Victorian Pharmacotherapy Review

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Executive summary

The project

The Drug Policy Modelling Program (DPMP): University of New South Wales in collaboration with the Health Services Research and Evaluation program at Turning Point Alcohol and Drug Centre conducted a review of the Victorian Pharmacotherapy Program, from here on referred to as the Opioid Replacement Therapy (ORT) program. The purpose of the review, as outlined in the Request for Quotation, was to develop an evidence-based options paper '*to ensure pharmacotherapy services in Victoria remain responsive to current and future demand while improving accessibility for clients and reducing service gaps'.*

The context

The Victorian 'community-based' ORT service model was established in the early 1990's in what was a deliberate strategy to normalise and de-stigmatise opioid dependence and make it a much more accessible treatment option. The key to this model was the provision of services primarily through general practitioners and community pharmacies. The other critical component of the model was the development of specialist services to treat the most serious and complex opioid dependence problems and provide the necessary supports to community-based ORT providers. At that time and in the early years of the operation of this model it was acknowledged as a great success. The fundamentals of the ORT model are as relevant today as they were fifteen years ago, however the growth of the program that we have witnessed, while it should be applauded, has placed the model under considerable strain.

Over the past four years the percentage of ORT clients in Victoria has increased by approximately 15% to the current level of more than 13,000 and over this same period the number of GP prescribers has declined by the same percentage (approximately 400 current active prescribers). This decline should be viewed in the context of an already low base with less than 10% of GPs involved in ORT provision in Victoria in any given year. Over 90% of ORT clients have their medications dispensed in community pharmacies and although the number of pharmacies involved in the ORT program has increased by 5 percent over the last four years, only about 40% of pharmacies are involved in the ORT program.

The Specialist Pharmacotherapy Services (SPSs), while acknowledged as providing good quality clinical services, cater for less than 5% of the total ORT client group, and only those who reside in close proximity to the four Melbourne-based services. Access to these services is difficult and virtually impossible for those in rural and remote areas. The original intent that SPSs would engage with community ORT providers in shared-care arrangements, and provide secondary consults or training has been largely unrealised. It should also be noted that there are now more ORT medication options available. Since the introduction of the buprenorphine/ naloxone combination product (Suboxone®), prescription rates in Victoria have risen from 13.6% of total ORT medication in 2006 to 30.1% in 2010. This rapid increase reflects the better safety profile and reduced diversion potential associated with buprenorphine-naloxone. Another important development has been the recognition of Addiction Medicine as a medical specialty in December 2009. This development and the potential for other professions to prescribe medications will continue to change the nature of the Victorian ORT program.

The methodology

The project was conducted from March to September 2010 and was guided by a project reference group of experts and stakeholders to the Victorian ORT system. Rather than

conduct another literature review, the project drew on recent work by DPMP (*Polygon: The many sides to the Australian opioid pharmacotherapy maintenance system*, Ritter & Chalmers, 2009), more recent published research, and grey literature relating to various aspects of the Victorian ORT system. From this literature a consultative options paper was developed outlining 43 options/solutions to address identified weaknesses in the Victorian ORT system. It was a deliberate strategy to identify a wide range of potential options and while some were a little 'blue sky' in nature, they were all evidence-based (detailed in Appendix 1). Reference Group members were very supportive of this approach and it provided the basis for the wider consultation process. A stakeholder list was generated in collaboration with the Department of Health and subsequently 22 key informants were interviewed and 21 contributed to one of 3 focus groups (reference group members, service providers and consumers). All stakeholders were provided with a copy of the consultative options paper and were asked to complete a 'pre-consultation checklist' that allowed respondents to indicate the level of priority they would attach to each of the 43 options. There was also an opportunity to indicate that they did not support an option at all (nil priority). All interviews were recorded and analysed, as were the completed checklists. Frequencies for 'high' and 'medium' priority were combined and an arbitrary cut-off point of 65% was set. This provided the basis for including options. If an option did not reach the cut-off but was close, the researchers drew on the research evidence and key stakeholder feedback to determine whether an option should be pursued further.

The major findings and (selected) key recommendations

The project highlighted that the Victorian ORT model fundamentals are sound. However some changes are now needed to address system strains arising primarily from rapid continued growth. These changes are necessary to ensure that continued ORT growth can be accommodated, emerging issues addressed and quality of care assured.

The major project findings relate to:

1. Inadequate specialist system and poor referral and support pathways between specialist and primary care;
2. Insufficient treatment places (prescribers and dispensers);
3. Lack of program affordability for clients;
4. Workforce development and support issues; and
5. Quality of care issues.

