

SELECT
COMMITTEE
ON DRUGS

INTERIM REPORT

METHADONE
TREATMENT
SERVICES
IN THE ACT

Presented 15 October 1992

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Select Committee on Drugs

Select Committee on Drugs

Committee membership:

Mr M Moore (Presiding Member)

Mrs K Carnell

Mrs E Grassby

Committee Secretary:

Mr R Owens

RESOLUTION OF APPOINTMENT⁽¹⁾

- (1) A select committee be appointed to inquire into and report on:
 - (a) the effectiveness of current legal and social controls on drug taking; and**
 - (b) other matters relating to drugs that the Committee considers should be drawn to the attention of the Assembly.****
- (2) The committee shall consist of three members.**
- (3) The Committee shall report from time to time, and its final report shall be presented to the Assembly not later than the last sitting day in 1992.**
- (4) The Committee shall have power to consider and make use of the evidence and records of the Select Committee on HIV, Illegal Drugs and Prostitution appointed during the previous Assembly.**
- (5) The Committee shall be provided with the necessary staff, facilities and resources.**
- (6) The foregoing provisions of this resolution, so far as they are inconsistent with the standing orders, have effect notwithstanding anything contained in the standing orders.**

¹ MoP (1992), No 1, as amended MoP (1992), No 8

Select Committee on Drugs

Invitat igitur vera ratio bene sanos ad iustitiam, aequitatem, fidem.

*(Those of sound nature, therefore, are summoned by the voice of
true reason to justice, equity and honesty.)*

*Cicero
De Finibus, I, xvi, 52*

PREFACE

The heartening part about the debate surrounding methadone distribution is that the protagonists have all accepted that we ought to be using a health model to deal with, what is largely, a medical problem.

In dealing with drug law reform this Committee, in a similar way to its predecessor from the 1st Assembly – the Select Committee on HIV, Illegal Drugs and Prostitution, has distinguished between the legal controls used to deal with drug problems through the criminal justice system and the medical methods available through our health system.

The differences of opinion surrounding how methadone should be distributed are about control. The essential characteristics of this debate focus on the balance between state interference and personal freedom. The freedom to choose, when such choices do not have a negative impact on others ought to be preserved and rigorously defended. Among the most vulnerable members of our society are drug users, particularly IV drug users and, therefore, it is even more important that their human rights and human dignity are defended. They are the group most susceptible to state control – the alternative to accepting what the state offers may well be a prison sentence, but certainly includes a life style that they have determined is unacceptable, for what ever reason.

In his report into Aboriginal Deaths in Custody, Royal Commissioner E Johnston, QC, recognised the importance of empowering individuals. The same principle applies in dealing with drug users and in most modern thinking about improving the health of all members of our society. The World Health Organisation's 1976 International Conference, in adopting its *Health for All by the Year 2000* slogan, emphasised the importance of empowerment; this was reinforced by the Ottawa Charter of 1986.

In 1989 Professor A J McMichael, speaking at the ANU, noted that 'Health Development connotes an active participatory approach'. If the theory is to be applied in practice we must ensure that those whose health is of concern are those who can have the widest possible range of choices.

The decisions of this Committee are concerned for the health of the Community as a whole rather than with bureaucratic and ideological control. The recommendations are to transfer power from the hands of service providers, as far as possible, into the hands of those who are ready to make major decisions about their own lives.

This report is but another small step in working towards drug law reform.

Finally I would be remiss if I did not place on the record my appreciation of the work done by my Parliamentary colleagues on the Committee, Mrs Kate Carnell and Mrs Ellnor Grassby, and my and their appreciation for the work done by the Committee secretary, Mr Ron Owens and also our appreciation to those who made submissions to the committee.



(Michael Moore)
Presiding Member
8 October 1992

TABLE OF CONTENTS

	Page
Committee Membership	ii
Resolution of Appointment	iii
Preface	v
1. INTRODUCTION	1
Establishment of committee	1
Conduct of the methadone inquiry	1
Legislation	1
Submissions	2
Witnesses	2
ACT Methadone Clinic	2
Interstate visit	2
2. THE NEED FOR CHANGE	3
Harm minimisation	3
The current program	3
Methadone Maintenance Program	3
Methadone Reduction Program	4
Dispensing/operating hours	4
Program costs	5
Criticisms	5
Program places	5
Waiting lists	6
Single site location	7
Single option program	7
Urinalysis	8
Purpose of testing	8
Compulsory testing	9
Non-medical use of test results	9
Invasion of privacy	9
Random testing	10
'Take away' doses	10
Diversion	11
3. THE CHANGES NEEDED	13
Philosophy	13
Program expansion	14
Potential patient numbers	14
Other service providers	14
Recommendation 1	15
Community pharmacies	15
Recommendation 2	15
Recommendation 3	15
General medical practitioners	15
Recommendation 4	16
Recommendation 5	16
Private clinics	16
Recommendation 6	16
The treatment program	16
Stage One	17
Stage Two	17
Stage Three	17
Stage Four	17

THE CHANGES NEEDED – cont'd

Changes	18
Legislative change	18
Private sector involvement	18
Administrative change	18
Waiting lists	19
Methadone Reduction Program	19
Urinalysis	19
Recommendation 7	19
Take away doses and transfers	20
Recommendation 8	20
Training	20
Inspections	21
4. AMENDMENTS TO THE ACT	23
Drugs of Dependence (Amendment) Bill 1992	23
Recommendation 9	23
Recommendation 10	23
Drugs of Dependence (Amendment) Bill (No. 3) 1992	24
Recommendation 11	24
Recommendation 12	24
LIST OF RECOMMENDATIONS	26
APPENDIX A	
Submissions	29
APPENDIX B	
Witnesses	30
APPENDIX C	
Contractual Document	31
APPENDIX D	
Client Information Booklet	33
APPENDIX E	
Drugs of Dependence (Amendment) Bill 1992	39
APPENDIX F	
Drugs of Dependence (Amendment) Bill (No. 3) 1992	41
DISSENTING REPORT – MRS E GRASSBY, MLA	43
INDEX	49

1. INTRODUCTION

Establishment of committee

1.1 The Assembly appointed a Select Committee on Drugs on 27 March 1992 ⁽¹⁾, to report by the last sitting day of 1992.

1.2 On 19 May 1992 ⁽²⁾ the Assembly amended the committee's resolution of appointment to allow it to report from time to time. This followed from a resolution of the committee to inquire into three specific areas namely:

- Methadone;
- Tranquillisers and benzodiazepines; and
- Alcohol and Youth.

Conduct of the methadone inquiry

Legislation

1.3 On 17 June 1992 Mrs Carnell introduced the Drugs of Dependence (Amendment) Bill 1992, the purpose of which is to:

"... overcome[s] a stumbling block to the expansion of the methadone program in the ACT. The Bill will expand the definition of "treatment centres' under the Drugs of Dependence Act to include the premises of a pharmacy ..." ⁽³⁾

1.4 On 8 September 1992 the Minister for Health introduced the Drugs of Dependence (Amendment) Bill (No. 3) 1992, the purpose of which is to:

"... facilitate higher rates of participation in, and access to, the ACT Methadone Program operated by the ACT Board of Health by increasing the number and location of places at which methadone may be administered." ⁽⁴⁾

1.5 On 8 September 1992 the Assembly referred both bills to this committee for inquiry and report by 15 October 1992. ⁽⁵⁾

¹ MoP (1992), No 1, p 7

² MoP (1992), No 8, p 40

³ *Hansard*, 17 June 1992, p 916

⁴ Drugs of Dependence (Amendment) Bill (No.3) 1992 – Explanatory Memorandum

⁵ MoP (1992), No 23, p 129

Submissions

1.6 The committee received nine submissions from groups and individuals concerning the Methadone Treatment Program in the ACT. For a list of the submissions received see Appendix A.

Witnesses

1.7 On 27 August 1992, at their request, Mr A Wilson and Ms M Marty from the Kobi Clinic, Bondi Junction (a private methadone clinic), appeared before the committee at a private briefing.

1.8 The committee, on 3 September 1992, held one public hearing into methadone treatment, at which 10 witnesses appeared before it. For a list of the witnesses appearing before the committee see Appendix B.

ACT Methadone Clinic

1.9 On 29 May 1992, with the approval of the Minister for Health, the committee visited the ACT Methadone Clinic and the Detoxification Unit, Woden Valley Hospital, where discussions were had with the doctors and staff running the facilities.

Interstate visit

1.10 During the course of its inquiries into methadone the committee visited Sydney over the period 3 – 5 June 1992. With the prior approval of the Premier of NSW the committee held discussions with Dr M MacAvoy of the Alcohol and Drug Directorate. The committee visited the Methadone Clinic at St Vincent's Hospital and spoke with its Director, Dr A Wodak. A visit was also made to Regency House, a private methadone clinic in Chippendale, and discussions were held with Dr R Seidler and the Nurse Unit Manager, Mrs S Banks.

2. THE NEED FOR CHANGE

Harm minimisation

2.1 This committee, like its predecessor in the first Assembly, the Select Committee on HIV, Illegal Drugs and Prostitution, believes that the most caring and humane approach to take, in dealing with, or relating to, drug dependent people, is one that is firmly posited in the philosophy of harm minimisation.

