll be able to. At the moment I’m just eating out of the soup van and going to the church for the odd meal and coming here [Next Door clinic] for breakfast every now and again (Damo, 26 years).

----------------------------

I come into organisations such as [the] Next Door [clinic], take fruit … often there’s fruit bowls around, take as much fruit as I can from those sorts of places. We have the food van come to my rooming house twice a week which is just an absolute godsend so I live on a lot of processed ham and cheese sandwiches. They fortunately drop off bread too and I usually find at least one wholemeal loaf and I live on lots and lots and lots of toast (Sage, 35 years).

----------------------------

I get food parcels from a place on Johnston street I think it’s St Vincent’s. I often get them from Next Door just here, St Marks occasionally, Home Ground, as I have a housing worker through Home Ground who sometimes brings round food parcels. I used to access food vouchers more than I do now. It is not as easy as it used to be to get food vouchers (Sara, 26 years).

Some services are not used by individual clients. This may be because, in the instance of the Sacred Heart Mission in St Kilda, the clientele is overwhelmingly male and some women admit finding the atmosphere intimidating. Alternatively, the Sacred Heart Women’s House does not allow males entry into the facility as it is a space established so that women, many of whom have been victims of male violence, are assured of safety from the aggression that they have experienced at the hands of men. This can leave young mothers with male sons in difficult situations, such as related by Rebecca below:

You used to be able to go to Sacred Heart but there are too many guys up there and my son is too old for that now. He doesn’t like it and he freaks out. You can’t take a 10 year old boy. We’ve had times where we’ve sat at the table and this guy is going to my son, ‘are you going to eat that bit’? They were eating off his plate – it’s not a place for kids. They do their best. It is so good that they are there because if you’ve really got nothing at least you can get a meal from there but its hard being a female going there. You’ve got drunks behind you they’re breathing down your neck. They’re invading your personal space. With kids they’ll [staff] often come over. I find with little kids they’ll bring you over some food but they can’t police everything.

With the Women’s House if you have a boy child you can only really have them there until [they’re] about eight years old so then you get that in between time and you can’t leave your child outside, you can’t say, ‘can you stay outside while I just go in for a minute’. I’ve had to do that, I’ve had to say to him stand at the door, because he’s tall for his age so he looks older. Its hard to go to the supermarket too and get [steal] bits and pieces that he will see, he’s really against that, that would be really bad (Rebecca, 38 years).
In other cases services were avoided because there was an expectation of certain obligations in order to receive assistance such as a meal.

*What about St Mary’s House of Welcome?*

They are good for food … but they make you pray. I don’t do the St Mary’s House of Welcome, because thank god I am atheist and I just don’t like the whole, beg for your supper… which essentially you are doing, being forced to pray, like a devout Christian (PJ, 35 years).

The health implications of a poor diet are obvious. In addition to poor nutrition, many participants in the research were already struggling with additional health problems as was made apparent in Section 6.

**Social isolation**

When one’s resources are insufficient to provide for even the basic (and universally expected) necessities of life such as food and housing, the idea of being able to afford entertainment or social interaction of most types is unrealistic. Social activities such as meeting a friend often require, for example, a transport fare and the price of a coffee. For many, days are spent in isolation – visiting a friend, the library, engaging in conversation or taking a walk provide the only means of relaxation or leisure.

*Food is difficult, what do you do for entertainment?*

Nothing, doing what we’re doing [talking], I mean, you’re more or less stuck. Home bound (Peta, 46 years).

----------------------------

I never go out. I don’t go to parties and all that. I am quite a reclusive, I think, in a way. I can’t afford to do the things that I would normally do if I was working … even to go window shopping is something I don’t do because it’s just a tease really. If you find, and you invariably will find something that you want, you can’t afford it (Matt, 42 years).

----------------------------

*What about money for entertainment, are things like the movies affordable?*

That’s when Friday nights become Friday nights, you know you just can’t party every day … we used to use [heroin] every day thinking we’d party every day sort of thing, but, well, that’s what weeks are structured around I suppose, what are you doing Friday night. So yeah once a week you go out and have a few, couple of shandies maybe, you know that’s about it but … ummm, you’ve really gotta be sort of working part time to really just get through (Russell, 39 years).

The sense of isolation experienced by some participants had severe implications for their mental health and increased feelings of marginalisation.
So financially, you get $445 a fortnight, pay about $200 a fortnight in rent, about $120 with all the medications a fortnight. How are you getting by?

It’s very hard mate. I really struggle, I guess having Anna and I together, it sort of makes it a little easier but we can’t enjoy ourselves, we can’t go to the movies or anything, we’re constantly under stress, we’re constantly worried, you know, and it’s not only with life. I mean I can work, you know I got a job there waiting for me but I just can’t, I’ve just lost my dad to cancer (Ray, 33 years)

While some are happy in their own company and others, such as Russell, budget to enjoy the occasional night out – for others, the inability to afford to frequent entertainment events or to take part in any activities due to a lack of money impacts heavily on their outlook.

**Denied pharmacotherapy**

Perhaps the greatest concern associated with levels of financial insecurity, is the awareness that once debt has been accrued, or even if a payment can’t be met for the first time, a dispensing pharmacist may refuse to dose a maintenance treatment client, a decision with dramatic consequences. Relating the need to prioritise her payment for her treatment above all else, Kristy spoke of this prioritisation on the basis of how ‘ratshit’ she would be if she were to miss her methadone dose. This was based, quite explicitly, on personal experience:

If I didn’t get the ‘done? Oh man, I wouldn’t be able to move, I’d be spewing, pissing, shitting, excuse the way I’m saying it but [out of] every orifice, you cough and you’ve gotta sit in the toilet with a bucket and like … you sweat. It’s just like hanging out [in heroin withdrawal], that’s exactly what it is, but you hang out worse. ‘Cause methadone’s stronger than heroin. Methadone is a lot longer [lasting], ‘cause with heroin, you inject it, so it’s straight in your blood, out through urine. It’s like cigarettes and alcohol because you ingest it orally it goes through every part of your body, so it has to come out of every part of your body, right? So sometimes it takes longer to start hanging out badly because you’re using the reserves you’ve got, like when I was on a 150 mls, I came down five mls every three days, and I got to 50 and I never felt a thing cause I’d built up so many reserves in my body … unless you do a marathon, you’re not using 150 mls worth a day. So it drew out all [the body’s stored reserves], that’s why I never felt it. My doctor kept saying are you alright, you know? I said yeah I’m fine, I felt nothing … Never felt a thing, because it builds up in your body so it takes you longer to really start hanging out,

It can sometimes take up to a week and then when you do [feel it], you’re a lot sicker, cause methadone’s about five times stronger than heroin …[laughs] (Kristy, 50 years).

---

40 The manner in which debt, or the inability to pay for a dose on a particular day, is resolved is dependent upon the individual pharmacist and their past experiences, personal values and relationship with their client / or patient (i.e. whether they are perceived as a client paying for a service or a patient of a health professional) – an issue addressed further below.
I’ve missed now and again but I missed on this [occasion when] I was on 125 [mls of methadone]. I’ve been 130 for about month and I missed one day and it took me a week to recover. One day [and] I was sick for a whole week, even though I was still getting it into me, one day just devastated me. Just hanging out, just full on hot and cold sweats, just going through like minor withdrawals yeah. I hate to say but about 18th, 19th hour [after dosing] I can feel it [wearing off], because I have mine, because I don’t like it, I don’t want to have it, I don’t have mine until the evening … (Peta, 46 years)

For some participants, unforeseen circumstances prevent them getting to their dispensing pharmacist within opening hours. Imagine, for example, a flat car tyre on a return trip from the country, still some distance from your dispensing pharmacist as occurred in the instance of one research participant. The potential for unexpected events to prevent patients contacting their dispensing pharmacist and having no access to a legal alternative was raised by a number of participants. The need for some form of back-up, whether a central register at a public hospital or arrangements with 24-hour medical clinics that would allow dosing of clients (with the pharmacists’ consent) requires some thought. The potential for a patient to not receive their medication, through no fault of their own, is very real given possibilities of vehicle breakdowns and accidents, parental responsibilities and other unexpected obligations that can arise without notice. The consequences of such an event taking place certainly justify closer attention to this issue. Although not the focus of this research, the consequences of inadvertent failure to procure medication from the pharmacy with which a participant is registered was a subject that arose often and needs to be addressed as a matter of some priority – particularly given that, at present, the only alternative means of staving off withdrawal are illegal.

In addition to unexpected occurrences, some participants found that their physical ailments prevented them from getting to the pharmacist. Bob has chronic and painful arthritis in his knee joints and back. He suffers the effects of severe kidney damage and is in treatment for clinical depression. He recalled one period during which he could not make it to his dispensing pharmacist, literally across the road:

It was [a matter] of getting up and getting over to the chemist, [but] before I had [taken] any form of pain relief, it was nearly impossible to get over there. They talked about takeaways, but I hadn’t been on [the program] long enough, you have got to be on it for three months or something before you can get takeaways.

So on occasions, you couldn’t make it three days in a row? What were the consequences of that? Withdrawal?

I got very, very sick. Yeah, very, very, very sick. Vomiting every 35 minutes and can’t sleep and sweating and just tossing and turning in bed and just basically praying that if it goes away, I will never miss another dose. It was terrible. I have probably jumped off [due to an inability to walk to the pharmacy] three times at 140 [mls of methadone] (Bob, 39 years).

41 Those in opioid maintenance programs can qualify for take away doses after they have demonstrated they are responsible and committed to their treatment over a certain period of time in treatment. This involves submitting to urine screening tests among other obligations.
If unexpected sickness, or circumstances such as homelessness, render contact with the dispensing pharmacist impossible, withdrawal is inevitable.

I get pneumonia in the summer. I was squatting, this is a couple of years ago, I was squatting not far from where I’m living now and I couldn’t make it from Hoddle Street to Smith Street, I’d get to Wellington Street and I couldn’t walk up the frigging hill. That’s pneumonia or pleurisy … which comes and goes. So missing a dose, yeah I miss a dose ‘cause I’m too sick to walk to the chemist and that’s just the lungs playing up.

And what was the impact of missing a dose?

You don’t work rest and play, you do lots … lots of resting. Yeah, you don’t move around a great deal … I can do it once every fortnight, I can miss a dose but I do feel it. Some people, some people, ‘oh I missed it, oh I’ve gotta get to the chemist it’s the third day, this that.’ I don’t know how they do it, I personally don’t know how they do it but, you know, horses for courses, everyone’s got different metabolisms (Russell, 39 years).