Specialist services and service connections

The specialist service system requires redevelopment and further investment to ensure that it is better able to cater for the needs of the more serious and complex clients (more treatment places; more comprehensive service provision; and more shared care). The specialist service as it is currently configured is almost irrelevant to ORT clients and community-based service providers located in outer metropolitan and, most particularly, in rural areas. The ORT system was originally conceptualised as a partnership between the specialist system and community or primary care providers. The aim was to develop client care pathways using various formal and informal agreements to ensure that there was good capacity to match the intensity of the services with complexity of the issues confronting clients (recognising that these change over time). Due to a range of factors this capacity for client movement has not occurred as was originally intended and it remains a problem in the Victorian ORT system. Specialist services also need to provide better back-up support for colleagues in the community component of the ORT system in terms of secondary consults, mentoring and training.

Selected recommendations:

- That DH thoroughly redevelop the SPS system to ensure that it meets current and emerging needs (adopting key service requirements as outlined on p 65);

- That DH increase the funding provided to the SPS's commensurate with the increased expectations of the redeveloped SPS services;
- That DH in collaboration with DH regional offices establish 'specialist hub' services in outer metropolitan and rural regions (adopting key service requirements as outlined on p 65);
- That local networks of services, including specialist and generalist programs, which include formal referral pathways and regular activities to build and maintain inter-agency relationships are created; and
- That shared care is incorporated into service operations, supporting program establishment in a manner consistent with guidelines.

Insufficient treatment places
Despite escalating demand for ORT, community provider (GPs and pharmacists) engagement in the program has levelled-off or is declining. Engaging ORT prescribers and dispensers remains a significant challenge in Victoria. The lack of treatment places makes the ORT service system difficult to access, particularly in some rural areas. Despite efforts over many years, less than 10% of GPs and 40% of pharmacists are currently involved. As a consequence, much of the increased service demand is being met by a small number of 'specialised' prescribers with very large caseloads (13% of prescribers treat more than 100 clients each and this represents 73% of ORT numbers). There are risks associated with what is probably an unintended program development, even though such services are meeting high service demand when other parts of the health system are unable or unwilling to do so.

Selected recommendations:
- That DH consider introducing some regulations around the large 'specialised' programs including quality assurance mechanisms and insurance regarding continuity of service delivery, given that the majority of Victorian ORT is provided by these large 'specialised' GP services; and
- That a pilot prescribing and dispensing "bus" (mobile service) in one rural/regional area is undertaken and an evaluation conducted.

Lack of program affordability for clients
Some of the strongest views expressed in this project concerned the issue of client fees. They have been consistently raised as inequitable, discriminatory and a critical problem for Victorian pharmacotherapy maintenance clients. Difficulty meeting the financial obligations of ORT has been identified as a major contributing factor to the deterioration of the relationship between dispensing pharmacists and clients and this can lead to involuntary treatment termination.

Selected recommendations:
- That a new fund be established and administered by an independent body (ideally PAMS) designed to assist clients with financial difficulties;
- That DH pursue the option of establishing a fee-relief program for clients who meet agreed-upon 'high risk' criteria; and
- That DH actively pursue the issue of the current Commonwealth medicines funding schemes as they can be applied to pharmacotherapy medications. While DH Victoria cannot force the Commonwealth or drug companies to change the funding arrangements, strong lobbying is required.

Workforce development and support issues
The key aspects to workforce development related to the development of capacity in the specialist system. This includes expert capacity to respond to clients with serious and complex needs, including pain management and responding to pharmaceutical opioid dependence. It is also critical to build this expertise to allow specialist support to other components of the ORT system. A key strategy that requires considerable resourcing is

the training and recruitment to Addiction Medicine Specialist positions. A second important consideration relates to the training and support provided for GPs and pharmacists. Greater flexibility is required in the design of training and support services, acknowledging that there are a number of ways that prescribers can acquire the knowledge necessary to work effectively with opioid dependent clients. Another finding was that pharmacists needed to be given the opportunity to participate in on-line education programs or participate in face-to-face training and networking opportunities with other ORT staff.

Selected recommendations:

- That the GP pharmacotherapy training and support program is redeveloped (as outlined on page 50-51);
- That DH put the prescriber training program to tender, and encourage tendering from the RACGP, RACP and GPV but not to the exclusion of other training providers;
- That the RACP, RACGP and GPV are engaged in and endorse the training program redevelopment;
- That DH in collaboration with the Pharmaceutical Society/Guild support/fund an ongoing ORT professional development program to complement the on-line pharmacist course currently under development;
- That DH strengthen the specialist component of the Victorian ORT system by funding 12 Addiction Medicine Specialist positions attached to specialist services;
- That DH in collaboration with the RACP considers the current arrangements for AMS training with a view to better funding and promotion.