2.2 Where drug dependent people choose to change their life styles, in favour of a less dependent environment, they should be encouraged and assisted to do so in a safe and none threatening way; in a program that is diversified to meet disparate needs, and which is non judgemental and easy to access.

2.3 A methadone maintenance program is, and should be promoted as, a medical treatment program; it is not an exercise in social control, nor is it a punishment regime.

The current program

2.4 The ACT Methadone Program, which offers a medical treatment program to 120 dependent opiate users, is a hospital-based program consisting of a Methadone Maintenance Program, which currently has 115 clients ⁽¹⁾, and a Methadone Reduction Program, currently with 5 clients ⁽²⁾.

Methadone Maintenance Program

2.5 The Maintenance Program is, primarily, abstinence orientated and involves a relatively high degree of intervention. It also includes rigorous and mandatory urine screening, medical assessments, counselling and periodic review. The Program's associated aims are to improve the dependent person's medical, psychological and social functioning. Dependent people are admitted to the program on a long term basis and their progress is routinely monitored through the support services ⁽³⁾.

¹ Submission from Department of Health, dated June 1992, p 5

² *Ibid*

³ *Ibid*

2.6 A copy of the document 'Contractual Document for Methadone Maintenance Programme', which is to be read and signed by every patient before commencing methadone maintenance at the Woden Valley Clinic, is at Appendix C.

2.7 According to the Department of Health's submission ⁽⁴⁾ a patient's average length of stay on the treatment program is 1.9 years and 19% of those patients who 'complete' the treatment program remain drug free for the following 12 to 44 months; a high success rate within the context of Australian abstinence programs. The committee is concerned, however, that these figures suggest that 81% of patients return to illicit drug use within a relatively short time of 'completing' the treatment program.

2.8 Recently a low intervention program has been introduced at the Woden Valley Methadone Clinic for dependent opiate users who are not ready, or do not wish at this particular stage in their lives, to seek professional involvement in their treatment process.

Methadone Reduction Program

2.9 The Methadone Reduction Program is a short term program the aim of which is to minimise the physical symptoms of withdrawal from opiates. Evidence given by the Department of Health, in their submission to the committee ⁽⁵⁾, indicated that this short term treatment program is effective in achieving its narrow aim. The program runs for approximately two to three weeks and over that period of time those on the treatment program are given gradually reduced doses of methadone until they have fully withdrawn from their opiate dependence. People on the treatment program are encouraged to use the counselling services available through the Clinic, but this is not a requirement of treatment.

Dispensing/operating hours

2.10 The current dispensing/operating hours of the Woden Valley Hospital Methadone Clinic are:

- Monday to Friday
 - 7.15 am to 10.15 am
 - 11 am – 12 noon
 - 4 pm – 5 pm

⁴ *Ibid*

⁵ *Op cit*, p 6

• Weekends and Public Holidays

11 am – 12.30 pm

1.30 pm – 3 pm ⁽⁶⁾.

Program costs

2.11 Advice given to the committee by Department of Health officials indicate that the current cost of the program is approximately \$4000 per person per annum ⁽⁷⁾. A number of witnesses appearing before the committee expressed some concern at the relatively high cost of the ACT program *vis a vis* those operating in other states. The committee thought the criticisms unfounded given the nature of the program, and supports Dr Butlin, Director of the Alcohol and Drug Service, who said in evidence, on this point:

We have a small scale, high intervention program, and in that respect I make no apology for it being a high quality but relatively more expensive program. I would say, however, in terms of its benefits to the community the \$4000 a year is a very small sum to pay compared to the alternative for many, which is gaol, at \$50,000 a year. ⁽⁸⁾

Criticisms

2.12 The remainder of this chapter deals with a number of criticisms of the Methadone Maintenance Program which were raised in submissions, in evidence before the committee or are the reasonable conclusions of the committee. They are criticisms directed at the design of the program and the consequential limits imposed by that design. The committee believes it important to state as emphatically as it can that these criticisms are not, and are not intended, to be directed at those who have responsibility for administering the program. In the opinion of the committee these people are entitled to the highest accolades for the services they provide in the most difficult of circumstances.

Program places

2.13 A major criticism of the current program is its restrictiveness in terms of the number of people who can access the program. And this matter is further complicated by statistics. According to the Narcotic and Opiate Dependency Syndrome Sufferers Association (NODSSA), a health consumer union for people on methadone, there are probably between 2000 and 3000

⁶ *Op cit*, p 7

⁷ Transcript, 3/9/92, p 98

⁸ Transcript, 3/9/92, p 98

people out in the ACT community who really need methadone⁽⁹⁾. According to the Department of Health, however, 'a reasonable working target is of the order of 350 people'⁽¹⁰⁾. This estimate of the number of potential people who might wish to access the program was challenged by the Acting Service Director of Assisting Drug Dependence Incorporated (ADD) who pointed out, in evidence before the committee⁽¹¹⁾, that in 1978 there were approximately 300 people on a physyptone maintenance program in a population of less than 190,000; in 1992, with a population of over 290,000, the suggestion that there are still only 300–350 people who might need maintenance must be open to question.

2.14 But whatever the number of people who might wish to make use of the Methadone Program in the ACT, be it 350 or 3000, current government policy is to provide 150 places by September 1992⁽¹²⁾.

2.15 On 8 September 1992 the Government introduced into the Assembly the Drugs of Dependence (Amendment) Bill (No. 3) 1992, the purpose of which is to facilitate higher rates of participation in, and access to, the ACT Methadone Program by increasing the number and location of places at which methadone may be administered. However, neither the Minister's 'in principle' speech nor the explanatory memorandum to the bill identify the extent, in terms of actual places on the program, by which the program will be extended.

2.16 It is still the committee's opinion, therefore, that the current methadone program will not be able to meet the demand for places and that, as a result, in some extreme cases, lives are being placed at risk.

Waiting lists

2.17 A subsidiary criticism to that concerning the limited number of places available for treatment, is the consequential long waiting list to access the maintenance program. Although some people, rightfully, are able to receive priority placing on the treatment program, the committee is concerned for those who, having faced up to the dependency crisis in their lives, are told nothing can be done for them for two to three months. The devastating effect of this problem was graphically pointed out to the committee by the President of the ACT Branch of the

⁹ Transcript, 3/9/92, p 66

¹⁰ Transcript, 3/9/92, p 93

¹¹ Transcript, 3/9/92, p 8

¹² Department of Health submission, p 7

Australian Medical Association (AMA) who, in evidence before the committee, cited an instance of a young addict who died within a week of being told it would be three months before a place on the treatment program would be available. In the opinion of Dr Allan: 'If he had been able to get on the program straight away he would still be alive'.⁽¹³⁾

2.18 The committee believes our community cannot accept such a tragic waste of young lives simply because of the limited availability of government resources; other means of assistance and other avenues to treatment must also be identified, supported and encouraged. For the benefit of the community at large, as well as for the individuals themselves, no one in need ought to be turned away.

Single site location

2.19 A major criticism of the current program is its single site location at Woden Valley Hospital. In the opinion of the committee this is a valid criticism, particularly in respect of those people on the program who have managed to stabilize and 'normalize' their lives, but still require a daily maintenance dose of methadone. Such people need simple access to their medication in a way which easily integrates with the routine of their daily lives. In the opinion of the committee, being forced, by program restrictions, to attend Woden Valley Hospital each day is not at all conducive to integration in, or the 'normalization' of, peoples lives.

2.20 The Drugs of Dependence (Amendment) Bill (No. 3) 1992 goes a substantial way towards addressing this particular problem. According to the Minister's 'in principle' speech:

"The proposed amendments will enable any government facility to be used as a distribution point for methadone treatment. Initially, health centres in central, northern and southern Canberra are proposed, but location and hours of operation will be tailored as far as possible to client needs."⁽¹⁴⁾

2.21 It is the committee's opinion, however, that a great deal more can be done to make medical treatment for opiate dependent people as available as any other type of treatment on which people are medically dependent.

Single option program

2.22 As described above (see paragraph 2.5) the methadone maintenance program in the ACT is basically a single option program; and that option has abstinence as its goal. This is

¹³ Transcript, 3/9/92, p 71

¹⁴ Hansard, 8 September 1992, p 2050

another important criticism of the program as, in the opinion of the committee, it prescribes other, and alternative, medical modalities. In evidence before the committee the ACT Branch of the AMA expressed a need for a fresh approach to the problem; Dr Allen also said:

"The first point I would make, in relation to narcotics, is that it is a medical problem and any solution should be seen in that context. ... [I]ndeed the people with narcotic addiction should be treated in the same way and accorded the same respect and the same compassion as people with any other medical problem."⁽¹⁵⁾

2.23 Whilst welcoming the introduction of the Methadone Reduction Program (*see* paragraph 2.9 above) the committee is concerned to see that the general treatment program be capable of catering for as many different medical treatment modalities as is possible. The committee believes that the medical and treatment needs of the opiate dependent patient are of greater importance than any government or bureaucratic preference for one treatment program over another.