It can get pretty severe. I had a period in February of [2007] where I actually had an internal infection. I was quite sick from that and couldn’t go to the chemist and I ended up 10 days without my Suboxone and I was a mess, I was actually sleeping in the hallway of my boarding house so that I could be next to the bathroom to get to the toilet, that was pretty horrific (Sage, 35 years).

Although there are a variety of reasons for pharmacotherapy clients failing to present at their dispensing pharmacy, the most common reason reported by research participants was the inability to pay dispensing fees. There is a belief amongst some pharmacists that many of those who do not present for treatment are not taking their treatment seriously … or are using illicit drugs instead. Such beliefs pander to stereotypical assumptions that characterise heroin users, past and present, as irresponsible and self-centred individuals whose short-term gratification outweighs their treatment obligations, despite these individuals having actively sought out treatment in a bid to address their illicit drug use. In contrast, there is significant evidence to suggest that many simply do not have the money to pay a daily, if not weekly, dispensing fee or have accrued existing debt to the pharmacist, and are unwilling to present to, literally in some cases, ‘beg’ for further credit in a manner that does little for one’s self-esteem. The consequences of being denied doses are addressed in the following section of the report.
Illicit drug use

One consequence of an inability to pay the dispensing fee required to obtain one's pharmacotherapy is that some individuals, rather than face the onset of withdrawal, will resort to using heroin. Indeed, a pharmacist may not be willing to allow a debt or, of the many that do, allow debt to increase beyond a certain point. However, many a heroin dealer will extend credit to a long-standing customer.

Have you ever got into a position where there has been no dose?

Yes, there's been a couple of times where I've had to come to places like [Access Health] to get a cheque made out to the chemist so I can get through ... there was the one time I actually couldn't do it and I went and got some heroin instead because I didn't want to be sick. I came back [to the treatment program] a couple of days later when I found money.

How did you find the money for the heroin if you couldn't find the money for the Bupe?

I got it on tick [credit] (Matt, 42 years).

I was about three days behind or something like that and I just said I can't pay you until pay day. [The pharmacist] said, unless you get the money I can't dose you, do you know what I mean? I was only there [on the program] about four or five days ... he was pretty ruthless. But that's the only other time I've been threatened with being cut off and had to get the money.

What do you do in those situations when you don't have a pay check coming in for a week?

Well I just have to go out and drive and get the money from somewhere do you know what I mean? Like you know what I mean, I've pinched something and got on [bought heroin], trying to survive the best way I can ... [On that particular occasion] I think I pinched something off some bloke that day, this was a few years ago now ...

I remember that was a Saturday morning when he wouldn't give me my dose and so I was only had to get through ... Saturday and Sunday and on the Monday morning, I went and seen the doctor and got back over there.

So you just looked after yourself for the weekend?

Yeah, I've been through that part having to go out every day shoplifting, you know what I mean, when you are running a bad habit, it's just hectic because you can't go to sleep of a night time, if you've been there you know what I mean. If you haven't got anything for the morning, you can't sleep properly the night time. You know, I'm going to be crook unless I earn ... (Terry 62 years).
[We owed the pharmacist] thirty bucks or thirty-five. Usually we pay them off and then they will give credit for a few times and then we will pay it off again, but this time …

_Are they saying that if you don’t pay it up, they will cut you off?_

Yeah, they have got all these things that you have to sign now. New rules and stuff about the bill, if you get behind … if you missed a certain number of days, we are going to chuck you off … a whole heap of stuff like that.

_So money is obviously a hassle, yeah?_

It is, yeah, it is usually just the money. I guess it is still cheaper to get bupe than it is to get on [buy heroin]. But it is usually easier to get credit from someone else [a dealer] than the pharmacy you know (Suzie, 32 years).

Obviously, while it is, initially, a short term means by which to deal with the disruption of one’s opioid maintenance treatment, there is the potential for the resort to heroin use to develop into a re-established dependency – particularly if the individual in question has missed three days of methadone doses at their dispensing pharmacist (five days for those receiving buprenorphine based pharmacotherapies). In such cases, clients must make an appointment to see their prescribing GP to acquire a new script on the basis that their opioid tolerance may have been affected and requires reassessment. However, in cases, one’s prescribing doctor may not be available. Helen found herself in the situation of her regular GP having gone on holiday without forwarding her treatment file to the practitioner entrusted with her ongoing participation in her maintenance program.

Now I couldn’t get any other doctor to see me because Doctor ____ wasn’t there to release my form and because I was honest from the get-go, I didn’t say I want to transfer doctors or whatever, I couldn’t get a fucking script at one point for three weeks. I started using [heroin] again – like hammer and tong, because I was on 60mls [of methadone] so I had to use [the equivalent of] 60mls worth [of heroin] a day – not to get off your face, you know, [just] so you don’t feel crook. Yeah, I was fucked. I was stuck in that rut again, having to [sex] work my arse off, pay all this fucking rent, do that [sex work and use heroin] (Helen, 38 years).

As Helen’s situation illustrates, turning to illicit heroin to counter the intense withdrawals of a sudden, involuntary cessation of treatment only to have problematic patterns of drug use redefine their lives is a very real danger. A return to criminal activity such as acquisitive crime and illicit (and dangerous) street sex work may occur at considerable cost to the individual concerned, while the potential prospects and opportunities afforded by the stability of the treatment program are lost. The costs of criminal activity will be borne by the community. The heaviest costs are intangible and are borne by despairing loved ones and family, whether mothers and fathers or sons and daughters or loving partners of the dependent individual.
Crime to cover costs

Given the potential consequences of not meeting the financial obligations of opioid maintenance treatment, some clients turn to increasingly desperate measures to ensure they are retained in their respective treatment programs.

A most unfortunate aspect of the need to pay dispensing fees reported by contributors to this research was engagement in minor criminal activity or sex work to ensure that treatment was not discontinued. This is, obviously, behaviour that opioid maintenance programs seek to counter by removing the continuous need for substantial amounts of money and replacing it with the stability of dispensed opioids supposedly affordable to those on the limited resources provided by government income support. However, those charged with determining the operational aspects of maintenance programs seem unaware of the difficulties faced by those on incomes below the poverty line who must meet the financial obligations of their treatment program along with paying for life’s other necessities.

I have been a working girl, so, at times, it has been a matter of going and doing a quick job. That way I can make sure that my medication is paid for ... My financial situation being so fucked up, if I am going for a walk [and] I have noticed something, an easy crime to commit ... I have ended up in trouble that way. The emphasis hasn’t been on doing the crime to get a drug. I am doing a crime to survive, because Centrelink just isn’t enough when you have got $50 going out in methadone payments. It is just not enough ...

It is me not surviving financially and methadone being a part of that. Because an extra $50 a fortnight is a lot. I am also trying to pay health insurance at the same time. I am just lucky I get a little bit of support from my family. But even with that, it’s not trying to live a life of luxury, I am just trying to survive ... and keep a roof over my head (Maria, 38 years).

----------------------------

You know, sometimes I have had to commit a crime to get the money and I don’t commit crime, but I have had to commit a crime to pay the chemist. So who are the drug dealers? I am not putting myself on a pedestal, but especially coming from a guy who doesn’t commit crimes. Like, if you ask me the question, Chad, when was the last time you committed a crime? I would say, well about three months ago, I am not going to say what. And then you say, well what for? I’d say I had to pay the chemist because he threatened to cut me off and then you ask me again and when was the last time you committed a crime before that? And I say, I don’t really know the times, but roughly a year before that and it was for the same reason and before that, I have done it three times.

I don’t commit crimes and I have committed three crimes in the last two and half years, and it is to pay my methadone, so that is pretty wrong. Especially cause after you have done the crime, if you have got a bit of conscience you feel sorry about it ... that is the bad part about it, you know. I really hated that, you know, [but] there was no other way out ... They are the times you are left in the lurch ...you know I could have ended up in jail (Chad, 47 years).

----------------------------
I know a lot of girls who would go back and work on the street. I mean, I personally can’t do that, apart from what I want to do in life, it’s just not a viable thing. A moral thing, a viable thing, it’s neither, it’s not for me. Although I have my ‘shopping’ [shoplifting] thing. I’ve just sold a lot of stuff [stolen shoes] to actually like, get $20 to, you know, like, just to live until next Tuesday (Jamie, 41 years).

-----------------------------

If you don’t get dosed, you will do anything to. The only other option is to use. And if you have got no money, you are going to walk out of that chemist and think, ‘fuck, I am not going to get through the night’. I am going to have to, you know will be walking past a cashier [ATM] and you will see a $50 note come out and you will just grab it and you will just run for dear life, you know what I mean? Or any easy target, you will walk past and see a laptop in a car, how easy is it to just smash a fucking window and walk off, people don’t even care. (Mick, 42 years)

Perpetrating such crimes, despite the circumstances, can lead to criminal convictions. Many participants have convictions related to their past involvement in acquisitive crime to meet the costs of their drug dependency. A further infringement, committed in a desperate attempt to keep on the treatment program and, ironically, avoid regular criminal activity or illicit sex work, may lead to incarceration – and the sense of hopelessness that invariably accompanies the loss of opportunity that had been afforded by active engagement with opioid maintenance treatment.

‘Liquid Handcuffs’

One of the major disadvantages of opioid maintenance treatment is that it requires frequent, if not daily, presentation at one’s dispensing pharmacist to receive prescribed medication. As a consequence, clients of opioid maintenance programs must ensure they are always able to present at their dispensing pharmacy for ‘dosing’. This has obvious implications for the ability to live a ‘normal’ life given that many pharmacists’ opening hours mirror those of other jobs that operate in accordance with standard 9–5 hours. Even for those who have qualified for takeaway doses, the ability to travel is greatly restricted. Asked about the negative consequences of being on methadone many participants cited:

The liquid handcuffs, not being able to travel. I’ve been around Australia but I haven’t travelled this decade … Melbourne’s me home town but I’ve been stuck here for seven years … cause I’m a single bloke, I can pack up and take off and, you know, it’s sort of left me a bit limited, a bit sort of grounded (Russell, 39 years).

-----------------------------

I wouldn’t recommend methadone to anybody on the planet, it’s like a chain around you, like a ball and chain, it traps you, you can’t go anywhere, you can’t move on. (Helen, 38 years)

-----------------------------
It’s being chained to the pharmacy. You can’t go away for the weekend spontaneously, there’s not much spontaneity in your life. You are bound to the chemist every single day of your life (Sage, 35 years).

It was an annoyance because I was working so sometimes, I couldn’t get it, because the chemist wasn’t open at 6.30 in the morning so I’d have to sneak away from work in the boss’s car and it would take me an hour to get to the chemist and have to wait and then race back to work, that was the inconvenience.