Quality of care issues

A range of issues were identified that could be clustered under the quality care umbrella. This included some long-standing issues such as inadequate dosing, particularly of methadone. Others that have emerged more recently include working effectively with other health care professionals to manage pain appropriately. Some of these issues relate to lack of initial training and on-going professional development, others may be attributable to the lack of specialist support and many might be addressed by the development and effective dissemination of clinical guidelines. There is evidence that some GPs are unfamiliar with Medicare complex care items that would remunerate them adequately to provide more comprehensive care. Another issue concerned the adequacy of administrative systems to manage permits and monitor prescriptions.

Selected recommendations:

- That pain management is considered to be part of core business, in terms of staff capacity and treatment expectations, at specialist services;
- That effective linkages between pain management clinics and prescribers are established and supported;
- That doctors, pharmacists and clients are educated about appropriate dosing levels;
- That the use of clinical guidelines to assess stability for unsupervised dosing is actively promoted;
- That client access to counselling and psycho-social services is supported by promoting MBBS items, using strategies for service co-ordination, and highlighting existing psychological services;
- That DH ensures that priority is given to further streamlining of the permitting system; and
- That DH ensures that any system developments allow 'prescription monitoring' to enhance ORT program safety and effectiveness.

1. Introduction

The Drug Policy Modelling Program (University of New South Wales) in collaboration with the Health Services Research and Evaluation program at Turning Point Alcohol and Drug Centre was contracted by the Department of Health to undertake a review of the Victorian Pharmacotherapy Program in March 2010.

The core project requirement was the development of a detailed and evidence-based options paper for the Victorian Pharmacotherapy Maintenance Program '*to ensure pharmacotherapy services in Victoria remain responsive to current and future demand while improving accessibility for clients and reducing service gaps'.* A further requirement was that the paper identified both short-term and long-term options and distinguished between those that could be conducted within current resources and those that would require additional resources.

The project commenced in March 2010 and concluded in September 2010. The project methodology entailed the development of a consultative options paper that was informed by published and other literature on the efficacy and effectiveness of pharmacotherapy treatments for opioid dependence and service system functioning. The consultative options paper was used as the basis for the key stakeholder consultation process. A Pharmacotherapy Review Reference Group provided expert guidance over the duration of the project.

Context and scope

The context provided for the project included some features that required specific examination including the age of the current service model (developed in the mid-1990's to meet different needs) and more recent changes (including the availability of a wider range of ORT medications; the emergence of pharmaceutical opioid dependency as an issue; and the development of the Addiction Medicine Specialty). In addition to the identified strengths of the system, the 'request for quotation' (RFQ) documentation outlined some limitations that needed to be considered. These included the difficulty recruiting and retaining GPs and community pharmacists; the impact of client dispensing fees; the capacity of the Specialist Pharmacotherapy Services (SPSs) to provide secondary support to primary care providers; and service gaps in rural and regional areas.

The RFQ documentation stipulated that this review would not include prison-based pharmacotherapy programs in Victoria which are the responsibility of the Department of Justice.

Terminology

There are various terms used in Australia to describe the pharmacotherapy treatment of people dependent on opioids including Pharmacotherapy Treatment (Commonwealth), Opioid Pharmacotherapy (WA), Opioid Dependence Substitution (SA) and Opioid Substitution Treatment (NSW). In Victoria, a number of terms have been used including Maintenance Pharmacotherapy for Opioid Dependence, Pharmacotherapy and Opioid Substitution Therapy. The RFQ document for this project used the term Opioid Replacement Therapy (ORT) and this term will therefore be used throughout this report.

People who receive ORT are variously referred to as patients, clients or consumers, sometimes even customers. We have chosen to use the term client throughout this report.

Background to ORT

In Australia, people who are opioid dependent have had the option of ORT since 1969 when methadone was introduced in Sydney, Australia. In Victoria the first methadone program was established by the Victorian Mental Health Authority in 1972 (Lancaster, 1975), although clients, mainly health professionals had been treated with methadone at the Austin Hospital since 1969 (Miller, 1975). In 1972 there were 150 clients receiving methadone in Victoria from government services, non-government organisations such as Moreland Hall, the Austin Hospital and General Practitioners (GPs) (Miller, 1975). Client numbers fluctuated but steadily increased to 390 in 1987 and then increased considerably in the following seven years to 2,600 in 1994. Figure 1 shows the increase in ORT numbers in subsequent years.

Prior to 2000, methadone was the only medication available for ORT use in Australia. Buprenorphine (as Subutex®) was approved for ORT use and included on the Australian Register for Therapeutic Goods in October 2000. A second sublingual tablet preparation, Suboxone®, containing buprenorphine and naloxone was approved by the Therapeutic Goods Administration in July 2005. Both medications are listed under Schedule 8 of the *Standard for the Uniform Scheduling of Drugs and Poisons* for the management of opioid dependence within a framework of medical, social and psychological treatment.