Urinalysis

2.24 A number of questions have been raised concerning the value of urinalysis in a dependent treatment program. These concerns relate to the purpose of the testing; the need for compulsory testing; the non-medical use of the test results; the invasion of privacy; and the random nature of the requirement.

Purpose of testing

2.25 As in all other testing options in medical treatment, the only purpose for doing a urinalysis test is that it be of some therapeutic benefit to the patient; that analysis must either be requested, or voluntarily agreed to, by the patient; and there must be no coercion or threat levelled against the patient to seek compliance. ACTIV in their submission⁽¹⁶⁾ gave the following quotation from the Woden Hospital Client Information Booklet 'On day two if unable to pass a supervised urine you may be given 1/2 your normal dose'. A copy of the booklet is at Appendix D. If, in the ACT Methadone Maintenance Program, urinalysis is done for any purpose other than for the therapeutic benefit of the patient, or if it is done under coercion or threat, then it must be stopped.

¹⁵ Transcript, 3/9/92, pp 69-70

¹⁶ Submission, dated June 1992

Compulsory testing

2.26 Any patient entering into this medical treatment program is entitled to those same rights and privileges which are enjoyed by any other patient on any other medical treatment program; and that includes a right of urinalysis refusal without jeopardising further treatment. In the opinion of the committee there is simply no justification at all for compulsory testing; the treatment program is a therapeutic one not a punishment regime.

Non-medical use of test results

2.27 The committee was disturbed to learn in evidence that the test results of urinalysis were being used for non-medical purposes, that is the application of the test results were being used for purposes other than the therapeutic benefit of the patient. In particular, both in evidence before the committee and in submissions, the committee was informed that a patient's right of access to 'take away' doses of methadone was entirely dependent on satisfactory, that is 'clean', urinalysis results; and ultimately a patient's place in the treatment program also depended upon satisfactory urinalysis results.

2.28 In any other medical treatment program such actions would be regarded as a gross violation of a patient's right to treatment and would bring about appropriate censorious action. The committee is firmly of the view that those who withhold treatment from a patient in the methadone maintenance program, simply on the basis of 'unsatisfactory' urinalysis, deserve, and should merit, the appropriate censorious action being taken against them.'

2.29 Any definition of 'satisfactory' and 'unsatisfactory' applied to the results of urinalysis must, and can only, be a definition that seeks to establish the health status of the patient. Any other definition, particularly one which attempts to make a moral decision about 'good' or 'bad' patients, has no place in a medical treatment program.

Invasion of privacy

2.30 A major concern for the committee has been the totally unacceptable practice of forcing patients to provide a urine sample in the presence of other people. This practice requires of a male patient that he be naked and exposed from the knees to the nipple line and for a female patient that she be naked, and exposed, from the knees to the waist and at no time must her hands be near her genital area.⁽¹⁷⁾ This practice is not to be countenanced. The provision of a urine

¹⁷ Submission from ACTIV League, dated June 1992

sample in any other medical treatment program requires that it be voluntary and that the sample be provided in private. There should be no distinction made between medical treatment programs.

2.31 The committee notes from evidence given before it, and from submissions it has received, that there is a proposal to view the giving of a urine sample, at the Woden Valley Hospital Methadone Clinic, by means of a video camera.⁽¹⁸⁾ It is the committee's firm view that there is no justification for such a degrading practice in a medical treatment program. The viewing of a patient, by either direct or indirect means, giving a urine sample must be stopped.

Random testing

2.32 It is the committee's considered opinion that the only urine sampling which can be ethically condoned, in relation to patients on the methadone maintenance program, is that which is the result of an agreement between the patient and their doctor, and the purpose of which is fully explained, and is acceptable, to the patient. Any other form of testing is an invasion of a person's privacy. Random, compulsory urine testing of patients on the ACT Methadone Maintenance Program is a punitive control measure and has no place in a medical treatment program; it must be stopped.

'Take away' doses

2.33 The committee is concerned at the punitive level of restriction placed on patients freedom of movement with the enforcement of, what appears to be, a very strict 'privileges – reward/punishment' approach to the provision of 'take away' doses. The Client Information Booklet says quite explicitly that 'take away' doses are a *privilege*. In their submissions to the committee both NODSSA and ACTIV stated that 'take away' doses are predicated on 'clean', that is 'good', urinalysis results.⁽¹⁹⁾ In evidence before the committee the representative from ACTIV said:

"If you do not do urines you cannot have take aways and that is only based on urines. It does not matter if you are holding down a full-time job, bringing up a family, if you do not produce clean piss for them when they want it, you do not get take aways. You can rarely get take aways."⁽²⁰⁾

2.34 As the committee has stated that urinalysis must be used to the therapeutic advantage of the patient only (*see* paragraph 2.24 above), the development of policy options with regard to

¹⁸ Transcript, 3/9/92, p 62 and submission from ACTIV League, dated June 1992

¹⁹ NODSSA submission, dated June 1992, p 11 and ACTIV submission, dated June 1992

²⁰ Transcript, 3/9/92, pp 10–11

the provision of 'take away' doses cannot, and must not, be predicated on the non-medical application of test results. Whether or not a patient should have access to 'take away' doses of methadone must be a decision made by the patients' doctor and made solely in the best interests of the patient.

2.35 The limiting of access to 'take away' doses as a reward or punishment is an insult to the dignity of the patient and cannot be justified. Nor must the provision of medication in this format be limited because of perceived administrative inconveniences.

Transfers, from and to interstate

2.36 The last major criticism the committee wishes to deal with is that relating to the transfer of prescription rights to and from interstate. Currently the treatment program makes it very difficult, and according to some witnesses impossible, for a patient to arrange for the availability of their medication at interstate locations. Such imposed difficulties can prevent a patient going on a holiday, can prevent a patient, in full time employment, from being able to undertake work related travel and can prevent patients from interstate visiting the Territory, for whatever purpose. Were such restrictions on one's right to travel to be applied generally to all the residents of this Territory, there would, justifiably, be an uproar. The committee simply asked 'why should anyone on a medical treatment program be forced, for any administrative reason, to forego their freedom of travel?'

2.37 No other medically dependent treatment programs impose such restrictions on administrative or punitive grounds. In the opinion of the committee, therefore, patients participating in the methadone treatment program must not have their ability to travel, to work, to play, to visit friends or relatives, or to take holidays circumscribed by the administrative or punitive decisions of the treatment program providers.

2.38 The committee can only repeat what it said earlier in this chapter; the ACT Methadone Maintenance Program is a medical treatment program, and must be regard as so by all those who participate in it – the Minister, health administrators, doctors, nurses and patients. It is not an exercise in social control and nor is it a punishment regime.

Diversion

2.39 It appears to the committee that a major concern among treatment program providers is the illegal diversion of methadone by patients. Although it is probably a fact of life that some methadone is diverted, the evidence given before the committee suggests there is very little diversion in Canberra and that, as a result, it is not a serious problem. Therefore, any program

administrative policies grounded in the threat of 'diversion' should be re-examined on the basis of there being no threat.

2.40 The representative from NODSSA made the point quite succinctly:

"I think diversion is a bit of an urban myth because I know, myself, that 24 hours after my dose I need the next dose. ... so there is not much chance that I am going to sell my next dose, especially considering that heroin only lasts for three hours ..." ⁽²¹⁾

— • —

²¹ Transcript, 3/9/92, p 52

3. THE CHANGES NEEDED

Philosophy

3.1 One of the more important criticisms levelled at the current program by both the major illicit drug and methadone user representative groups is the arbitrary and dogmatic approach taken by service providers toward patients; the 'punitive' nature of the program. According to NODSSA:

"The use of the moral model of drug abuse treatment allows for the service provider to dispense treatment according to a set of moral judgements rather than by accredited ethical, or medical guidelines."⁽¹⁾

And according to the ACTIV League:

"However the contradictions, the punitive practices, and the power relations of the ACT system of methadone prescription are problematic ..."⁽²⁾

3.2 It is the committee's belief that the fundamental philosophy behind any methadone treatment program, be it a withdrawal program or a maintenance program, should be firmly grounded in a medical treatment model, which has as its core the policy of harm minimisation and the privilege of the patient/doctor relationship, and which excludes the imposition of non-medical social mores and moral judgements. In the opinion of the committee three important factors follow from such a philosophy:

- *Primacy of patients' needs* – any treatment program should be designed, solely and primarily, to meet the health needs of its patients;
- *Empowerment* – any treatment program should acknowledge its patients' rights of control over their own lives – their own health, their own welfare, and their own life styles; and
- *Support* – any treatment program ought to be supportive of its patients and ought not seek to control them, either socially or morally.

3.3 It is also important, in the opinion of the committee, that the opiate medication dispensed to patients on a methadone treatment program ought not to be stigmatised nor specialised in any way as well, in other words there should be no moral judgements made, neither covertly nor overtly, concerning the administration of methadone.

3.4 Methadone is a 'schedule 8 drug'⁽³⁾; it should be treated as such and should be

¹ NODSSA submission, dated June 1992, p 11

² Submission, dated June 1992

³ The term 'schedule 8 drugs' in fact refers to drugs of dependence as listed in schedule 1 of the *Drugs of Dependence Act 1989*;

subject to all the controls appropriate to such drugs, but no more. It should not be brought out for special attention, nor for special additional controls; particularly by those who might, for non-medical reasons, wish to exercise exclusive control over the treatment regime.