[I was on it] about two and a half years, three years and it was taking up the majority of my [time]… well, I thought it was, like the important stuff I needed to be doing, it was taking up that valuable time. [On] public transport it would take me an hour to get there, you’d sit down and wait, you’d run into people [you knew from your heroin using days] and that’s what I didn’t like … it made it hard (Perry, 40 years).

The whole day was based around it. If you left at a certain time in the afternoon then it would take you too long to get to the chemist before it closed, if you left after six you would miss being able to [get your dose]… Like transport on Sundays takes longer and at night it is actually on a slower [timetable) so there’s been times when I’d miss the chemist because I left at a certain time, after six, you wouldn’t think it would be too late to leave but it would end up being [too late] (Rebecca, 38 years).

For those who do want to travel, arranging to have their pharmacotherapy dispensed by another pharmacist can be onerous – involving, as it does, the necessity of the patient finding a new prescribing doctor and a dispensing pharmacist, even if the move is temporary:

I am doing the right thing, not using and doing everything by the book but you feel quite trapped with methadone, particularly travelling. You are trying to lead a normal life again and that is really hard. They can give you the option of transferring. Where, let’s say you wanted to go to Mt Isa; you have to transfer to Mt Isa. To do that, you have to find a doctor in Mt Isa that is going to [prescribe] it, because then you need to see a doctor before you pick up your first dose at Mt Isa. You need to find a chemist in Mt Isa and there may only be a couple of chemists in Mt Isa or a couple of doctors in Mt Isa, but you need someone who is actually going to take you on.

Generally they can’t, because they are full with patients. Same with the chemist and to do that you have to go to your doctor and you have to ring up your chemist here to let them know you are going away and then the next chemist that you are coming and a doctor in Mt Isa [to let them know] that you are coming and then you have got to go to that doctor as soon as you come to town, you know, to make an appointment, so you can’t turn up on a weekend, because he is not going to be open. So you have got to find a day that he has got to be there and you are going to be there and match all your flights up and it is just a nightmare. I have done it before … But it is a nightmare, it is an absolute nightmare, especially if it is Christmas or Easter which is when my family are interstate (Sandy, 37 years).
Travel Costs

A further financial cost borne by clients is the need to pay for transport to and from their dispensing pharmacist. At the time of writing, a Metcard daily concession ticket in inner Melbourne costs $3.50. If an individual is required to present on a daily basis, that adds up to $24.50 per week – for many the total transport costs are as much as, if not more than, the dispensing fees that they are obliged to pay.

At my old home, I could ride my bike there everyday but because I’ve been relocated and didn’t get much of a say, I’ve been put in the city of Darebin so I do have to get public transport every day… I didn’t realise it would be that expensive to buy tickets every day but it actually is (Sara, 26 years).

The main thing that’s been a problem is having to travel because we’ve been homeless and stuck in this bit of a loop. Now that I’m close by its no big deal I can get there and get it sorted out but that’s only been the last couple of months. We’ve been in Chadstone. Where ever we’ve been sent it’s been miles away and so its four hours out of the day, there and back.

You were in Broadmeadows for a while?

Yeah, then at one point it was Prahran to I think it was Thornbury … and I can’t [organise to] move chemists until I know where I’m going … (Helen, 38 years)

The costs of public transport lead some to seek to avoid the prohibitive costs by resorting to fare evasion, with inevitable results:

I jump the train yep. Touch wood I’ve only been done once in the last 12 months. Because I suffer mental illness so I actually will get [the fines] revoked anyway by means of a letter from my GP. So it is not something I worry about but it is a hassle in that I’ve got to go through a lot of paperwork to get it revoked and it is a pain in the neck - just being targeted by the inspectors is quite humiliating. Everybody stops and stares at you as they go through all your personal details.

Exactly, yeah, that’s right so often if I see them I’ll just avoid catching that transport. That has meant at times I’ve missed my dose because I’ve had to get off the train because they’ve been on it so, yeah, it is a pain in the neck. (Sage, 39 years)

Do you get two trams in [to collect your methadone]?

When I can afford it yeah I do … or it’s either one bus which I can get. I’ve got so many Met fines that I can’t afford to get any more so I can’t do that – see that’s the other thing because of methadone I’ve got a ridiculous [amount], like, $12,000
worth of Met fines. They won’t go easy on you because you’re on methadone – straight away, ‘oh, drug addict’. I will get locked up for a little while but that’s alright. (Helen, 38 years)

The desire to avoid further fines and the lack of a transport fare leads to some having to walk extensive distances in order to pick up their medication: simply because, in the days leading up to their next income support payment, they don’t have the money for a two-hour tram ticket.

There’s always the day that you struggle because you can only do so much with the amount [of money] that you get. My biggest problem I would say would have to be transport because I’m too scared to get on a tram without a ticket to get $100 fine or a $200 fine – that’s what depresses me that sort of stuff. I’ve got to walk or be sneaky about catching transport or I look for tickets …

Are you saying you actually struggle to pay the public transport fares?

With everything else, yeah, absolutely even though they’re two bucks … but you got to remember they only last for a couple of hours so it is going to cost you four bucks regardless. If I’ve got to go and pick up my ‘done I’ve got to make sure I’ve got four bucks in my pocket because if I don’t have the four bucks I’m going to get kicked off the tram or get in the shit and it is not worth it … or there goes my bills, it throws me out of whack – but I choose not to do that so I don’t put myself in that position because I’m aware of it and I go, alright, if I haven’t got a ticket I can’t catch a tram (Perry, 40 years).

The costs of opioid maintenance program dispensing fees – approximately $60 per fortnight for most clients – have far greater ramifications when limited incomes of those individuals in treatment are considered. These incomes must pay for food, accommodation and other needs as well as for their treatment regime to be dispensed. The additional costs of dispensing fees are numerous and, while not always tangible, include:

- The need to prioritise medication over food and accommodation – which may lead to having very little in terms of food and a less than secure standard of accommodation;
- The reliance on emergency services that, in effect, are compelled to cover a deficit caused by clients’ prioritisation of their dispensing fees; this means that the money for food and accommodation expenses is recouped by seeking emergency assistance from over-stretched community service organisations;
- The need to return to petty crime or sex work (and risk incarceration) in order to pay for treatment intended to stop precisely that behaviour;
- The sickness of withdrawal if these options are not available;
- Travel costs and the risks that accompany fare evasion;
- The return to heroin use if one cannot afford dispensing fees and their treatment is involuntarily discontinued.
Consequently, for the sake of a debt of $30, an individual whose life has gradually regained a semblance of stability and is benefiting from the opportunity to address housing or employment issues, perhaps even the underlying trauma that drives their use of drugs – is left without access to legal opioids. Consequently, they are denied legal opioids while remaining dependent upon opioids, inevitably compelling the return to a ‘lifestyle’ chasing an income sufficient to meet the demands of this dependency via illicit opioids. The broader costs of such involuntary cessation of treatment have already been addressed in some detail.
a·bu·sive (ə bū/sīv), adj.
- or ill-treatment. 2. characterizing abuse. 3. corrupt.

a·but (ə būt'), v.i., abut·ted, abut·ting
adjacent to (often fol. by on or to) another

a·but·ment (ə būt/ment) n.
structure which receives the thrust of a
Dispensing Fees and their Effects on Client-Dispenser Relations

First thing on pay day, believe me, that is the main priority – Straight from the bank to the chemist (Dennis, 40 years).

The following section addresses the impact of dispensing fees, their non-payment and accumulation of debt on a client’s ability to remain in opioid maintenance treatment. In doing so, it investigates the relationship between pharmacist and client. It argues that a mutually respectful relationship may engender a greater effort on the part of clients to pay what they are able to pay – especially if they feel they are being treated with concern and empathy by a health professional, which is how any paying customer would expect to be treated by a pharmacist. And yet the only thing separating an individual on an opiate maintenance program from, for example, an individual collecting a prescription for tranquilisers or antibiotics is a value judgement – they are both customers paying to receive a treatment dispensed by a health professional.

Consumer debt

The issue of dispensing fees has contributed to deteriorating relationships between many a client and their dispensing pharmacist. This is one of the most significant costs incurred as a consequence of dispensing fees. As one pharmacist noted, his role as a pharmacist is to take a broader interest in his clients’ health as opposed to simply dispensing medication to them. However, a relationship damaged by a client’s debt and a pharmacist’s demand for its payment removes the potential link between the client and a sympathetic health care practitioner. For many pharmacists and their clients, arrangements such as direct debit, are made to avoid potential problems with debt. Indeed, this option is sometimes placed before clients who have accrued a debt as their final option to be undertaken if they wish to continue to receive their pharmacotherapy.

I am getting [the dispensing fee] taken out of me dole at the moment, as of like last week, I just started paying for it, so they are taking it out of me dole.
Why did you arrange to have it taken out of your dole?

I had to, because I couldn’t afford to pay [to] pick up me dose and I owed [the pharmacist] money. He said, ‘Unless you sign this [direct debit form], we can’t dose you.’ So I had to sign the bit of paper to get dosed, pretty much.

How much debt were you in?

I was only like $20 or $30 in debt, but that was enough … basically he said, I am not going to dose you, until you sign the paper … or unless you have got the money to pick up, you know. I didn’t have the money, you know and it was the weekend. The only way around it was to go and do crime and I thought, there is no way I am doing that, I may as well just jump back on the gear. I signed the bit of paper – said, ‘Bugger it’. It is a lot easier being on methadone. I just sit at home, you know, play me music, keep out of trouble (Matthew, 25 years).

Direct debit can remove the very real fear that there may be a time when an individual does not have any money for their maintenance program – particularly given that this problem may have arisen in the past due to the individual’s inability to control their cravings for illicit drug use. PJ, another ‘payday’ user, chose to have his payments directly taken from his income support payments to avoid any further problems with pharmacy debt as a consequence of continued illicit drug use. Explaining why, he reiterates the aforementioned continued use of drugs as one of few means of coping with life’s difficulties that many long-time users know:

I am seeing [pharmacist in Fitzroy] and it is a very cordial relationship, but only because my payment is direct debited, so there is never arguments about money … It was my idea, because after all the trouble that I had had previously, a lot of trouble with chemists wanting to get paid and I just didn’t have the money, I didn’t want to be in that position anymore. Your life is so unstable as it is, even when you are stable in the sense of like, I am a payday user, so it is not like I am on the hustle everyday to raise $100, I do it once every two weeks and I have to save up all this shitty feeling, dark days, holding that one day of relief, that has to get me through for another two weeks … How dumb (PJ, 35 years).
In contrast to the difficulties the amount of $5 per day (or $30 per week) represents to low-income earners on opioid maintenance programs, most pharmacists argue, not unreasonably, that $5 a day is not sufficient to cover dispensing fees. As noted in Section 5 of this report, the fee has remained unchanged since the 1980s.