The policy environment

The first national ORT policy guidelines were introduced in 1977 (National Health and Medical Research Council, 1977). The guidelines were revised in 1983 (Commonwealth Department of Health, 1983) and 1985 (Ministerial Council on Drug Strategy, 1985). The current national policy is outlined in the *National Pharmacotherapy Policy for People Dependent on Opioids* (Intergovernmental Committee on Drugs, 2007). The current policy outlines the goals and objectives of treatment as follows:

> 'The broad goal of opioid treatment is to reduce the health, social and economic harms to individuals and the community arising from illicit opioid use. Pharmacotherapies for opioid dependence should be part of a comprehensive treatment program, with access to counselling and other ancillary services available to all individuals'.
>
> The objectives of pharmacotherapy treatment are to:
>
> - Bring to an end or significantly reduce an individual's illicit opioid use;
> - Reduce the risk of overdose;
> - Reduce the risk of blood borne diseases; and
> - Improve general health and social functioning, including a reduction in crime.
>
> These objectives are achieved by engaging and retaining people dependent on opioids in treatment' (Intergovernmental Committee on Drugs, 2007, p. 7).

The Victorian pharmacotherapy policy *(Policy for Maintenance Pharmacotherapy for Opioid Dependence)* and subsequent amendments (listed on the Victorian Government health information website - www.health.vic.gov.au/dpu/reqhealth.htm#Medical_practitioners) are designed to be consistent with and read in conjunction with national policies and guidelines. The policy goals include 'normalising the patient's life, integrating them back into the community

and keeping them in treatment where necessary' (Drugs and Poisons Regulation Group, 2006, p. 10).

Efficacy and effectiveness of medications used in ORT

The benefits of ORT for clients and the community are well established in a body of research literature that now extends over 40 years. A brief summary of the two main medications used will be provided rather than a detailed account of this large body of research.

Methadone is a synthetic opioid agonist which, in adequate doses (60 – 100mg per day) can suppress withdrawal symptoms and opioid craving for at least 24 hours. It is currently the most common pharmacotherapy used in ORT in Australia and is recognised internationally as an effective method for treating opioid dependence. There is consistent evidence from controlled trials, longitudinal studies and program evaluations that methadone treatment for opioid users is associated with reductions in heroin use, criminal activity, deaths due to overdose, and behaviours associated with a high risk of HIV transmission. It has also been demonstrated to improve health and social functioning (Amato et al., 2008; Faggiano et al., 2003; Mattick et al., 2008; Ritter & Chalmers, 2009).

Buprenorphine is a partial opioid agonist that has been used for pain relief in Australia since the 1980s. Buprenorphine (as Subutex®) was included on the Australian Register for Therapeutic Goods in October 2000 as a treatment for opioid dependence. A second sublingual tablet preparation, Suboxone®, containing buprenorphine and naloxone was approved by the Therapeutic Goods Administration in 2005. Buprenorphine is considered to be an important alternative to methadone for the treatment of opioid dependence, and may attract more people into treatment. Buprenorphine offers potential advantages in terms of safety, the relative ease of withdrawal, the need for less frequent administration, ease of transition into other treatments and flexibility of treatment. The effectiveness of buprenorphine is similar to that of methadone in terms of reduction of illicit opioid use and improvements in psychosocial functioning; however buprenorphine may be associated with lower rates of retention in treatment (See Lintzeris et al., 2006; Ritter & Chalmers, 2009 for a review of the literature).

2. Description of the Victorian system

Community-based prescribing and dispensing

The Victorian ORT service model is described as 'community-based' where drug dependence is 'normalised and de-stigmatised' based on the provision of services primarily through general practitioners and community pharmacies. The service model justification is that ORT should be readily available and offered in a service setting where medical care for serious illness and injury associated with injecting drug use and dependence can also be provided (Drugs and Poisons Regulation Group, 2006, p. 10). This service model is primarily funded through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and client fees. This service model differs from all other states and territories which rely on public clinic service provision to some extent (see Table 1).

Table 1: Number and nature of pharmacotherapy dosing point sites by jurisdiction, 2008–09

Dosing point sites	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Total %
Public clinic	37	**—**	10	1	2	1	1	2	54	**2.5**
Private clinic	12	**3**	—	—	—	—	—	—	15	**0.7**
Pharmacy	572	**407**	354	235	185	52	26	7	1,838	**85.2**
Correctional setting	1	**10**	12	2	9	1	1	2	38	**1.8**
Other	87	**16**	98	9	2	—	—	—	212	**9.8**
Total (no.)	709	**436**	474	247	198	54	28	11	2,157	100.0
Total (per cent)	32.9	**20.2**	22.0	11.5	9.2	2.5	1.3	0.5	100.0	..