Program expansion

Potential patient numbers

3.5 From the evidence placed before the committee there appears to be a real need to expand medical treatment options for those people, being opiate dependent, seeking medical assistance. Although the committee is not fully sure of the numbers of dependent people who might wish to seek medical treatment or assistance, it is of the opinion that the official estimates of some 300–350 people ⁽⁴⁾ is a little on the conservative side, but also believes that claims of up to 3000 potential clients ⁽⁵⁾ seem highly speculative.

3.6 The committee is as aware as any of the need for appropriate fiscal restraint in a time of contracting health care budgets and the reduction of Commonwealth funding in this area. Nonetheless the current provision of 150 places on the ACT Methadone Treatment Program, at the most, is meeting only 50 per cent of the demand for medical assistance; and in reality is probably meeting a lot less of the demand.

Other service providers

3.7 It seems appropriate to the committee, therefore, to seek other health care service providers to augment the provision of methadone treatment services by the public sector. Such a move, the committee believes, would be of benefit to the community without incurring expenditure from the public purse. All that is being recommended by this committee is that those health care providers already operating in the community at large, that is pharmacies and medical practitioners, simply be allowed to expand their health care facilities to include some additional 200 to 300 opiate dependent people, should they choose to do so.

³ Cont. for historical reasons 'schedule 8' has remained in common usage when referring to the drugs of dependence listed in schedule 1.

⁴ Transcript, 3/9/92, p 93

⁵ Transcript, 3/9/92, p 66

Recommendation 1

3.8 The committee recommends:

That the restrictions, legal and administrative, which limit the provision of treatment for opiate dependent people to treatment centres conducted by the Department of Health be lifted.

Community pharmacies

3.9 The provision of medication to opiate dependent people from community pharmacies has several advantages both to patients and to the public purse:

- patients needing little supervision can receive their medication from community pharmacies, allowing more costly medical and counselling resources to be focused on those most in need;
- medication becomes more accessible to these patients because of the location and hours of operation of pharmacies; and
- the user-pays system allows greater numbers to access the service.

Recommendation 2

3.10 The committee recommends:

That community pharmacies, should they so choose and should they meet the relevant statutory requirements, be permitted to dispense, on prescription, methadone to opiate dependent people.

Recommendation 3

3.11 The committee recommends:

That the premises at which a pharmacist practices pharmacy be included in the definition of "treatment centre" in the *Drugs of Dependence Act 1989*.

General medical practitioners

3.12 The committee can see no reason why general medical practitioners, competent in treating opiate dependent people, cannot provide a health treatment regime for such patients as consult them with a dependency problem. Allowing general medical practitioners, who wish to do so, to treat people with a dependency problem (a) gives patients a fundamental right of choice as to their consulting physician and (b) reduces the demand on the already overburdened public treatment service.

Recommendation 4

3.13 The committee recommends:

That general medical practitioners, should they so choose and should they meet the relevant statutory requirements, be permitted to provide health care for, and to prescribe methadone to, opiate dependent people.

Recommendation 5

3.14 The committee recommends:

That the premises at which a general medical practitioner conducts his or her medical practice be included in the definition of "treatment centre" in the *Drugs of Dependence Act 1989*.

Private clinics

3.15 In the opinion of the committee the establishment of a private methadone clinic in the Territory also has a number of benefits. It will reduce the burden on the Woden Valley clinic by providing the same range of treatment options and it will augment the current Government proposal to expand the public treatment service to allow the dispensing of methadone at health centres. And further, as with general medical practitioners, it will provide patients with a range of treatment options from which to choose.

Recommendation 6

3.16 The committee recommends:

That private medical clinics, should they so choose and should they meet the relevant statutory requirements, be permitted to provide health care for, and to prescribe methadone to, opiate dependent people.

The treatment program

3.17 The committee proposes that there be a basic reshaping of the ACT Methadone Treatment Program along the following broad general outline:

- **Stage 1** Immediate medical intervention to meet the critical and initial needs of opiate dependent people seeking assistance;
- **Stage 2** Stabilising the general health and well being of patients by means of medical support, methadone dose levels and, if sought, counselling;

- **Stage 3** Patient to choose future direction of treatment:
methadone reduction – a withdrawal option; or
methadone maintenance – an ongoing treatment option; and
- **Stage 4** Ongoing treatment and/or support through the patient's choice of agencies:
Methadone clinics, both public and private;
General Practitioners; or
Pharmacies.

3.18 Stages 1, 2 and 3 can, in the opinion of the committee, be both hospital based and private clinic base; the choice of treatment centre being, as it ought to be, the patient's.

Stage One

3.19 Stage 1 is the initial and most important intervention. Opiate and heroin dependent people make the choice to change their dependency life style amidst social, family and emotional crises; and the most distressing thing they can hear at such a time is "Sorry we can't help you; come back in a few months". The Methadone Program must be restructured in such a way so that as few barriers as possible stand in the way of some one getting into a methadone treatment program; either at Woden Valley Hospital or at a private clinic.

Stage Two

3.20 The core elements of stage 2 are the establishment of a viable and ongoing doctor/patient relationship and the 'normalization' of the treatment regime into an ordinary or standard medical treatment program. The duration of this stage is basically a medical decision, and one that ought to be made in consultation with the patient.

Stage Three

3.21 At this stage patients are empowered to make a choice about the future direction of their treatment; a choice made in consultation with their doctor, but ultimately their own. Although this general outline sees such a choice being made at stage 3 it does not preclude a patient making such a choice about their treatment upon immediate entry into the program, at the conclusion of stage 1 or during stage 2. Nor should the choice, made at any stage in the program, be an irreversible one.

Stage Four

3.22 Stage 4 is probably a new direction for the Methadone Program. It assumes that patients have, in the medical opinion of their doctor, reached a stage in their medical

rehabilitation where they have the right and the health status to be regarded as ordinary, normal citizens of our society, albeit with a medical condition. From which it follows that any further medical treatment regime or medical and social support mechanisms ought to be a matter of personal choice.

Changes

3.23 There are, in the opinion of the committee, only two fundamental changes which need to be made to make a methadone medical treatment program more readily accessible to the general community; there needs to be legislative change and there needs to be administrative change.

Legislative change

Private sector involvement

3.24 The *Drugs of Dependence Act 1989* needs to be amended to lift the restrictions on those who can provide this particular form of medical treatment; and that simply requires an amendment to the definition of 'treatment centre' in section 121 of the Act to include pharmacies and doctors' surgeries.

Additional public sector sites

3.25 The committee supports the Government's proposal to expand the public sector provision of methadone maintenance services by establishing dispensing facilities in health centres and thus supports, in principle, the *Drugs of Dependence (Amendment) Bill (No. 3) 1992* introduced into the Assembly by the Minister for Health. The committee does, however, have some concerns regarding the application of paragraph 80 (1) (c) of the Act as that paragraph relates to the dispensing of methadone by unsupervised nurses at the health clinics and the consequent cost implications.

3.26 The details of these legislative changes and the financial implications of them will be discussed in chapter 4.

Administrative change

3.27 In the opinion of the committee the specific administrative changes needed in the provision of this form of medical treatment to opiate dependent people are those associated with the methadone treatment centre currently located at Woden Valley Hospital.

Waiting lists

3.28 It is the committee's opinion that the proposed private sector expansion into the provision of methadone treatment will lead to a beneficial reduction of pressure on public facilities; particularly with those patients who are at stages 2 or 4 of their treatment. In these circumstances the committee believes there is an opportunity for the Woden Valley Clinic to expand its involvement in stage 1 treatment without incurring additional costs. Taking up such an opportunity would also have the beneficial effect of reducing the length of time patients must spend on the waiting lists.

Methadone Reduction Program

3.29 In keeping with the philosophy of providing the most appropriate care to patients the Woden Valley Clinic will, in the opinion of the committee, need to expand its Methadone Reduction Program. Currently there are 5 patients on this program (*see* paragraph 2.4). More places need to be made available for it to become a realistic treatment option for patients.

Urinalysis

3.30 One of the most important administrative changes that needs to be made at the Woden Valley Clinic is to the administrative arrangements concerning urinalysis. The committee is quite firm in its view that:

- there should be no compulsory testing;
- no non-medical use be made of test results;
- there should be no random testing; and
- the giving of urine samples is to be done in private.

Urinalysis is to be done for therapeutic purposes only and is to be solely a matter between the patient and the doctor.

Recommendation 7

3.31 The committee recommends:

That –

- (a) the urine testing of patients attending methadone treatment programs conducted by the Department of Health be done only at the request of a doctor in consultation with the patient;**
- (b) the results of a urine test of a patient attending a methadone treatment program conducted by the Department of Health be strictly confidential between the doctor and that patient; and**

- (c) **the giving of a urine sample by a patient attending a methadone treatment program conducted by the Department of Health be done in private without observation, either immediate or remote.**

Take away doses and transfers

3.32 Patient access to 'take away' doses of medication is a medical decision to be made by the patient's doctor. It is the committee's view, therefore, that there needs to be a liberalising of the administrative policy, at the Woden Valley Clinic, with regard to the provision of medicinal 'take away' doses. As the committee said at paragraph 2.35, the limiting of access to 'take away' doses as a reward or punishment is an insult to the dignity of the patient and cannot be justified. Nor must the provision of medication in this format be limited because of perceived administrative inconveniences.