For a program of methadone, I charge $30 a week, for 7 days. Whether you come in every day, or three times a week, [it’s] $30. If I was going to go by the [standard] dispensing fees, nearly $7 or something, we should be charging $42 a week – without taking anything else into account, just for dispensing, as pharmacists. Only charging $30 a week is dirt, dirt cheap.42 I’ve been doing this since 1980 and back then it was suggested that it be $5 a day, $30 a week – that was a long time ago. If you’re in a profession, you’ve got to be remunerated in a fair and equitable manner (North Fitzroy pharmacist).

Research participants readily acknowledged that their financial difficulties were often the cause of disagreements and sometimes verbal arguments with their pharmacists. At the same time, those pharmacists interviewed emphasised the rarity of situations becoming physically threatening. One pharmacist in North Fitzroy spoke of only having to physically remove clients from his pharmacy three times in the course of 30 years of dispensing opioid maintenance pharmacotherapies. The issue of financial difficulty is one that pharmacists acknowledge. However, there is a belief, on the part of some, that many clients lack commitment, as opposed to money, and that this is the central cause of their failure to complete maintenance programs.

There’s quite a few [clients] that will come in, try it for a few weeks and for one reason or another give it away and then come back a month or two later. I don’t think finance is the main reason, it might be one of a few main reasons; [but] commitment to the program, commitment to making it work is often an issue (Inner Melbourne pharmacist).

This is given some credence by the continued drug use of some maintenance program clients. When told of research participants describing the difficulties they had making payments for their treatment, one pharmacist responded:

Then you ask them if they can afford to use heroin or smoke or anything like that … they have got to have priorities. If they want to really get off the drugs, they will have to make that their number one priority (St Kilda pharmacist).

This again confuses the issue of drug use with simple choice. It must be underscored that the cost of withholding treatment for both the individual and the community, of which they are part, would be far greater than the cost of subsidising the dosing of clients in maintenance treatment so that less were removed due to their inability to meet the financial requirements of the program. The benefits of such a substantial reduction in heroin use

42 This is a valid point. The standard dispensing fee for ready-prepared medications is currently $5.44. However, as opioid maintenance pharmacotherapies are classified as ‘dangerous drugs’ an additional $2.71 is charged to cover measures such as secure storage and additional paperwork, bringing the dispensing fee to $8.15 under changes to the Schedule of Pharmaceutical Benefits from 1 January 2008.
from, for example, a $4,000 per week habit to a $50 per fortnight pattern of use must be recognised. The issue is that these benefits need to be sustained – the greater the period in treatment, the greater the benefit to the client and the greater the probability that the client will completely eradicate all illicit drug use in their lives (see for example Graycar et al. 2002; National Drug and Alcohol Research Centre 2001).

The potential benefit to the client does not remove the need for pharmacists as professionals to expect (and receive) recompense for carrying out their professional duties. If fees are not paid, then pharmacists are caught in the middle by the inability of policy makers to address a very apparent problem affecting retention in a successful treatment program that offers significant benefits to client and community alike. It is pharmacists who must discontinue treatment whilst aware of likely consequences. This awareness sees many pharmacists allowing debt to be accrued before they deny further dosing.

The position of the dispensing pharmacist is unenviable – they are entitled to be paid for their professional services. Since dispensing fees for opioid maintenance medications are not incorporated into PBS subsidies, as are the majority of medications listed under the Scheme, pharmacists have no choice but to ask the client to pay this fee that forms a regular part of their income. Given the extreme financial hardship of many low-income clients, many are not able to do so and treatment will inevitably be discontinued, usually leaving the pharmacist in question writing off the amount owed as ‘bad debt’ – a financial loss. Some pharmacists are willing to tolerate different degrees of debt. Others may impose more stringent policies regarding their willingness to ‘dose’ those patients who are unable to pay for that day’s dose.

Debt is a problem, yeah. We actually don’t dose them after a certain time. So we cut that down.

So it’s a matter of clients getting to a certain amount of debt and, at that point, unless they start paying it off, they’re cut off? So do you end up having to write off a lot of bad debt?

Sure … and there is nothing much we can do about it, but we keep it as minimal as possible now. People know that if they don’t pay, they don’t get a dose, so it is kept to a minimum now (St Kilda pharmacist).

I’d imagine you have debt running with a certain number of your clients?

Absolutely.

---

43 One client of the pharmacist in question had noted the more stringent regime, stating: I’m seeing ______ around the corner there … he’s actually changed his note on his board. They used to give you 3 days leeway, if you haven’t paid, you could have 3 days of credit, and then you had to pay daily for your dose, which is $6 a day. Now he’s even cut out the 3 days grace. If you’re behind on your doses, then you don’t get dosed (Jamie, 41 years).
Is that one of the primary reasons for them being moved off?

In a lot of cases it is.

So do you end up having to write off a lot of debt?

Absolutely. I mean what else can you do? (Inner Melbourne pharmacist)

The issue of debt cannot be ignored. ‘Bad debt’ costs individual pharmacists several hundreds, if not thousands, of dollars each year. It makes the recruitment of additional pharmacists to share the burgeoning load of pharmacotherapy clients even more difficult and is a significant obstacle to the success of the community pharmacy model that operates in Victoria. The following participant’s attitude to payment of dispensing fees makes the demands of pharmacists so affected wholly understandable.

My last chemist I owed two and a half thousand dollars. I put [my dispensing fees] on account. I couldn’t afford to pay for it so he let me open an account, big mistake to let me have an account when I’m a drug addict.

I turned around and said to him, don’t let me get any more than a couple of hundred dollars [on the account] and when he let me get that much (two and a half thousand dollars) I thought oh fuck I’m not paying that much no fucking way. He said even if I pay him $10 [extra] a week – I said no way. I said the government pays you for issuing it anyway so you’re not losing nothing anyway…So the [pharmacy] in Sydney [my debt ran] to the thousands, the one in Bentleigh I owed him about 70 or 140.

How did that resolve itself?

I just didn’t pay it, jumped off and didn’t pay it. Jumped off and didn’t go back and didn’t pay it, didn’t worry about it. The next time I go back to the chemist he’ll probably jump on me for it (Adrian, 40 years).

It is unfortunate that those few with such attitudes do not appreciate the difficulties they create for income-poor recipients of opioid maintenance treatment, for example the aforementioned obligation to sign demeaning contracts and / or pharmacists who become reluctant to provide leeway in circumstances of a temporary inability to pay.

At the other end of the spectrum, the amount of debt accrued by pharmacists continuing to prescribe to patients who are consistently unable to pay their dispensing fees leads to pharmacies having to cease delivering maintenance programs because it actually costs the

---

44 This mistaken belief – that the pharmacists receive methadone and buprenorphine for free and that the dispensing pharmacists are simply profiteering off their addiction by charging fees to dispense the medication – is relatively common among clients of opioid maintenance programs. Pharmacists are paid dispensing fees for handling, preparing and providing all medications; however, in most cases, these are incorporated into the price of the medication once the PBS subsidy has been taken into account. The government pays the cost of opioid maintenance medication (a substantial cost in the case of buprenorphine) and supplies it free to pharmacists, but given that this medication is not covered by the relevant sections of the PBS Act, pharmacists must charge the consumers the dispensing fees that the PBS would usually subsidise.
Dispensing Fees and their Effects on Client-Dispenser Relations

pharmacy money to provide it. The closure of the program at the My Chemist pharmacy in Fitzroy in 2005 is an example of a pharmacy losing money and no longer being able to afford to provide a treatment – and is a reminder that the stereotyping of pharmacists by some of those on opioid maintenance programs as ‘scavengers’ is just as inaccurate as stereotypes of those dependent on opioids as ‘junkies’.

The above discussion demonstrates the quandary facing pharmacists – an approach with no flexibility will likely see a client return to the street. Too much flexibility will lead to a service that costs the pharmacist and is ultimately unsustainable. The key is finding a balance, and pharmacists who achieve this balance enjoy a mutually respectful relationship with their patients. The value of a long-standing, trusting relationship with their pharmacists is a vital link for patients in opioid maintenance programs as the following examples attest:

[Client names a pharmacist in Carlton], he’s been the best pharmacist I know so far.

What sort of hassles have you had with other ones?

Just like not being able to fix my bill up on time and that sort of thing … Occasionally it stoped me from getting my doses here and there. So I ended up going to [him] and the first week I was with him he said if you come in every day I’ll give you your first week for nothing so I have sort of just stuck with him ever since. If I do get behind in my bills and that he gives me a bit of time to fix it all up. (Will, 28 years)

Have you ever gotten into debt? How has the chemist handled that?

Pretty good actually, because for the first few years I was really good and never got behind and was always ahead. I started to drop behind slowly, slowly … I lost my job in 2000, so yeah, when I lost my job, I sort of fell behind then … it built up to be quite a bit. I paid some of it back. I’m still behind, only a couple of weeks. [The debt’s been running] a few years now … but because I was always a good client, until the debt, I’ve never been any trouble to them. I always pay nowadays, so I haven’t let it get behind any further (Simon, 39 years)

An empathetic understanding is crucial to a pharmacist helping patients manage their maintenance treatment so as to gain the greatest benefit possible. They must also be prepared for unexpected events to arise demanding that their clients prioritise other factors before their pharmacotherapy. This is especially the case for those with young children.

You’re paying 10 bucks extra a fortnight because of debt owing. How much is the debt?

It is several hundred dollars – that was my own doing. I was doing direct debit each fortnight, [but] I’ve got three children that aren’t in my care and when I get my rent, my methadone and assorted other things taken out I end up with $150 a fortnight to live on so occasionally I stop the direct debit when I’ve got a kid’s birthday or something like that coming up just so that I can accommodate my children and then I pay it off by $10 a fortnight (Sage, 35 years)
The relationship in this particular case was such that a mutually agreed arrangement allowed the debt to be paid off, hopefully without imposing too onerous a condition upon the patient in question. Unfortunately, adding the debt, in small amounts, to regular fees is one of the primary means pharmacists use for recovering debt. If one thinks logically about the circumstances of the debt, its repayment is only going to further burden individuals struggling to survive. Given that clients were in circumstances in which meeting the $50 or $60 a fortnight was proving difficult, adding a further $10 to this may make meeting the revised payments prohibitive.