Source: AIHW (2010). NOPSAD Collection: 2009 report, Bulletin No 79, Table 6 (p 17).

The most recent publically available data on ORT in Victoria show that there were 12,576 clients on the ORT program in 2009 (Australian Institute of Health and Welfare, 2010). This number now is approximately 13,000 (Jauernig, pers. com. 2010). Forty six percent of clients are aged between 30 – 39 years and 50% of total ORT clients are female.

In Victoria, on any given day clients attend to pick up ORT medications from a range of dosing points as follows:

- 92% dosed in pharmacies
- 6.0% dosed in correctional facilities
- 1.0% dosed in SPS
- 1.0% dosed in hospitals

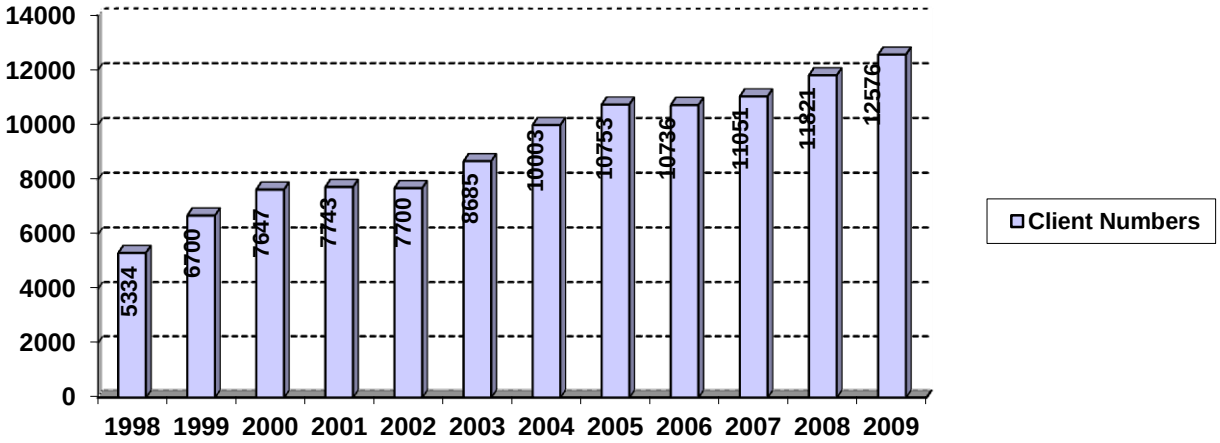

Figure 1: Clients on ORT in Victoria on a specified day - 1998 - 2009
Source: Adapted from AIHW (2010). NOPSAD collection: 2009 report, Bulletin No 79, Table 2 (p 10).

Over the past four years the percentage of ORT clients in Victoria has increased by about 15% (see Figure 1). The Victorian data in Table 2 show a steady decline in the use of the buprenorphine mono product (Subutex®), from 26.6% of all ORT medications in 2006 to 7.5% in 2010. This is the reverse of what has occurred with the buprenorphine/naloxone combination product (Suboxone®) which has risen from 13.6% of total ORT medication in 2006 to 30.1% in 2010. Methadone has remained largely unchanged over this period.

Table 2: Total number of clients receiving ORT on a 'snapshot/specified' day, by type of pharmacotherapy provided in Victoria (2006- 2009)

Pharmacotherapy	**2010 n**	**2010 %**	**2009 %**	**2008 %**	**2007 %**	**2006 %**
Methadone	8072	62.4	62.5	60.6	60.0	59.6
Buprenorphine	967	7.5	8.5	10.2	14.0	26.8
Buprenorphine/naloxone	3888	30.1	29.0	29.2	26.0	13.6
Total	**12,927**	**100**	**100.0**	**100.0**	**100.0**	**100.0**

Source: Adapted from AIHW (2010). NOPSAD Collection: 2009 report, Bulletin No 79, Table 3 (p 11). DH Unpublished data (January 2010).

Despite the increase in ORT client numbers, there has been an overall slight decline in the number of prescribers over this period (-1.3%). Notably, the decline between the 2008 and 2009 NOPSAD census dates was -13.7% and the more recent DH data from 2010 show that this trend continues (see Table 3).