3.33 In concert with a freeing up of the administrative policy with regard to 'take away' doses it is also necessary, in the opinion of the committee, to relax the policy concerning the availability of transferable prescription rights. If only because a patient's right of access to transferable prescription rights is a medical decision to be made solely by the patient's doctor in the best interests of that patient's health and well being. And at a philosophical level, patients undergoing medical treatment in the methadone treatment program must not have their ability to travel, to work, to play, to visit friends or relatives, or to take holidays circumscribed by the administrative or punitive decisions of the treatment program providers.

Recommendation 8

3.34 The committee recommends:

That –

- (a) **the right of access to 'take away' doses of methadone medication by a patient attending a methadone treatment program conducted by the Department of Health be determined by that patient's consulting medical practitioner only; and**
- (b) **the right of access to interstate transferable prescriptions for doses of methadone medication by a patient attending a methadone treatment program conducted by the Department of Health be determined by that patient's consulting medical practitioner only.**

Training

3.35 An issue of concern for the committee has been to ensure that pharmacists and general medical practitioners involved, or seeking to be involved, in methadone treatment

programs be competent to do so. This was an issue the committee raised in public hearings with the Pharmacy Guild and the Pharmaceutical Society who informed the committee that an accreditation program is being organised by the NSW Branch of the Pharmaceutical Society which would be available to pharmacists in the ACT. ⁽⁶⁾ Training for general practitioners is available through a certificated program at Woden Valley Hospital or alternatively through training programs sponsored by the NSW Alcohol and Drug Directorate.

Inspections

3.36 The committee is well aware that some criticisms have been raised about an increased financial burden on the public purse should community pharmacies be allowed to dispense methadone. As far as the committee has been able to ascertain the additional costs referred to would be incurred by the need to inspect pharmacies to insure they are meeting their legal responsibilities with regard to the storage and handling of methadone. The committee is at a loss to understand why this issue of additional costings has been raised.

3.37 Every pharmacy in the ACT is currently required by law to provide a monthly return to the pharmacy inspectors of the Department of Health. This 'Drugs of Addiction' report identifies all schedule one drugs dispensed during the month, in the following format:

- Surname, title, given name and address of recipient;
- The prescription number;
- Drug name, strength, form and directions;
- The prescribing doctor's name and date of the prescription;
- The prescription code; and
- The name of the dispensing pharmacist and the date of dispensing.

3.38 The pharmacy inspectors also inspect each pharmacy in the ACT twice a year to ensure that the pharmacist is abiding by the law with respect to record keeping concerning, and the dispensing practices of, dangerous drugs.

3.39 Methadone is simply a schedule eight drug ⁽⁷⁾; there are legal requirements and inspection requirements currently in place concerning the dispensing of schedule eight drugs by pharmacists – the committee has not been able to find an acceptable explanation as to why

⁶ Transcript, 3/9/92, pp 30–31

⁷ The term 'schedule 8 drugs' in fact refers to drugs of dependence as listed in schedule 1 of the *Drugs of Dependence Act 1989*; for historical reasons 'schedule 8' has remained in common usage when referring to the drugs of dependence listed in schedule 1.

allowing a pharmacist to dispense one more 'schedule eight' drug will lead to increased and unacceptable expenditures of public money.

— ● —

4. AMENDMENTS TO THE ACT

Drugs of Dependence (Amendment) Bill 1992

4.1 The Drugs of Dependence (Amendment) Bill 1992 was introduced into the Assembly on 17 June 1992 by Mrs Carnell ⁽¹⁾. The bill was referred to this committee, for inquiry and report by 15 October 1992, on 8 September 1992. ⁽²⁾ A copy of the bill is at Appendix E.

4.2 The committee has examined the bill in the light of its current inquiries into the ACT Methadone Treatment Program, the recommendations made earlier in this report and the provisions of the Drugs of Dependence (Amendment) Bill (No.3) 1992.

4.3 As the committee believes that the provisions of this bill seek to achieve different, but not mutually exclusive, aims from those of the Drugs of Dependence (Amendment) Bill (No. 3) 1992, it can see no reason why this bill should not be agreed to in principle.

Recommendation 9

4.4 The committee recommends:

That the Drugs of Dependence (Amendment) Bill 1992 be agreed to in principle.

4.5 To reflect the earlier recommendations of this report concerning the expansion of methadone treatment in the ACT (*see* paragraphs 3.5 to 3.16) the committee believes clause 3 of the bill should be amended to provide for doctors' surgeries to be defined as 'treatment centres'. It is also the committee's opinion that this amendment has no fiscal implications on the public money of the Territory.

Recommendation 10

4.6 The committee recommends:

That clause 3 of the Drugs of Dependence (Amendment) Bill 1992 be amended by inserting in the proposed definition of 'treatment centre' the

¹ MoP (1992), No 12, p 61

² MoP (1992), No 23, p 129

following new paragraph:

"(c) premises at which a medical practitioner practices medicine;"

Drugs of Dependence (Amendment) Bill (No. 3) 1992

4.7 The Drugs of Dependence (Amendment) Bill (No. 3) 1992 was introduced into the Assembly on 8 September 1992 by the Minister for Health and the bill was referred to this committee, for inquiry and report by 15 October 1992, on the same day.⁽³⁾ A copy of the bill is at Appendix F.

4.8 The committee has examined this bill in the light of its current inquiries into the ACT Methadone Treatment Program, the recommendations made earlier in this report and the provisions of the Drugs of Dependence (Amendment) Bill 1992.

4.9 As the committee believes that the provisions of this bill seek to achieve different, but not mutually exclusive, aims from those of the Drugs of Dependence (Amendment) Bill 1992, it can see no reason why this bill should not also be agreed to in principle.

Recommendation 11

4.10 The committee recommends:

That the Drugs of Dependence (Amendment) Bill (No. 3) 1992 be agreed to in principle.

4.11 In order to give effect to the committee's recommendations concerning the establishment of private methadone clinics in the Territory (*see* paragraphs 3.15 and 3.16), the committee believes the bill should be amended to expedite applications for grants of approval to conduct a treatment centre.

Recommendation 12

4.12 The committee recommends:

That the Drugs of Dependence (Amendment) Bill (No. 3) 1992 be amended by adding at the end thereof the following new clause 6:

³ *Ibid*

Approval – grant

"6. Section 150 of the Principal Act is amended by adding at the end thereof the following new subsection:

'(3) The Board, on receipt of an application in accordance with section 149, shall, within 28 days of the receipt of that application, determine, in accordance with subsection (1), whether or not to grant an approval to the applicant to conduct a treatment centre of the type specified in the application at the premises specified in the application.'".

LIST OF RECOMMENDATIONS**Recommendation 1 (Paragraph 3.8)**

That the restrictions, legal and administrative, which limit the provision of treatment for opiate dependent people to treatment centres conducted by the Department of Health be lifted.

Recommendation 2 (Paragraph 3.10)

That community pharmacies, should they so choose and should they meet the relevant statutory requirements, be permitted to dispense, on prescription, methadone to opiate dependent people.

Recommendation 3 (Paragraph 3.11)

That the premises at which a pharmacist practices pharmacy be included in the definition of "treatment centre" in the *Drugs of Dependence Act 1989*.

Recommendation 4 (Paragraph 3.13)

That general medical practitioners, should they so choose and should they meet the relevant statutory requirements, be permitted to provide health care for, and to prescribe methadone to, opiate dependent people.

Recommendation 5 (Paragraph 3.14)

That the premises at which a general medical practitioner conducts his or her medical practice be included in the definition of "treatment centre" in the *Drugs of Dependence Act 1989*.

Recommendation 6 (Paragraph 3.16)

That private medical clinics, should they so choose and should they meet the relevant statutory requirements, be permitted to provide health care for, and to prescribe methadone to, opiate dependent people.

Recommendation 7 (Paragraph 3.31)

That –

- (a) the urine testing of patients attending methadone treatment programs conducted by the Department of Health be done only at the request of a doctor in consultation with the patient;
- (b) the results of a urine test of a patient attending a methadone treatment program conducted by the Department of Health be strictly confidential between the doctor and that patient; and
- (c) the giving of a urine sample by a patient attending a methadone treatment program conducted by the Department of Health be done in private without observation, either immediate or remote.

Recommendation 8 (Paragraph 3.34)

That –

- (a) the right of access to ‘take away’ doses of methadone medication by a patient attending a methadone treatment program conducted by the Department of Health be determined by that patient’s consulting medical practitioner only; and
- (b) the right of access to interstate transferable prescriptions for doses of methadone medication by a patient attending a methadone treatment program conducted by the Department of Health be determined by that patient’s consulting medical practitioner only.

Recommendation 9 (Paragraph 4.4)

That the Drugs of Dependence (Amendment) Bill 1992 be agreed to in principle.