I’m getting methadone at Turning Point … It costs 60 a fortnight. I had about $850 worth of debt and because I was behind in payment, instead of being $60 a fortnight they were charging me $5 a day, which is $70 a fortnight. And, [on top of that, I was paying] $10 a fortnight off the debt … so it was $80 a fortnight. On the dole payment I couldn’t afford that. I pay rent and electricity and medication, my tablets, interferon and all that stuff. So it really made it too difficult, I couldn’t afford it I was left with maybe $20 to eat for a fortnight.

You were saying that’s why you got into debt in the first place, by Turning Point putting up the price?

It just made it snowball worse. I didn’t get why they put it up because I was behind and if anything they should work out a deal and put it down because there’s a $5 dispensing fee.

Why the charge at a daily rate?

Because I was behind. If I was in front or up to date with payment, it’s $60 you get that one day free but if you’re behind it’s daily. [At] $5 a day so it’s $70 a fortnight. I don’t get it but that’s how they work it … (Ade, 27 years)

Understandably, given the level of bad debt written off by pharmacies, most will not take a client who is transferring pharmacies without a letter of reference from their previous dispenser. The tone of this letter can be assumed if the reason for the client’s transferral is the breakdown of their relationship with the pharmacist who is penning it. This may permanently block the access of opioid dependent individuals, to the best available treatment option due to financial debts that, when considering the costs of a heroin dependency, are relatively minimal. This was the reason for one survey participant continuing his ‘maintenance’ program by buying diverted buprenorphine from the street (at a cost of approximately $160 per fortnight). One participant related his own experience with an empathetic medical practitioner who falsely recommended him to a pharmacist as a ‘new’ client so as to negate the necessity of a reference letter from his pharmacist who had discontinued his treatment due to debt. Alternatively, individuals may approach doctors claiming never to have been on a program before. This greatly compromises those involved, reflecting the desperation of the opioid-dependent individual seeking assistance as well as their health practitioner’s concern for their patient’s health. Anecdotal evidence, such as Paul’s experience below, suggests such compromises are not rare.
Have you had past problems sort of getting into debt with the pharmacists? Have you had to change pharmacists?

Yes, I have had in the past because of that. I got too far in debt and they wouldn’t dose me unless I paid up. So a couple of times I ended the program through that.

What happens in those circumstances when they won’t dose you?

They won’t dose you and it’s pretty hard to find another chemist because they always like to speak to the previous chemist and the previous chemist says this person has a debt … so until you pay, they won’t take you on. So yeah it’s a nightmare. I mean it’s self inflicted, but it’s hard on a low income sometimes. But now, each fortnight my first priority is I go straight to the chemist and pay them for the two weeks in advance so I won’t get in that predicament again, I pay $60 a fortnight.

When you’ve been kicked off before and you’ve had debts with other chemists how long has it taken to start up another regime with a new chemist?

A while … I’ve had to have a bit of a break. Like I said I was buying off the street and then I’ve had to begin a program as a start-up, so I’ve actually told a few lies, like I’ve actually gone back to the doctors and the doctor’s said well he’s a start-up. And the chemists just take me on as a start-up not really knowing that I’ve been on the program before (Paul, 54 years).

A further complication that ignores the reality of the poverty at the root of the client debt problem is the fact that many pharmacies will not take a client unless they can pay for their first week in full – an obvious obstacle to those who have been transferred due to their inability to meet the costs of treatment at another pharmacy.

What would happen if you got put off the programme because you couldn’t pay?

I’d have to go and find another chemist. You’ve got to have a week [of dispensing fees] upfront now too. They won’t take you on unless you’ve got a week up front.

People that are trying to do the right thing it just makes it harder and harder. And they wonder why people go off and score again. You get kicked off the program for the sake of $10 or something … And they know that you’ll get your money the next [pay] day (Michaela, 48 years)

Clients of maintenance programs express further dissatisfaction regarding the required payment of dispensing fees for days on which they do not actually present and have their medication dispensed (i.e. having been dispensed takeaway doses in one ‘transaction’). Frustration is often expressed by clients about the charging of dispensing fees on a daily basis, even if a client only presents 2-3 times a week as many do given their meeting the criteria required to qualify for the receipt of take away doses of their pharmacotherapy.

*Start-up* in this instance is taken to mean as a first-time participant in an opioid maintenance pharmacology program.
You’re on Suboxone right, now you might be able to explain this, if you pick up say today right and you got two takeaway doses for two days, would you have to pay for them? You do? I mean … it’s a big jib for us, because even if we don’t go for two days, we’re not in their face, we’re not disturbing their peace [and] we’re still paying …

I’d go and pick up a month’s dose … if I could; [but] I got to pay for a month’s [dispensing fees]. I mean we just haven’t got that money to do that, that’s the thing that they’ve got to try and understand in helping us. I mean I try and get off it but how do I get off it. I’ve got to find money to come and pay you and it makes it very hard (Pio, 45 years).

Guidelines for the dispensing of buprenorphine / naloxone allows up to 28 days of medication to be taken away from a pharmacist – obviously once stringent conditions are met. However, as experienced by one participant in this research, the dispensing of 28 days worth of medication was accompanied by a request for 28 days of dispensing fees – $120 – despite the fact that it was dispensed in one exchange. This is not only a complaint of clients. Many practitioners in drug and alcohol agencies had hoped the availability of buprenorphine / naloxone and the corresponding increase in takeaway doses may see pharmacists charge dispensing fees in accordance with the number of times the medication was dispensed. Research has shown that this is yet to happen (Winstock et al. 2007). It certainly seems hard to argue for the validity of paying dispensing fees to cover days when medication is not actually being dispensed (other than to compensate for others’ bad debt).

Respect

One of the intended benefits of dispensing opioid pharmacotherapies from community pharmacies was regular contact of clients with qualified and professional health practitioners in the form of their pharmacists. Certainly, a pharmacist in St Kilda justified his call for a pecuniary increase in dispensing fees on the basis of the counselling of ‘patients’ on opioid maintenance programs:

I think, really, if we looked at everything, it should be $10.00 … there is the work in ringing up the doctors and making sure that the dose is right, we have to prepare the doses, we have to prepare takeaways, we have to make sure that the scripts are in date and also, we have to counsel the patients when they come in (St Kilda pharmacist).

The degree to which dispensing pharmacists counsel their patients is, of course, a matter of personal choice on the part of the pharmacist (and really determines whether the pharmacist sees the individual participating in an opioid maintenance program as a patient in need of care or a business client). Disagreements about payment of dispensing fees will almost certainly negate the possibility of one’s pharmacist serving as a source of professional information and advice.

My pharmacist, apparently the, the bupe, was, he wasn’t doing bupe, ‘Jason, you’ve got to get on Suboxone soon or else you’ll have to go to another pharmacist.’ He’s a good pharmacist, yeah doesn’t look down on you if you’re in first and he’ll see you first you know, bar if someone else came in. DN …yeah brilliant bloke, brilliant bloke (Jason, 40 years).
You’re getting a pretty good deal, fifty bucks a fortnight?

Yeah it is 25 [a week] if you pay it in a fortnight, you know what I mean? I’m getting two days free. If I pay it daily, it’s costing me seven bucks a day. So 42 bucks – if I pay day by day it costs me double, it costs me nearly 80 bucks [a fortnight]. But if I pay a fortnight ahead, what he’s doing is giving me four days for nothing so it is alright. I’ve been going there – I used to do the ‘done program with him and found them really, really good. [There are] not many people on the program there so I don’t run into too many people and he’s a really, really nice bloke. He treats you just like a normal person, because he’s known me for a while and knew my missus and all the rest of it so he knows me fairly well. I’ve stuck with him and I think that’s why I get a bit of a discount because I’m consistent like, I’ve been consistent with him and I don’t get behind or anything like that (Perry, 40 years).

-------------------------------

[I’ve seen] three different chemists, because I moved three different times. The first time, when I was in my house, I had been using and then I stopped. I had been seeing the pharmacist a bit and he was lovely, Chemist in Chapel Street, he is brilliant. He must have about 100 patients, I reckon, and he knows everyone by their name as soon as they walk in, he makes time to say hello and have a little chat. Unless he is incredibly busy, which he is generally anyway.

But he was great too, because if you were going away and you are like, ‘It would be really great if I had an extra day over Easter or something. He would say, ‘Here, take this’. He was great (Sandy, 37 years).

The above examples are of pharmacists who brought a pragmatic and empathetic approach to their practice. It must be noted that, apart from the manner in which the Schedule of Pharmaceutical Benefits discriminates against them in respect of dispensing fees, this precisely what clients of opioid maintenance programs are – paying customers who are receiving prescribed medication to treat what is acknowledged by every tier of government in Australia as a health problem and not an issue for the criminal law (despite the reluctance to enshrine this acknowledgement via legislative reform). This was summed up best by one pharmacist with 30 years of experience in dispensing opioid maintenance pharmacotherapies in North Fitzroy. When asked why he continued to dispense opioid maintenance treatment, he replied:

Why do I keep doing it? It’s part of being a pharmacist. Do I give up on all asthmatics who walk into the pharmacy? Do I give up on all diabetics? They’re all customers when they walk in the door, I don’t put them to one side. They’ve got a problem – that’s why I’m a pharmacist, to help people who have got health problems. Why shouldn’t I?

Why [should you have to wait for others to be served first]? There’s no reason. You’re a paying customer just like Mrs Smith is a paying customer. Why discriminate? This is the way the world sees the drug addict. If they had MS, multiple sclerosis? What are you going to do, leave them on the ground and fend for themselves? It’s what society perceives when it hears ‘drugs’.
I’m not going to make them sit in a certain area – here [the customers] all get treated the same. Why should we treat this person any differently? They’ve all got scripts. Where is it written on her face that she’s a ‘junkie’ – she’s not. She might have issues, she might have problems – therefore, why should I tell her to go and sit in the corner over there and wait for Mrs Smith to get her prescription filled first? Mrs Smith has got problems too, she’s got a script, she’s got her own issues … I treat everyone the same and that’s why I don’t have hassles here. 

*There are plenty of pharmacists who don’t treat them as any other customer…*

That’s right, that’s where the problem lies. Those pharmacists that don’t do that don’t see themselves as being a true pharmacy professional – they don’t ask themselves, ‘what problem’s this fellow got? He’s got a health problem – might be drugs – but why can’t we look after him?’ (Pharmacist, North Fitzroy)

In the manner suggested above, a number of participants spoke of very warm relationships with pharmacists who were concerned for and actively asked after their well-being:

> We are probably a month behind. But [the pharmacist] is more understanding, they know our situation. Like, when you tell them that you’re living in your car, they give you leeway. It is not like, ‘well who cares, there are lots of other people doing it as hard as you’. We get along really good with this pharmacist and she has given us a lot of leeway. You know, we will throw $50 bucks here and there where we can and she is happy with that. You know what I mean? … I am on Valium and that and when them scripts come in, I have to pay for them. She can’t give me no leeway on that … This is the first pharmacist that we have ever got along with, that you can actually sit there and tell your problems to and she will try and help you. Do you know what I mean?  She is pretty good (Mick, 42 years).