General Practice Victoria's 2007/08 Annual Survey of Divisions[1] provided the following estimates of the Victorian GP workforce:

- Number of Practicing GPS – 5,966 (4,641 full time)

[1] General Practice Victoria: http://www.phcris.org.au/divisions/sbo/detail.php?id=505 – Accessed 20/5/10

- Percentage of females – 34.4%
- Number of General Practices – 1,687

This survey information and the NOPSAD census data (Australian Institute of Health and Welfare, 2010) would suggest that less than 10% of Victorian GPs were involved in ORT prescription in 2007. DH data show that in early 2010 there were 397 ORT prescribers in Victoria.

Table 3: Total number of ORT clients, prescribing and dosing points in Victoria (2006 – 2010)

	2006	2007	2008	2009	2010 (Jan)
Total number of clients	10,736	11,051	11,821	12,576	12,927
Total number of prescribers	463	493	529	457	397
Total number of dosing points	413	425	431	436	442
Clients per prescriber (mean)	23.2	22.4	22.3	27.5	32.6
Clients per dosing point (mean)	26.0	26.0	27.4	28.8	29.2

Source: Adapted from AIHW (2010). NOPSAD Collection: 2009 report. Bulletin No.79, Table 6, (p 33). DH Unpublished data (Jan 2010).

Table 3 also shows that over the 2006 - 2010 period the number of dosing points has shown a modest increase (5.3%). ANEX (2010) noted that there were 1,146 pharmacies in Victoria and the NOPSAD collection for 2009 (Australian Institute of Health and Welfare, 2010) reported that there were 436 'dosing points.'[2] DH data show that in January 2010 there were 442 active dosing points in Victoria. This would suggest that less than 40% of community pharmacies were involved in the ORT program in Victoria in 2009.

As of January 2010 there were 397 prescribers in Victoria. Each prescribed ORT to at least one client and up to 1,000 (median = 10). Table 4 shows that 65% of prescribers prescribe to between 1 and 20 clients, however this only represents 8% of the total Victorian ORT client caseload. Thirteen percent of prescribers prescribe to more than 100 clients, and this represents 73% of all the ORT client numbers (10 prescribers account for 30% / one third of all clients in Victoria).

[2] In Victoria this 'dosing point' would equate to 'community pharmacy' with very few exception (such as the Austin Hospital)

Table 4: Client case loads of Victorian prescribers

Numbers of clients per prescriber	**% of prescribers**	**% of total ORT patient numbers**
20 or less	65%	8%
21 to 50	15%	9%
51 to 100	8%	10%
More than 100	12%	73%

Source: DH unpublished data, January 2010.

Summary data

In summary, approximately 13,000 clients are currently in ORT treatment in Victoria. The medications prescribed are as follows: methadone – 63% of total ORT; buprenorphine-naloxone – 30%; and buprenorphine – 7%. There are approximately 400 active accredited ORT prescribers who prescribe for between 1 client only and up to 1000 clients (median = 10) each. It is of note that 10 prescribers treat 30% of the total ORT population. The medications are dispensed from 442 active dosing points across Victoria, broken down as follows: 92% in community pharmacies; 6.0% in correctional facilities; 1.0% in SPSs; and 1.0% in hospitals. Given the complexities associated with the census data and the dispensing and GP data, these are approximations only. We have deliberately rounded off the numbers to avoid giving a sense of any false precision. These basic summary statistics on the ORT system in Victoria will be used to explore some of the options later in the report.

Specialist Pharmacotherapy Services

The community-based program in Victoria is supported by a range of specialist programs and support services. Specialist Methadone Services (SMSs) (now known as Specialist Pharmacotherapy Services – SPSs) were established in Victoria in 1994 as part of a redevelopment of drug treatment services. Government alcohol and drug services were closed and resources re-allocated to increase the range of community-based services. SMS's were developed to provide support for those people receiving methadone treatment 'with complex medical, psychiatric or psychosocial problems' (Hales & Cox, 1999). At the time it was envisaged that the SMS would operate in association with a general teaching hospital. The service objectives were:

- To provide specialist assessment and treatment services to methadone clients with significant medical, psychiatric and/or psychosocial problems;
- To provide consultancy services for health practitioners involved in providing community and hospital-based methadone and other opioid pharmacotherapy;
- To participate in the training of health practitioners involved in providing methadone services (including medical practitioners, pharmacists, nurses and counsellors) (Hales & Cox, 1999).

The Drug and Alcohol Clinical Advisory Service (DACAS)

DACAS is a 24-hour telephone service for health professionals seeking advice on the clinical management of people with alcohol and drug problems. The service provided by Turning Point Alcohol and Drug Centre is staffed by Addiction Medicine Specialists. In addition to general clinical management advice, DACAS also has a specific role in the ORT program. For example there is a requirement in Victoria that non-approved, 'deputising' GPs routinely seek and record advice from DACAS on matters such as dose increases or take-aways (Drugs and Poisons Regulation Group, 2006).