Recommendation 10 (Paragraph 4.6)

That clause 3 of the Drugs of Dependence (Amendment) Bill 1992 be amended by inserting in the proposed definition of ‘treatment centre’ the following new paragraph:

"(c) premises at which a medical practitioner practices medicine;"

Recommendation 11 (Paragraph 4.10)

That the Drugs of Dependence (Amendment) Bill (No. 3) 1992 be agreed to in principle.

Recommendation 12 (Paragraph 4.12)

That the Drugs of Dependence (Amendment) Bill (No. 3)1992 be amended by adding at the end thereof the following new clause 6:

Approval – grant

"6. Section 150 of the Principal Act is amended by adding at the end thereof the following new subsection:

'(3) The Board, on receipt of an application in accordance with section 149, shall, within 28 days of the receipt of that application, determine, in accordance with subsection (1), whether or not to grant an approval to the applicant to conduct a treatment centre of the type specified in the application at the premises specified in the application.'."

- * -

APPENDIX A

SUBMISSIONS

ACT Intravenous Drug Users League

Anonymous

Assisting Drug Dependence Inc

Australian Medical Association – ACT Branch

Department of Health

Narcotic and Opiate Dependency Syndrome Sufferers Association Inc

**Pharmaceutical Society of Australia (ACT Sub Branch) and Pharmacy Guild of Australia –
ACT Branch**

Mr A Stankevicius

Dr M Tedeschi

APPENDIX B

WITNESSES

ACT Intravenous Drug Users League

Ms Judith Therese Byrne – Co-ordinator

Assisting Drug Dependence Inc

Ms Claire Caesar – Acting Service Director

Australian Medical Association – ACT Branch

Dr Robert John Allen – President

Dr Keith Powell – Member

Department of Health

Ms Gillian Mary Biscoe – Chief Executive Officer

Dr Andrew Thomas Butlin – Director, Alcohol and Drug Service

Narcotic and Opiate Dependency Syndrome Sufferers Association Inc

Mr Anthony William Roben – President

Ms Amanda Corkery – Secretary

**Pharmaceutical Society of Australia (ACT Sub Branch) and Pharmacy Guild of Australia –
ACT Branch**

Mr Bill Arnold – Vice-President, ACT Branch, Pharmacy Guild of Australia

**Mr Peter John Holder – Chairman, ACT Sub-branch, Pharmaceutical Society of
Australia.**

APPENDIX C

**CONTRACTUAL DOCUMENT FOR METHADONE MAINTENANCE
PROGRAMME (MMP)**

(To be read and signed by each client before commencing Methadone Maintenance)

July 1989

AIM

Long term the aim will be to remain free of heroin and other illicit drugs both while taking and following the cessation of Methadone.

Short term benefits will include being free from the social effects, physical harm and legal consequences arising from illicit intravenous drug use.

While the ACT Methadone Maintenance Programme is not time limited it is recommended that the reduction phase begin after two years on a full MMP. The rate of reduction is negotiable. Clients seeking extension of their programme beyond two years may be required to show cause as to why the extension should be granted.

OBJECTIVES

1. To provide Methadone, in a linctus form (ie liquid form) daily.
2. To ensure daily contact with the unit nurse member of the Alcohol and Drug Service (A&DS) staff. This allows for comment from the client as to how he/she is progressing. It ensures a regular monitoring of progress and where necessary can be the means of quick referral to another member of the A&DS (eg counsellor or medical practitioner).
3. It is required of all, who undertake this programme that they maintain contact with both a doctor and a counsellor. Counselling is viewed as an essential part of the programme and will assist clients to deal with the dependency state.

CONTRACTUAL DETAIL

Having been advised by the A&DS Hospital Unit staff that I may begin on a methadone maintenance programme, I:

1. Agree to abide by the Rules of the Clinic as shown in the Client Information Booklet.

2. **Agree to be, at all times, courteous in dealing with staff and other people I meet in the hospital; accept that violence or abuse towards unit staff, other clients or hospital staff is unacceptable behaviour and that if I am violent or abusive then I may be removed from the programme, either rapidly or slowly as circumstances dictate.**
3. **Agree to provide a passport size photo if so requested by the staff (in most cases a photo is provided by staff. However circumstance may rule this out).**
4. **Will be prepared to be reviewed regularly (currently at three month intervals) by a counsellor and doctor and, within reason, accept his or her advice as to investigations and management.**

I also accept that the medical staff are not in a position to provide a general practitioner medical cover and for this reason I will be prepared to visit a local GP or Health Centre as the need arises.

APPENDIX D

CLIENT INFORMATION BOOKLET

A.C.T. METHADONE CLINIC

CLIENT INFORMATION BOOKLET

**Alcohol and Drug Service
Woden Valley Hospital**

Telephone Number (062) 244 2191

January 1992

ACT Health provides Methadone Programmes at the Alcohol and Drug Service Woden Valley Hospital Unit. Counselling Services are viewed as an essential part of these programmes.

The aim of the Service is to assist you to lead a drug-free life and develop a satisfying, healthy lifestyle.

Methadone can be a dangerous drug. Its use in combinations with other drugs will increase this danger.

The information in this booklet is meant to give you a clear indication of what is available to you and our requirements while you are on the programme.

RULES (for people on a maintenance programme)

1. You are required to attend the Unit every day of the week to pick up methadone. The dispensing hours are –

Monday to Friday

7.15 – 12 pm
4.00 – 5.00 pm

Weekends and Public Holidays

7.15 – 10.30 am
11.00 – 12.30 pm
1.30 – 3.00 pm

These are not absolute. They may be varied by staff to meet changing circumstances. Notification of change will be given. In the interests of others please ensure arrival 15 minutes before closing times as there is usually a queue and supervised urine may be requested.

2. Your Methadone must be swallowed in the presence of the person administering the drug.
3. One dose per day will be provided. If missed for any reason this dose will be forfeited.

4. Since the reason for you attending the hospital is to take Methadone, you are expected to leave the hospital once that dose has been taken. The hospital should not be seen as a public meeting place.
5. If you fail to collect your Methadone on three (3) consecutive days your dose will be withheld until you have been reviewed.
6. You must attend a review with the nursing staff and doctor every three (3) months. This is essential for the continued prescribing of Methadone. Methadone can only be legally prescribed for a 90 day period. To ensure renewal of your script it is essential that appointments be made and kept before the 90th day.
7. Requests for supervised urines are made on a random basis. The regime is as follows:
 - (a) if you are unable to pass a supervised urine on request, you will be dosed, and informed that you must provide a urine the following day.
 - (b) On day two, if unable to do a supervised urine, you may be given your usual dose, with the option of re-appearing later in the day to provide the urine. If at the end of day two you have not passed a supervised urine, then the episode will be recorded as a contaminated urine. The usual consequences of contaminated urine will apply.
8. The onus is on the client to return.
9. Extra urines will/may be taken in the following circumstances:
 - (a) When Methadone has been missed on the previous day.
 - (b) When dispensing staff suspect drug use on that day.
 - (c) Following a take-away dose – not for routine Sunday take away.
10. The use of illicit drugs – as seen in contaminated urine specimen while on the Methadone Programme will result in review and possible discharge from the programme.
11. Substitution of urine is an unacceptable practice, and if detected, dispensing staff have the right to refer you to the prescribing doctor to discuss your problems before you get your Methadone dose for that day.

12. If at presentation to the Unit the staff feel confident that you are under the influence of a mood changing drug your Methadone dose for that day may be refused or reduced.
13. For a variety of reasons clients may be asked to provide breath analysis using the alcometer.
14. In keeping with ACT Board of Health policy, building 7 is a No Smoking Facility. We therefore request your co-operation in not smoking while inside the building.
15. Clients are asked to drive slowly and carefully around the hospital grounds, obeying STOP SIGNS, GIVE WAY SIGNS and observing parking rules.

RESTRICTIONS

1. Clients who actively engage in criminal activities whilst on Methadone Programmes will be at risk of being taken off the programme.
2. Violence and/or abuse within the Hospital towards staff, clients or other persons will not be tolerated. Clients involved will be asked to leave at once, and if necessary, the Police will be called. The Methadone Programme may be terminated immediately for clients concerned in any way with violent and abusive behaviour.
3. It is acknowledged that while you have the right to withdraw from the programme at any time, it will be to your advantage to discuss this issue with the A&DS staff prior to making that decision.
4. Information provided to this service is treated confidentially.

TAKE AWAY REQUESTS

Take-away doses are regarded as a privilege not a right.

Our policy is as follows:

1. ALL clients receive a take-away dose on Christmas Day and Good Friday because of public transport difficulties on those days.
2. Take-away doses, at any other time, are not available to clients on Methadone Reduction Programmes.

3. No one is to receive take-away doses until he or she has been on the programme for a sufficient time to observe that he/she is progressing according to unit guidelines. This is usually three months.

An exception may be made in the following circumstances:

- (a) Work reasons which are verifiable.
 - (b) For urgent other reasons which are verifiable, eg, serious illness, court appearance, death of immediate family member.
4. When requesting a take-away dose please ask one of the nursing staff for the appropriate form, put your request in writing and leave it with the staff. At least ten (10) days notice is required.