While there is no evidence to suggest that the majority of pharmacists involved with opioid maintenance programs are discriminatory, the greater majority of participants spoke with considerable antipathy about several pharmacists, past and present, who had dispensed their medication. Certainly, the notion of providing any counselling was the exception to the rule:

> Did you every get any extra assistance, I don’t mean financial, in terms of other health problems with your previous chemists? Did they ever talk to you about other health needs?

No. It was go over there – like you had a certain area that you went to try and hide you from the ‘normal’ customers – get dosed, then get straight out, not even allowed to look at the shelves or nothing. You just had to go to this certain area and sit down and if you started looking around, he would come and tell you off and say, ‘sit down or get out’, you know. Obviously people were thieving from there and they put it down to the people coming in and picking up their methadone (Mick, 42 years).

Such experiences led Mick to leave this pharmacy, a fortunate move resulting in the empathetic relationship he enjoys with his current pharmacist. It is of great concern when a pharmacist, instead of realising their potential value as a source of needed health advice to clients, treats those on maintenance programs as somehow inferior to other customers.
Discriminatory treatment was repeatedly raised by research participants, treatment that inevitably led to a deterioration of relations between pharmacist and client – for many, to a point at which they were told to find a new pharmacy if they wished to continue treatment.

_The chemist that stopped dosing you, did he try and work out an alternative payment plan - anything like that?_

No, it just came to a big argument and it was just, ‘get out and don’t worry about what you owe. See you later’. With the other chemist, it wasn’t because of non-payment or anything like that. It was because me and my girlfriend had a verbal argument and than the next day we went in, he said, you have got two days to find another chemist.

_The pharmacist your girlfriend had an argument with, was that building for some time?_

That was building up for a long time. He just didn’t like us from the very first time he met us. The bloke that owned the pharmacy did, so you know, when he was on, it was sweet but when the other pharmacist was on, it was just hell. He was so smug, he was so arrogant. He would make you wait for half an hour, you know, when it is meant to be a five minute sort of thing. He would go and stock shelves and say, oh it is coming and then there would be other methadone patients come in and there would be six of us in line and that is when he would come over - talk about wanting to grab someone over the counter! It was just bullshit. I hated going there everyday for my doses and I know heaps of other people did too. Like if you fell more than three days behind, he wouldn’t dose you and that is only $15 bucks, you know what I mean? They are holding your dose over your head, it is just not on (Mick, 42 years).

There was a chemist that I was seeing in Abbotsford and we had an extreme breakdown in communication. He had, as far as I am concerned, very stupid rules. On one occasion he tried to kick me off my buprenorphine after missing three days when I knew very well it was five days [I could afford not to present]\(^46\) and I actually was subjected, a couple of times, to quite extreme verbal abuse by the pharmacist for asking questions like, ‘why am I paying for days I’m missing, even between scripts’, [and] for challenging him when he did try and kick me off the programme after missing three days.

They had a rule where methadone or bupe patients were not allowed to enter the premises if there were any other customers inside and one time I did enter the premises not knowing there was a customer in there and that caused problems.

_You’re expected to hover at the front and when it was all clear you come in?_

\(^46\) According to the Policy for Maintenance Pharmacologies for Opioid Dependence, methadone treatment is to be discontinued if a client does not attend for treatment for three consecutive days. This is to ensure their prescribing doctor is able to address such issues as illicit drug use that has occurred in the interim or the potential for overdose due to a lowered tolerance and adjust their dosage accordingly. In the case of buprenorphine (either with or without naloxone), treatment is to be discontinued if a client misses five consecutive days of treatment.
Yep. I had a friend who, one of the clauses as part of his seeing a chemist in Ferntree Gully or somewhere was to ensure that he had showered before he came in every day (Sara, 26 years).

-----------------------------

Yeah everybody does [sign a contract]. You’re not allowed to bring friends in, [you have to] stand in a certain spot, as a human being you’re put down the rung a bit … The other day the girls that work there were joking around, sitting down pretending they were a methadone patient and I was there and they’re going, ‘oh, I haven’t got money to pay and I want takeaways’. To me it wasn’t funny, on the surface it was funny but deep down I thought ‘is that what they really think?’ They should debrief people that work at the chemist [and tell them] that people who go on methadone aren’t all going to shop lift their stuff, they aren’t all idiots … and then she said and they sleep all day. It’s, like, it’s just not a fair thing (Rebecca 38, years).

As illustrated in Section 5 of this report, contractual agreements that explicitly communicate (some) pharmacists’ discriminatory attitudes towards clients of opioid maintenance programs may only add further weight to the burden endured by financially impoverished and vulnerable participants in opioid maintenance programs.

Respect is obviously a two-way street and a number of clients do display the very characteristics upon which pharmacists stereotypical assumptions are able to rest. In the weeks in which I spoke to pharmacists who participated in the research, one pharmacist’s wife was attacked, physically, by a female client of their pharmacy’s maintenance program and her male counterpart. However, isolated incidents such as this cannot excuse the discriminatory treatment that a small number of practitioners extend to all clients on pharmacotherapies for opioid dependence. For some pharmacists, judgmental attitudes may develop as a consequence of debt and issues of non-payment as well as having to deal with that minority of clients who may be obnoxious, demanding and, in the case of the above example, physically threatening and violent, perhaps encouraging a perception that opioid dependent individuals are a ‘group’ of people who do not fulﬁl their treatment obligations so are not deemed worthy of the professional pharmacists’ respect. For other pharmacists, the fact that recipients of opioid pharmacotherapies must personally pay dispensing fees as opposed to having them subsidised like ‘normal’ pharmacy customers may act to distinguish them as an unworthy ‘other.’

A most frustrating aspect of clashes between clients and pharmacists is that effective treatment is rendered impossible. Consequently, the stability afforded by the treatment program is lost and, all too often, followed by a relatively rapid return to a chaotic lifestyle of heroin dependency. This inflicts considerable, if not fatal, harm on the dependent individual, the costs of crime and insecurity on the community, and the heartache and horror experienced by the families of those affected.

You get locked in. Like these people in the chemist know they can turn around and slap me and kick me in the face and belittle me – not that they have – and I can’t say a word against them, but I have seen it with other customers, you know what I mean – like people that don’t pay their bills and stuff. You know, knock-about young kids who don’t know the value of a dollar, who don’t understand, who have had
alcoholic and drug [affected] parents, and yet these so-called righteous people treat
them like shit. And I say nothing … it just ends up that they walk out and they think
that they are sweet, but those kids hit the street and do vicious crimes, you know.
They get kicked off the program as a consequence, wouldn’t they?

Yeah …or they just walk out, because they don’t want to be treated like that. Their
pride. That is the one thing that I like about them, their pride and it is sad to watch,
but that is what happens. And then if they don’t pay the chemist there and they go
to another chemist … they can’t go to another chemist until they pay their bill [at
their original chemist]. So, how are they supposed to have the money, when they
have a habit and everything in between … you need a lot of money to buy heroin to
keep yourself going, do you know what I mean?

They are not having food, you know, let alone anything else, so how are they going
to get the money to pay that chemist bill, unless they get lucky with a crime or
whatever, you know. Because the amount of heroin that you need is three or four
times more when you are actually on methadone. If you get kicked off, you need
three or four times more heroin than what another junkie would need, you know.
So they are trapped and they don’t really realise that trap until they fall into it, cause
they are young, you know (Chad, 47 years).
Conclusion: the Need for Subsidisation

On the basis of the evidence presented in this report, there is little in the way of a rational argument against subsidising dispensing fees paid by low-income earners to receive opioid maintenance pharmacotherapies that offer their best chance of escaping the sickness and criminality of heroin dependence. An inability to pay dispensing fees is frequently the cause of patients having maintenance treatment discontinued involuntarily and immediately – and providing a ‘choice’: severe opioid withdrawal or illicit activity. In instances, those who cannot afford to pay off their debt or, at some pharmacies, the day’s fee, commit crime or engage in illicit sex work – solely to pay their debt and continue to receive medication that, ironically, was prescribed to prevent such behaviour. Alternatively, they may resort to heroin use. As one participant noted, while a pharmacist won’t give credit, many a dealer will. Dealers that don’t allow credit will be paid by other means – proceeds from acquisitive crime or the sale of one’s body. If sufficient money to buy heroin is acquired, but the dispensing pharmacist has made clear the fact they are not going to supply the client’s dose in an exchange that is less than harmonious, a return to that pharmacist with one’s illicit gains – even if the pharmacy is still open – may now be secondary to ‘getting on’.

Those who prioritise their dispensing fee payments above all else so as to avoid the horrors of opioid withdrawal often find themselves without sufficient money to sustain an adequate diet for themselves, let alone for those dependent upon them. This is a situation that is often resolved by petty crime such as shoplifting or, more commonly, by extensive reliance upon emergency services and charitable organisations as reported by the overwhelming majority of research participants.

The first option for subsidisation involves the Victorian State Government following the pragmatic lead of their colleagues in the ACT and directing the Department of Human Services directly fund the dispensing fees charged to patients of opioid maintenance programs. It is acknowledged that pharmacists, as professional practitioners, are entitled to fair remuneration for their services in dispensing the pharmaceutical medication involved in opioid maintenance programs, as they are in the case of practically every other PBS-listed pharmaceutical they dispense under prescription, as provided by the federally regulated Schedule of Pharmaceutical Benefits.

The second option is the pragmatic option available to Commonwealth policy makers. Pragmatic insofar as it would address similar problems in other Australian states and territories. Amendment of the relevant legislation and the Pharmaceutical Benefits Scheme to include methadone, buprenorphine and buprenorphine / naloxone alongside other medications in Section 85 of the National Health Act 1953 would be a logical
reform that should have accompanied the move from dispensing opioid maintenance pharmacotherapies in public clinics to community pharmacies whose professional pharmacists need to be paid for their services on a fee-for-service basis, as opposed to block funding which might pay for salaries in other occupations. The advantage of this option it simply entails the extension of a system that is already in place and understood by pharmacists and clients alike. Using the PBS and associated safety net provisions would also have the advantage of providing equity to clients given that different pharmacies charge different rates for dispensing pharmacotherapies. Many financially vulnerable individuals are ill-equipped if not unable to pay such fees and the costs that result are far higher than the predicted cost of either of the options presented for subsiding the dispensing fees associated with opioid maintenance programs.