DirectLine

DirectLine is the 24-hour telephone information, counselling and referral service operated by Turning Point Alcohol and Drug Centre. This service is funded by the Department of Health to be the first point of contact for people seeking access to the ORT program in Victoria. The service maintains contact with authorised GP prescribers and negotiates client access to their services. DirectLine also maintains a database on ORT participating pharmacies, counsellors and drug treatment services.

The Pharmacotherapy Development Program

The Department of Health employs Development Officers whose role it is to support and build the capacity of the community component of the ORT program. The officers work directly with GPs and pharmacists to recruit new participants and link them to other parts of the ORT system.

Pharmacotherapy Regional Outreach Worker (PROW) Program

The PROW program was implemented in 2001-02 (originally called the Methadone Regional Outreach Worker Program) in response to an identified need to support rural GP prescribing and pharmacy dispensing for the ORT program. The role of PROWs was to promote the use of ORT pharmacotherapy; to develop local and regional partnerships between GPs, Divisions of General Practice and drug treatment services; and to improve client access. The workers were originally located in four rural areas (Leongatha, Wangaratta, Bendigo and Mildura). A review of the program conducted by Turning Point in 2004 found that the program was moderately successful in recruiting GP prescribers and pharmacists to the ORT program in regional areas and therefore improving client access. The reviewers concluded that the program had 'significant potential to enhance pharmacotherapy services to clients' (Swan et al., 2004, p. 10).

Pharmacotherapy Advocacy, Mediation and Support Service (PAMS)

Harm Reduction Victoria operates the Pharmacotherapy Advocacy, Mediation and Support Service (PAMS) in Victoria. PAMS works with clients and ORT service providers to mediate better service outcomes. This often involves sorting out client and service provider issues in an attempt to maintain treatment continuity. The PAMS annual report 2008-2009 (Lord, 2009) notes that the vast majority of calls to the service are from ORT clients. The majority (84%) are on benefits or a pension. Of the calls, 68% relate to dispensing services and 27% to prescribers. The main issues dealt with are payment of dispensing fees and/or debt management (38%), requests for ORT information (17.5%) and problems relating to take-away doses (8%). The service is funded by the Department of Health to respond to 25 cases per month. The demand on the service is such that PAMS consistently exceeds these targets (See Figure 2).

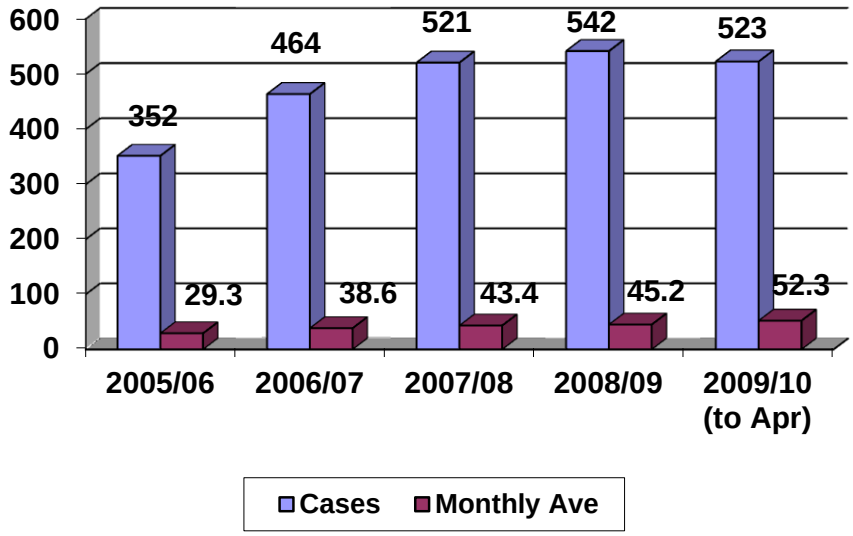

Figure 2: Number of Pharmacotherapy Advocacy, Mediation and Support cases and monthly averages for years 2005/6 - 2009/10
Source: Correspondence from Harm Reduction Victoria: Pharmacotherapy Advocacy, Mediation and Support Service (PAMS). March 17th, 2010.

GP Pharmacotherapy Training

The Department of Health contracts organisations to develop and deliver training programs for GPs wanting to become authorised ORT providers. For the last three years the program has been conducted by Turning Point Alcohol and Drug Centre in conjunction with Southern and Western Health. The program included the development and delivery of two on-line units (*Understanding and Working with Heroin and Heroin Dependence*; and *Treatment Options for Heroin Dependence* – both can be accessed from the RACGP website). Completion of the units is a requirement of the training program which also includes a day of face-to-face training. Over the last 3 years 120 GPs were trained in the 20 one-day courses that were conducted. This seems to be a good outcome given that the total number of GP prescribers in Victoria in any year is around 400. Despite extensive course marketing; provision of opportunities for mentoring; and ongoing education and support, the program struggles to attract more participants. The course is of high quality, as evidenced by consistently positive participant evaluations (Connolly, 2009).