TEMPORARY TRANSFERS

1. Temporary transfers are not available to clients on Methadone Reduction programmes.
2. Temporary transfers are not available during the first three (3) months of a Methadone Maintenance Programme except for emergencies.

Nursing staff must be given:

- a. Three (3) weeks notice
 - b. Firm dates
 - c. Address in other centre.
3. For temporary transfer requests: please ask one of the nursing staff for the appropriate form, put your request in writing and leave it with the staff.

PHARMACY INFORMATION ON THE DRUG METHADONE

1. It is a synthetic opiate and therefore dependency to it may occur. This will not occur when on a reduction programme, as the dose is steadily decreased.

2. It is likely to cause constipation. Thus two litres of fluid per day plus a high fibre diet is recommended.
3. In the liquid form, as used in the clinic, the sugar content may cause caries or bad breath. Cleaning with a tooth brush soon after taking the drug is recommended.
4. For the majority of people it does not cause significant side effects. However, if an additional opiate is taken (eg street heroin) an overdose reaction may occur. The same effect may result if a heavy dose of sedative is taken, (eg Serapax) or following the smoking of cannabis (ie marijuana).
5. A person's immunological system is not impaired by the drug.
6. It does not cause physical damage to the unborn child (embryo/foetus). However as small a dose as possible is recommended for pregnant women. The smaller the dose the less severe will be the withdrawal reaction of the new born child.
7. It does cause sedation among those who are not used to it. For this reason new clients to the programme, or clients who increase their dose should exercise caution while driving a car or motor bike, or operating heavy machinery.

APPENDIX E

1992
THE LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

(As presented)

(Mrs Carnell)

Drugs of Dependence (Amendment) Bill
1992

A BILL
FOR

An Act to amend the *Drugs of Dependence Act 1989*

The Legislative Assembly for the Australian Capital Territory enacts as follows:

Short title

1. This Act may be cited as the *Drugs of Dependence (Amendment) Act 1992*.

Principal Act

2. In this Act, "Principal Act" means the *Drugs of Dependence Act 1989*.¹

Interpretation

3. Section 3 of the Principal Act is amended by inserting in subsection (1) the following definition:

"treatment centre" means –

- (a) a hospital, nursing-home, hostel or other institution that ordinarily provides treatment for persons who are drug dependent in relation to any drug of dependence; or

(b) premises at which a pharmacist practices pharmacy;

but does not include a hospital or other health facility conducted by the Board;"

Interpretation

4. Section 121 of the Principal Act is amended by omitting the definition of "treatment centre".

Approval – application

5. Section 149 of the Principal Act is amended by omitting from paragraph (2) (b) all the words after subparagraph (vii) and substituting the following subparagraph:

"(viii) the treatment to be conducted at the proposed treatment centre and, in particular, whether it includes the administration of methadone; and".

NOTE

1. Ordinance No. 11, 1989 as amended by Nos. 21 and 38, 1989; Act No. 63, 1990; Nos. 5 and 44, 1991.

APPENDIX F

1992
THE LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

(As presented)

(Minister for Health)

Drugs of Dependence (Amendment) Bill
(No. 3) 1992

A BILL

FOR

An Act to amend the *Drugs of Dependence Act 1989*

The Legislative Assembly for the Australian Capital Territory enacts as follows:

Short title

1. This Act may be cited as the *Drugs of Dependence (Amendment) Act (no. 3) 1992*.

Principal Act

2. In this Act, "Principal Act" means the *Drugs of Dependence Act 1989*.¹

Interpretation

3. Section 3 of the Principal Act is amended by omitting from subsection (1) the definition of "methadone program treatment centre" and substituting the following definition:

"methadone program treatment centre" means a treatment centre or other facility where methadone is administered to drug dependent persons for the treatment of their drug dependency –

(a) conducted by the Board or the Territory; or

- (b) approved under Division 4 of Part IX for that purpose;
whether or not the primary purpose of the centre or facility is to provide treatment for persons who are drug dependent;"

Interpretation

4. Section 95 of the Principal Act is amended by omitting the definitions of "prescribed person" and "ward" and substituting the following definitions:

"'prescribed person' means –

- (a) a licensee;
- (b) a pharmacist in control of a dispensary;
- (c) a Chief Pharmacist;
- (d) a medical practitioner, dentist or veterinary surgeon; or
- (e) a person in charge of a methadone program treatment centre;

'ward' includes a methadone program treatment centre, whether or not the centre forms part of an institution;"

Patients' records

5. Section 108 of the Principal Act is amended by omitting ", where the centre is not a ward" and substituting "that does not form part of an institution".

NOTE

1. Ordinance No. 11, 1989 as amended by Nos. 21 and 38, 1989; Act No. 63, 1990; Nos. 5 and 44, 1991; Nos. , 1992.

**DISSENTING REPORT AND ADDITIONAL COMMENTS –
MRS E GRASSBY, MLA**

INTRODUCTION

The aim of this Committee has been to inquire into the efficacy of the ACT Methadone Program. In the course of this enquiry two competing Bills have been introduced to the Legislative Assembly and referred to this Committee for consideration. These Bills had both been drafted to address perceived problems with the ACT Methadone Program. There has been criticism levelled at the Methadone Program and the Committee has attempted to address these criticisms and where necessary recommend change.

While I concur with much of the final report there are some vital areas which I believe have been over simplified or not addressed with sufficient objectivity to arrive at a workable strategy for the ACT Methadone Program to implement.

I was moved by the candour of some who came to give their point of view and dismayed by others who I believe were self-serving in their interests.

CONFLICT OF INTEREST

Whilst the Committee was assured by pharmacy guild members and Ms Carnell herself that there was no commercial advantage to individual pharmacies in the dispensing of Methadone I would question this assertion as it is incumbent on small business owners to maximise their profit potential.

The expertise that Ms Carnell brought to the Committee as President of the ACT Pharmacy Guild, a pharmacist and a pharmacy proprietor was welcome, however, her ability to objectively examine the potential role of pharmacies in the Methadone program could be questioned in the light of her personal interests.

DISPENSING

The statement that, 'For the benefit of the community at large, as well as for the individuals themselves no one in need ought to be turned away', is one that I am generally happy to support. I feel that such a statement must be considered in the light of the constraints of Budget expenditure which ultimately has the potential to postpone the achievement of our ultimate goal of dispensing Methadone to those wishing to take part in the program.

However, I believe that the Government has set an appropriate agenda for the expansion of the Methadone program that will enable a greater number of participants to take part.

It is my belief that the Government's *Drugs of Dependence (Amendment) Bill (No3) 1992* with its stated aim of expanding the Methadone Program will additionally have the welcome consequence of decentralising the dispensing of Methadone to a certain degree. This in turn will assist in the greater accessibility by the client, of the services offered. This accessibility will ease the strain of having to travel long distances to one central base and allow for more flexibility in the client's life style and employment. The provision that allows opiate dependent persons diagnosed as stable to progress away from non stabilised clients recognises that persons on the Methadone program are in different stages of their treatment and should be treated in such a way. Additionally it is a welcome move to remove stable clients from the more 'at risk' environments in line with the stated goals of the Methadone Program overall.

I welcome the establishment of three Methadone dispensing points in central, northern and southern Canberra however I would urge the Government to consider a third site operating in Narrabundah with a view to future expansion into Belconnen.

When adequate service of the wider community is achieved I recommend that data be gathered on the success or otherwise of the trialling of take-away doses and holiday doses at these sites. Upon their analysis I recommend that the Government consider applications from the private sector for licence to operate a private clinic in the ACT.

I support in total Recommendation 8:

That –

- (a) the right of access to 'take away' doses of methadone medication by a patient attending a methadone treatment program conducted by the Department of Health be determined by that patient's consulting medical practitioner only; and**
- (b) the right of access to interstate transferable prescriptions for doses of methadone medication by a client attending a methadone treatment program conducted by the Department of Health be determined by that patient's medical practitioner only.**

PHARMACISTS AND MEDICAL PRACTITIONERS

While I believe the decentralising of the dispensing of Methadone to be beneficial to the client I feel that it is not in the best interest of the client for pharmacists or general practitioners to dispense Methadone.

It is my opinion that pharmacies are primarily a commercial enterprise and as such their focus is on volume of sales, customer service and supply. It is difficult to see where the relevance of dispensing methadone fits into the running of a commercially viable enterprise. The dispensing of methadone must be done with care and attentiveness to the wellbeing or otherwise of the client attending. I believe that this kind of consideration to the client will be difficult to provide considering the commercial demands of a busy dispensing pharmacy.

It may be useful to consider that on a recent trip to Sydney by the Committee we were told by the Health Department of NSW a most tragic event involving a client receiving Methadone at a local Pharmacy. The client had been murdered and his body not discovered for five days. He had not been present at the Pharmacy for his daily doses during this time and yet his absence had not been reported by the dispensing pharmacist or a staff member. It is an understandable and yet disturbing consequence of a busy pharmacy attending to the needs of a large number of customers on a daily basis.

One might consider that had the client had a medical emergency between doses and was attending a clinic for his daily dose, his absence may be reported and action taken to establish the client's status and necessary action taken and perhaps a life saved.