In evaluating the viability (and cost) of such changes, one must consider the comparative costs of many individuals having treatment discontinued against their wishes. There is the immediate cost of crime which impacts upon the broader community, from the personal tangible loss of property and the indirect costs of increasing insurance premiums through to the intangible loss of trust and security. Alternately, there is the loss of self-esteem for those who ‘choose’ to turn to sex work to fund their medically prescribed treatment. The sheer idiocy of a health program in which financial need comes before well-being cannot be better communicated than by this most unpalatable reality. This raises obvious human rights arguments integral to the case of patients of opioid maintenance pharmacotherapies. Why does one group of persons not deserve the same health care as the rest of the population? Moral judgements and perceptions of the type that underlie such discrimination would demand that those diagnosed with Type 2 Diabetes as a result of lifestyle ‘choices’ or that injuries or chronic illness acquired through involvement in illegal activities would have to pay the dispensing fees for their PBS subsidised medications.

There is the cost to community service agencies (and, ironically, the governments that fund them) due to the reliance upon these services for food and accommodation assistance as a consequence of the prioritisation of dispensing fees leaving inadequate resources to address these needs. Further, many thousands of people donate to these charitable organisations. Consequently, given that such monies are not designated for any specific purposes, the charity of individual Australians and their families is, at least in part, paying for the government’s failure to provide universal health care.

The aforementioned costs resulting from crimes by those who return to an illegally financed cycle of illicit drug use in place of the treatment that has been discontinued deserve special emphasis. The thousands of dollars required to meet the needs of dependent heroin use cannot be acquired through legitimate sources, meaning the return to an existence revolving around a perpetual cycle of ‘rorts’, ‘earns’ and ‘getting on’. Or, alternately, to the self-eviscerating debasement of illicit sex work – whether in exploitative illegal brothels or on the street in an ‘occupation’ characterised by physical and / or sexual assault and in which one’s murder is an ever present risk (see Rowe 2006). These alone could be arguably greater than the cost of subsidising the dispensing of pharmaceuticals designed to remove individuals from this self-destructive cycle and replace it with the stability needed to address their most basic needs – including, perhaps, whatever drives their ‘choice’ to self-medicate with illicit drugs.
Finally, the lifestyle of dependent heroin use is one in which the health costs wrought on the individual are paid for through public health funding (see Rowe 2003), a further cost that adds weight to the need to do whatever possible to remove individuals from this lifestyle. When the reality of the situation is laid bare, the lack of subsidisation for opioid maintenance programs defies rational thought.

There is an argument as to whether subsidisation should cover the whole or a partial cost of the charged fee. An argument put forward by those who wish to see clients pay dispensing fees is that the financial obligations of the program encourage participants to appreciate its value – that were it free it would not be ‘appreciated’, particularly given that the medication itself is already paid for in full by the Commonwealth government at considerable cost. However, the experiences of those in this report make it clear that, for those who are genuine in the desire to escape the misery of drug dependency, the program is greatly appreciated; the perils experienced by those who are forced to sell themselves or to commit crimes to pay their dispensing fees considered alongside those who prioritise the stability their maintenance program affords, above other necessities such as food, must surely underscore their ‘appreciation’ of the program.

If pharmacists are to be remunerated fairly, there is a case to be made for the dispensing fee to be set at the level prescribed by the Pharmaceutical Benefits Scheme - $8.15. However, the circumstances of low-income earners who struggle to pay the fees demanded under current arrangements for the dispensing of opioid maintenance treatment, let alone being able to afford the costs associated with a nutritious diet and stable, secure accommodation, demonstrate the desperate need for reforms to fully subsidise the dispensing fees. This would go a considerable way towards retaining clients in treatment so that they gain the greatest benefit possible from their treatment.

In financial year 2005/06, there were 10,736 pharmacotherapy patients in Victoria (HMA 2007). If a daily dispensing fee of $8.15 was paid by the government, it would equate to weekly payments of $57.05 per client. This would translate to an annual cost (based on the last reported number of pharmacotherapy clients in the State) of approximately $32.4 million. If subsidisation was restricted to those with health care cards – approximately 80 per cent of those of opioid maintenance programs, the cost would fall to $25.9 million per annum.

Further, if the state government determined that dispensing fees were to be paid only when medication is dispensed, the price of subsidisation would drop significantly. Under existing arrangements, although it is a matter of individual discretion, most pharmacists continue to charge dispensing fees at the daily or weekly rate whether a client presents seven days per week, or, due to the availability of takeaways, three days per week. That a pharmacist is able to dispense 28 days worth of medication in one transaction and yet charge the client for 28 days of dispensing fees is clearly exploitative. The ability to charge such fees may be justifiable on the basis that they compensate for bad debt that pharmacists incur. However, this means that the more financially able participants are unfairly compensating pharmacists for those whose circumstances have led to debt. A great many patients of opioid maintenance programs may only present two or three days per week, under the Victorian guidelines that allow for four to five takeaways per week. In specific circumstances, involving employment for example, a patient can be dispensed 28 days of buprenorphine / naloxone combination pharmacotherapies.
A drop in cost for fees on an as-presents basis would see the cost to government of subsidies for clients collecting medication on, for example, three days a week, reduced from $57.05 per week to $24.45. If half the clients in possession of a Health Care card met the expectations that allowed for four takeaways per week, the cost to government would be reduced to approximately $12.95 million on the basis of dispensing fees as established by the PBS. To put the figure in perspective, according to Premier John Brumby the government accrues $1.5 billion per annum through gambling revenue (ABC News, 2007) – a significant proportion of which could rightly be assumed to come from problematic or ‘addicted’ gamblers.

Subsidisation represents a substantial saving to the government and community via reduced costs associated with both the criminal justice and public health systems. It would also remove the costs to the community through the loss of tangible items to acquisitive crimes committed by those whose treatment has been involuntarily been discontinued. Unfortunately, opiate dependency cannot be similarly discontinued and for the lack of $30 a week, the dependent individual must make the thousands required to meet the demands of his or her dependency through the illicit market. Those who suffer such losses also lose a sense of security. Finally, it would remove the intangible, immeasurable sense of loss amongst family members and friends who must deal with the consequences of another, sadly avoidable, fatal heroin overdose.
Conclusion: the Need for Subsidisation
References

Age, The, 1985. ‘Bowen cautious on plan to give addicts heroin’ 2 January;


ACT Health (Alcohol & Other Drug Policy Unit) 2005. Increasing Community Based Pharmacotherapy Places in the ACT Pharmacotherapy Program – Issues & Options May;


Commonwealth Department of Community Services and Health 1988, National Methadone Guidelines CDHS&H, Canberra;

Commonwealth Department of Human Services and Health 1995. Review of Methadone Treatment in Australia CDHS&H, Canberra;


Drugs and Crime Prevention Committee, 1998. Inquiry into Drug Reform Strategy (Transcript of evidence presented, 6 November);

Drugs & Poisons Unit (DHS Victoria) 2006. Policy for Maintenance Pharmacotherapy for Opioid Dependence DHS, Melbourne;


Fitzgerald J. 1999. Regulating the Street Heroin Market in Fitzroy/Collingwood, Vic Health, Melbourne;


Green, C. 2002. Minimising the Harm of Illicit Drug Use: Drug Policies in Australia, Queensland Parliamentary Library, Brisbane;

HMA (Healthcare Management Advisors) 2007. Funding Model Options for Dispensing of Pharmacotherapies for Opioid Dependence in Community Pharmacy Final Report, 14 June;


IHRA (International Harm Reduction Association) 2005, ‘Newsflash’ 4 July;


Lintzeris, N., Lee, S., Scopelliti, L., Mabbut, J, Haber, P.S. 2008. ‘Unplanned admissions to two Sydney hospitals after naltrexone implants’ Medical Journal of Australia 188(8), 441-444;


Masters, C. 2006. ‘A splintered cross society has to bear’ The Daily Telegraph 16 June, 27;


Mercer, C. 2000. ‘Smack Street, Melbourne’ in K van den Boogert, N. Davidoff (eds.) Heroin Crisis Bookman, Melbourne;

Muhleisen, P. 2002. ‘Maintenance treatment for opioid dependence – who should pay?’
Australian Pharmacist 21(8), 414-418;
Australian Pharmacist (Supplement) 17(8), 7-12;
Nader, C. 2005. ‘Drug treatment program forced to close’ The Age 16 September, 7;
O’Neil, G. 2007. Submission to the Inquiry into impact of illicit drug use on families 14 March;
Packham, B. 2007. ‘Addicts may lose children’ The Herald Sun 14 September, 2;
Parsons, J. 2002. ‘Opioid dependence – are pharmacotherapies effective’ Australian Family Physician 31(5), 4-5;
Pharmacy Guild of Australia 2000. Substance Abuse in Australian Communities Submission to the House of Reps Standing Committee on Family and Community Affairs;
Premier’s Drug Advisory Council, 1996, Drugs and our Community, Victorian Government, Melbourne;
Rushforth, B. 2004. ‘Junkies, druggies, addicts, scum?’ Student British Medical Journal March, 131;
Schubert, M. 2008 ‘“Homelessness tsar” wants action’ The Age 28 January;
Sikora, K. 2006. ‘Mall drug clinics – methadone users sent to pharmacies for their dose’ The Daily Telegraph 5 July, 7;
Topp, L. 2007. ‘Lure of the needle’ Of Substance 5(4), 18-20;
Walker, J. 2003. Methadone Liquid Handcuffs – What’s wrong with the methadone program’ Junk Mail 5, Summer;
Zajdow, G. 2004. A critical sociological perspective on harm minimisation’ in P.Mendes, J. Rowe (eds.) Harm Minimisation, Zero Tolerance and Beyond Pearson, Melbourne, 73-82.
Appendices

Survey Tool 1

Date of Interview

Interviewer ID

Pharmacotherapy Questionnaire
SECTION 1: DEMOGRAPHICS

1.1 How old are you? ___________ (years)

1.2 Are you
   Male  □
   Female □
   Transgender □

1.3 In which country were you born? _______________________

1.3.1 Do you identify with an ethnic or cultural background other than Australian?
   (Aborigine, Australian-Italian, Australian-Vietnamese etc.)
   ___________________________