Therefore, I do not agree with Recommendations 1, 2, 3, 4 or 5.

With regard to Recommendation 8, At this stage of the implementation of the Government's program I do not recommend the implementation of private clinics in the ACT. However, I support in principal the treatment program outlined in point 3.17.

I believe that stage 4 should be corrected to read :

Ongoing treatment and/or support to the client.

I recommend that 3.18 be corrected to read:

At this point in time Stages 1, 2, 3 and 4 should be offered only at Woden Valley Hospital or at designated clinics run by the Department of Health.

URINE TESTING

While urinalysis has had a great deal of criticism within the existing program it is my view that it is a useful tool within the medical context and therefore should be used.

Urinalysis is an essential diagnostic tool of medical practitioners in a variety of presentations. As part of the 'Duty of Care' urinalysis is a valid method in establishing a client's present

position within the program. It is incumbent on the medical practitioner who administers any drug therapy to verify the safety of the drug and suitability of the dosage being prescribed.

I recognise the medical requirement to establish authenticity of a urine sample given by a client new to the program or with poor performance, therefore, I recommend some kind of verifying procedure. I stress that this must be done with minimal intrusion to the client and with the greatest respect for human dignity.

A urine test seeks to establish the health status of the client and on this basis I believe that any attempt to use a failed test to make a moral decision about a client is inappropriate within the program. Urinalysis must be used only within the context of the therapeutic benefit to the client.

I recommend that less frequent urine testing be implemented among stable clients or those clients on low intervention programs.

With regard to Recommendation 7 in the Committee's report I recommend:

That -

- (a) **the urine testing of patients attending methadone treatment programs conducted by the Department of Health be done only at the request of a doctor in consultation with the client;**
- (b) **the results of a urine test of a client attending a methadone treatment program conducted by the Department of Health be strictly confidential between the doctor and the client; and**
- (c) **the giving of a urine sample by a client attending a methadone treatment program conducted by the Department of Health be done with the consideration of establishing the authenticity of the sample given and in conjunction with the respect and privacy of the client.**

AMENDMENTS TO THE ACT

Drugs of Dependence (Amendment) Bill 1992

I do not agree with Recommendations 9, 10 or 12.

In regard to Recommendation 11 I believe that the Drugs of Dependence (Amendment) Bill (No.3) be agreed to in total. Therefore it should read:

That the Drugs of Dependence (Amendment) Bill (No.3) 1992 be agreed to.

FINAL COMMENTS

It has been the undertaking of the Committee to look into the operation of the ACT Methadone Program.

It is my view that the Methadone program is a vital service to the ACT Community. It offers opiate users an opportunity to remove themselves from the illegality of obtaining heroin on a daily basis. It facilitates a 'door to change' and provides an opportunity for users to address their dependence within the context of the provision of a legal, medically supervised alternative. I believe the Methadone Program is essential to those wishing to address their addiction and move beyond it.

Apart from a methadone service I believe there should be made available through Government funds a program both residential and non-residential to support those wishing to remove themselves from the risk environment and to avail themselves to counselling, training employment schemes and general rehabilitation into the mainstream community and if possible assistance provided for spouses and children.

Although such a scheme would inevitably place a greater strain on the ACT Health budget the Government should examine the possibility of diverting any surplus funds arising from the Health Minister's Bill which provides for a 'user pays' system to be instituted within the ACT Methadone Program to fund this expanded service.

It is incumbent on the Government to ensure that all members of the community are able to avail themselves of health services, regardless of the nature of the illness. Therefore the ACT Methadone Program is an essential part of our Health Care Program.

It is evident to me after my extensive overseas visits to clinics and universities in the USA, the UK and Europe that our only viable option in the understanding of the abuse of drugs within our society and the consequent healing is through an education process.

The family is the most potent of all the influence groups and as such the child's experience in the family provides the basic filter for identity. If the family role model is dysfunctional the children are in danger of becoming dysfunctional adults themselves. Appropriate education can be the factor that guides children to become competent and capable regardless of what life has dealt them.

Our schools can be an arm of prevention. That is, they can teach prevention strategies that promote health by empowering youth with the resources necessary to confront complex, stressful life conditions and to lead satisfying and enriching lives.

I believe that only through a program that promotes the training of teachers in risk assessment identification of 'at risk' children and the teaching of skills to students by trained teachers in problem-solving, crisis management, social bonding to positive role models and resiliency building, will we be able to provide our youth with positive, life affirming goals to assist in the living of their lives in health and empowerment.

A handwritten signature in black ink, appearing to read 'Elnor Grassby', with a long horizontal flourish extending to the right.

Elnor Grassby MLA
12 October 1992

INDEX

A

Abstinence policy, 3, 7
 Accreditation programs, 21
 ACT
 Intravenous Drug Users League, 8, 10, 13
 Methadone
 Clinic, 2, 4, 10
 Program, 3, 6, 8, 10, 14, 16, 17, 23, 24
 ACTIV. *See* ACT Intravenous Drug Users League.
 ADD Inc. *See* Assisting Drug Dependence Inc.
 Administrative change, 18
 Alcohol, 1
 Alcohol and Drug
 Directorate, NSW, 2, 21
 Service, 5
 Allen, Dr R, 8
 AMA. *See* Australian Medical Association.
 Assisting Drug Dependence Inc, 6
 Australian Medical Association, 7, 8

B

Banks, S, 2
 Benzodiazepines, 1

C

Commonwealth funding, 14
 Counselling services, 3

D

Department of Health, 4, 5, 6, 21
 Dependent opiate users, 4, 14, 15, 16, 17
 Detoxification Unit, 2
 Dispensing hours, 4
 Diversion, 11
 Doctor – Patient relationship, 10, 13, 17
 Doctors – Training, 21
Drugs of Dependence Act 1989, 18
 Drugs of Dependence (Amendment) Bill
 1992, 1, 23, 24
 Drugs of Dependence (Amendment) Bill
 (No. 3) 1992, 1, 6, 7, 18, 23, 24

H

Harm minimisation, 3, 13
 Health
 Care budget, 14
 Centres, 16, 18
 Needs, 13
 Status, 18
 Treatment, 15

I

Inspection of pharmacies, 21
 Interstate visit, 2

K

Kobi Clinic, 2

L

Legislative change, 18

M

MacAvoy, Dr M, 2
 Maintenance
 Dose, 7
 Option, 17
 Marty, M, 2
 Medical
 Modalities, 8
 Practitioners, 14, 15, 17, 18
 Training of, 20
 Treatment, 7, 13, 14, 18
 Program, 3, 9, 17, 18
 Medication, 7, 13, 15
 Methadone, 1, 5, 7, 13, 21
 Methadone
 Dose, 9, 16
 Maintenance Program, 3, 7, 9, 10, 11
 Reduction Program, 3, 4, 8, 19
 Minister for Health, 1, 2, 6, 7, 18, 24

N

Narcotic and Opiate Dependency Syndrome
 Sufferers Association, 5, 10, 12, 13
 NODSSA. *See* Narcotic and Opiate
 Dependency Syndrome Sufferers
 Association
 Nurses, 18

O

Operating hours, 4
 Opiate dependence, 4, 7, 8

P

Patient – Doctor relationship, 10, 17
 Patient rights, 9, 13, 15, 18, 20
 Pharmaceutical Society of Australia, 21
 Pharmacies, 14, 15, 17, 18
 Pharmacies
 Inspection of, 21
 Monthly returns, 21
 Pharmacists – training of, 20

Pharmacy

- Guild of Australia, 21
- Inspectors, 21
- Physeptone maintenance program, 6
- Priority placements, 6
- Privacy, invasion of, 9, 19
- Private methadone clinics, 16, 17, 19, 24
- Program
 - Choices, 17
 - Costs, 5
 - Expansion, 14, 18, 19
 - Places, 5, 6, 14
 - Public hearing, 2
 - Punishment regime, 3

R

- Regency House, 2
- Rehabilitation, 18
- Resolution of appointment, 1

S

- Schedule 8 drugs, 13
- Schedule one drugs, 21
- Seldler, Dr R, 2
- Select Committee on HIV, Illegal Drugs and Prostitution, 3
- Service providers
 - Private, 14
 - Public, 14
- Single
 - Option program, 7
 - Site location, 7
- St Vincent's Hospital, NSW, 2
- Submissions, 2

T

- Take away doses, 10, 20
- Training, 21
- Tranquillisers, 1
- Transfers, 11, 20
- Treatment centre, 18, 23, 24

U

Urinalysis

- Clean results, 9, 10
- Compulsory, 3, 9, 19
- Definition of results, 9
- Invasion of privacy, 9, 19
- Non-medical use, 9, 10, 19
- Purpose, 8
- Random testing, 10, 19
- Therapeutic value, 8, 10, 19
- User-pay system, 15

W

- Waiting list, 6, 19
- Wilson, A, 2
- Withdrawal
 - Option, 17
 - Symptoms, 4
- Witnesses, 2
- Wodak, Dr A, 2
- Woden Valley Hospital, 2, 7, 8, 10, 16, 17, 18, 19, 20, 21

Y

- Youth, 1