1.3.2 What is/was the main language spoken in your family home?
   ___________________________

1.4 Are you a parent? (If no go to question 1.5)
   Yes □  No □

1.4.1 If yes, how many children do you have?
   ___________________________

1.4.2 If yes, do your children live with you?
   Yes □  No □

1.4.2 If your children do not live with you, who do they live with?
   Other parent □
   Extended family □
   In care □
   Adopted □
   Grown up/Left home □
1.5 How much education did you complete? (tick the highest level)
- Primary
- Some secondary education
- Completed secondary education
- Post-secondary TAFE/trade
- Some tertiary education
- Completed tertiary education
- Post-graduate qualification

1.6 In the last 12 months, which of the following best describes your employment status?
- Employed full-time
- Employed part-time
- Casual/Occasional work
- Unemployed
- Student
- Home duties
- Other (specify) ________________________

1.7 In the last 12 months, what is the suburb/town/place where you have lived or spent most time (even if homeless)?  __________________________________

1.8 Which best describes your current living arrangements?
- Private owner
- Private rental (own)
- Private rental (shared)
- Public housing
- Transitional housing
- Parents’ house / flat
- Friends’ house / flat
- Rooming / Boarding House
- Refuge / Shelter
- Squat
- No fixed address
- Other ________________________________
1.9 How many meals do you eat on average per day?  
_______________________________

1.10 Are there times when you cannot afford food?  
_______________________________

1.11 What drugs have you used in the past month?  
Heroin  □  
(Meth)amphetamines  □  
Cocaine  □  
Ecstasy / Trips  □  
Valium, Xanax, Serapax  □  
Temazepam, Normison  □  
Marijuana  □  
Tobacco  □  
Alcohol  □  
Other ________________________________

SECTION 2: HEALTH

2.1 In the last 12 months, have you experienced any of the following?  
Pneumonia  □  
Bronchitis  □  
Gastroenteritis  □  
Asthma  □  
Sexually transmissible infection  □  
No known health problems  □  
Other (please specify)  __________________________________________

________________________________________________________________________
________________________________________________________________________
2.2 In the last 12 months, have you had any of the following?

- Missed hit
- Scarring/bruising (track marks)
- Septicaemia (blood poisoning / infection of bloodstream)
- Dirty hit (felt sick after injection)
- Abscess (infected, red and pusy injection site)
- Cellulitis (skin inflammation indicated by redness, swelling, hot around the injection site)
- Phlebitis (infected veins indicated by redness extending along veins)
- Endocarditis (infection involving heart valves)
- No injection-related problems
- Other (specify) _______________________________________________________

2.3 Have you ever tested positive for hepatitis C?

- Yes  
- No  
- Never been tested  

2.4 Do you believe you have a good understanding about the transmission and treatment options for hepatitis C?

- Yes  
- No  

2.5 Have you ever tested positive for hepatitis B?

- Yes  
- No  
- Never been tested  

2.6 Have you ever been vaccinated against hepatitis B?

- Yes  
- No  

2.7 Have you ever tested positive for HIV?

- Yes  
- No  
- Never been tested  

2.8 Do you believe you have a good understanding about the transmission and treatment options for HIV?

- Yes  
- No  

2.9 Have you experienced any of the following conditions in the past 12 months? (tick all that apply)

- Schizophrenia
- Depression
- Paranoia
- Anxiety
- Panic attacks
- Other (specify)

2.10 (If applicable) Are you taking any prescribed medications to help your condition?

- Yes
- No

2.11 (If applicable) Are you taking any non-prescribed substances for your condition?

- Yes
- No

2.11 Have you ever required hospitalisation for treatment for mental illness?

- Yes
- No

2.12 Are you concerned about the state of your teeth?

- Yes
- No

2.13 How many times have you seen a dentist in the past two years?

_______________________________

2.14 In the last 12 months, have you overdosed?

_______________________________ (if yes, how many times?)

2.15 Of all the health issues discussed, what do you believe is the major health or health-related problem currently affecting you?

___________________________________________________________________

2.16 Next major problem?

___________________________________________________________________
SECTION 3: Pharmacotherapy

3.1 Have you even been prescribed?
- Methadone
- Buprenorphine
- Bupe / Naloxone

3.2 Are you currently prescribed?
- Methadone
- Buprenorphine
- Bupe / Naloxone

3.2.1 How long have you been prescribed this medication continuously?
- Less than 3 months
- Less than 6 months
- 6 months – 1 year
- 1-2 years
- 2-5 years
- More than 5 years
- If more than 5 years, how long? ______________

3.2.3 How many times have you started a program and ‘jumped off’ or been kicked off before completing it?

____________________________________________________________________

3.2.4 Is your Chemist located locally? What is the travel time from your home to your dispensing chemist? ________________________________

3.2.5 Are there travel costs involved? If yes, how much? ______________

3.2.5 How much does your methadone / bupe cost each fortnight? __________

Thanking you
Survey Tool 2

Date of Interview

Interviewer ID

Pharmacotherapy Questionnaire

RMIT
SECTION 1: DEMOGRAPHICS

1.1 How old are you? ___________ (years)

1.2 Are you
   Male
   Female
   Transgender

1.3 In which country were you born? _______________________

1.3.1 Do you identify with an ethnic or cultural background other than Australian?
   (Aborigine, Australian-Italian, Australian-Vietnamese etc.)

1.3.2 What is/was the main language spoken in your family home?

1.4 Are you a parent? (If no go to question 1.5)
   Yes   No

1.4.1 If yes, how many children do you have?

1.4.2 If yes, do your children live with you?
   Yes   No

1.4.2 If your children do not live with you, who do they live with?
   Other parent
   Extended family
   In care
   Adopted
   Grown up/Left home
1.5 How much education did you complete? (tick the highest level)
- Primary
- Some secondary education
- Completed secondary education
- Post-secondary TAFE/trade
- Some tertiary education
- Completed tertiary education
- Post-graduate qualification

1.6 In the last 12 months, which of the following best describes your employment status?
- Employed full-time
- Employed part-time
- Casual/Occasional work
- Unemployed
- Student
- Home duties
- Other (specify) ________________________

1.7 In the last 12 months, what is the suburb/town/place where you have lived or spent most time (even if homeless)?  __________________________________

1.8 Which best describes your current living arrangements?
- Private owner
- Private rental (own)
- Private rental (shared)
- Public housing
- Transitional housing
- Parents’ house / flat
- Friends’ house / flat
- Rooming / Boarding House
- Refuge / Shelter
- Squat
- No fixed address
- Other ________________________________
1.9 How many meals do you eat on average per day?

1.10 Are there times when you cannot afford food? Yes ☐ No ☐

1.11 What drugs have you used in the past month?
- Heroin ☐
- (Meth)amphetamines ☐
- Cocaine ☐
- Ecstasy / Trips ☐
- Valium, Xanax, Serapax ☐
- Temazepam, Normison ☐
- Marijuana ☐
- Tobacco ☐
- Alcohol ☐
- Other ________________________________

SECTION 2: HEALTH

2.1 In the last 12 months, have you experienced any of the following?
- Pneumonia ☐
- Bronchitis ☐
- Gastroenteritis ☐
- Asthma ☐
- Sexually transmissible infection ☐
- No known health problems ☐
- Other (please specify)______________________________________________________

________________________________________________________________________
2.2 In the last 12 months, have you had any of the following?

Missed hit
Scarring/bruising (track marks)
Septicaemia (blood poisoning / infection of bloodstream)
Dirty hit (felt sick after injection)
Abscess (infected, red and pussy injection site)
No injection-related problems
Other (specify) _______________________________________________________

2.3 Have you ever tested positive for hepatitis C?
Yes ☐   No ☐   Never been tested ☐

2.4 Do you believe you have a good understanding about the transmission and treatment options for hepatitis C?
Yes ☐   No ☐

2.5 Have you ever tested positive for hepatitis B?
Yes ☐   No ☐   Never been tested ☐

2.6 Have you ever been vaccinated against hepatitis B?
Yes ☐   No ☐

2.7 Have you ever tested positive for HIV?
Yes ☐   No ☐   Never been tested ☐

2.8 Do you believe you have a good understanding about the transmission and treatment options for HIV?
Yes ☐   No ☐

2.9 Have you experienced any of the following conditions in the past 12 months? (tick all that apply)
Schizophrenia ☐
Depression ☐
Paranoia ☐
Anxiety ☐
Panic attacks ☐
Other (specify) ______________________________________________________
2.10 (If applicable) Are you taking any prescribed medications to help your condition?
Yes ☐ No ☐

2.11 (If applicable) Are you taking any non-prescribed substances for your condition?
Yes ☐ No ☐

2.11 Have you ever required hospitalisation for treatment for mental illness?
Yes ☐ No ☐

2.12 Are you concerned about the state of your teeth?
Yes ☐ No ☐

2.13 How many times have you seen a dentist in the past two years?
_______________________________

2.14 In the last 12 months, have you overdosed?
_______________________________ (If yes, how many times?)

2.15 Of all the health issues discussed, what do you believe is the major health or health-related problem currently affecting you?
___________________________________________________________________

2.16 Next major problem?
___________________________________________________________________
SECTION 3: Pharmacotherapy

3.1 Have you even been prescribed?
- Methadone
- Buprenorphine
- Bupe / Naloxone

3.2 Are you currently prescribed?
- Methadone
- Buprenorphine
- Bupe / Naloxone

3.3 What is the longest period you have been prescribed this medication continuously (at any one time)?
- Less than 3 months
- Less than 6 months
- 6 months – 1 year
- 1-2 years
- 2-5 years
- More than 5 years
If more than 5 years, how long? __________

3.5 Was it difficult to locate a prescriber of methadone / buprenorphine?
- Yes
- No

3.6 How long do you / did you have to travel to pick up your methadone / buprenorphine? (in minutes)
- Up to 15
- 16-30
- 31-45
- Over 45

3.7 Are there travel costs involved? If yes, how much? ______________

3.8 How much does your methadone / bupe cost each fortnight? ________

3.9 Are you happy with the service provided by your dispenser?
- Yes
- No
3.10 Have you had any of the following experiences when dealing with a prescribing GP or your pharmacist?

<table>
<thead>
<tr>
<th>Experience</th>
<th>Prescribing GP</th>
<th>Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banned from service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unfriendliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Difficulties (debt)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding of financial difficulties and related planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prejudice / Discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting time too long</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive, caring service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time taken to address other health needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embarrassed to use service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear of confidentiality being broken</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural / language difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restrictive hours of service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A mutually respectful relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.11 Are you prescribed any further medications? If so, please list along with relevant dispensing fees if you are aware of it:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Thank you for your time. This information is to be used to provide support for recommendations to the federal and state governments for the subsidization of the dispensing fees currently charged for opiate maintenance treatment.
ARAWDEAL?