3. Strengths and limitations of the Victorian ORT model

The strengths of the Victorian ORT model, while persisting today, may have been more evident when it was initially designed. The model we see today emerged in the late 1980s and was consolidated when the service system was restructured in the early 1990s. At this time ORT was not readily available as a treatment for opioid dependence. Pressure at the time to expand the program in response to the HIV threat and make it more geographically accessible was accommodated by the capacity and willingness of some GP prescribers and community pharmacists to get involved.

Strengths

Responsiveness to concerns of HIV spread

ORT expansion in the late 1980s was one of a number of deliberate strategies designed to avert an HIV epidemic. In Victoria the expansion occurred in the community/private sector. In 1989 there were 641 people receiving methadone in Victoria. Of this group 60% were treated in community/private programs. In 1990 the total number of ORT clients was 1,407 with 88% treated in community/private programs. The number of clients on public programs had dropped by 35% over this short period (Gaughwin et al., 1993). Engagement of the community/private sector with resultant cost shifting to the Commonwealth was the strategy used in Victoria to rapidly expand the ORT program at this time.

The rollout of an effective treatment for opioid dependence

Responding to HIV concern in Victoria had secondary benefits for the drug treatment sector. It served as a catalyst to provide many additional ORT places in a treatment modality that has been demonstrated to be highly effective and cost-effective relative to other treatment types (see Ritter & Chalmers, 2009 a review). This pressure to expand provided the necessary impetus to cut through the ideological and political concerns about this treatment type and ensured that it would become and remain the cornerstone of drug treatment in this state.

Integration of opioid dependence treatment into primary health practice

The Victorian ORT model was based on sound principles. The aim was to promote community-based service expansion, delivered primarily by Department of Health approved GP prescribers and community pharmacists. It was emphasised that the service model would provide easy access to local, non-stigmatised services where holistic health care could be provided. This was an attempt to normalise the medical treatment for opioid dependence.

Linkages with specialist services

Other specialist services were developed to support community ORT providers. This included opportunities to refer clients with 'significant medical, psychiatric and/or psychosocial problems' for assessment and stabilisation by five Specialist Methadone (now Pharmacotherapy) Services. A review of this service type in 2000 found that clients and other service providers rated the quality of service provision highly. However the reviewers did note that these services had difficulty referring stabilised clients on due to the lack of available GPs and community pharmacists. They also noted that the expectation that SMS services provide consultation and training to hospital and community-based ORT program staff was not being met (Hales & Cox, 1999).

Other ORT system supports

Twenty four hour telephone support services (Drug and Alcohol Clinical Advisory Service and DirectLine) were also developed to support ORT service staff and clients and have provided easily accessible clinical and referral advice for many years. Although it has

proved difficult to engage GPs in ORT, the training provided as a prerequisite to DH prescriber approval has been of high quality. It has included the development of training materials, on-line training modules and high quality face-to-face teaching and follow-up (Connolly, 2009). The development of PAMS was an innovative way to promote treatment continuity and better service outcomes for consumers and community ORT providers where relationships had, or were about to break down.

Summary

Changes to ORT services in Victoria since the late 1980s have been a pragmatic response to the need for rapid service expansion and can be justified by the principle that opioid dependency should be treated where possible in the primary health care system, in conjunction with a range of specialist support services. Uptake of ORT by the community/private sector was rapid particularly from 1985-2000. Over this time the Victorian ORT service model appeared to be meeting the needs of ORT clients and many of the strengths of the model persist today.

Limitations of the Victorian Pharmacotherapy System

The system was designed to meet the service needs of the early 1990's

The Victorian ORT system was restructured in the early 1990's at a time when there were fewer clients, fewer ORT medications available, greater capacity for GPs and community pharmacists to absorb ORT growth and a smaller number of clients requiring specialist services. Rapid expansion (10-20% per annum) and emerging issues such as pharmaceutical opioid dependence have placed the system under great pressure. There is a significant number of opioid users who are between treatment or yet to be engaged in treatment who would benefit from it and may engage in it if it was more accessible (Ritter & Chalmers, 2009). The administrative systems for managing data and permitting have been described as cumbersome and may serve as a disincentive to working in ORT. Consumers now have a greater voice in ORT matters, but there is still some way to go to involve them to the extent you would expect in what is described as a 'client-centred' service system (HRV 2007).

The role of ORT in Victoria is understated and undervalued

The role of ORT in the Victorian AOD service system is understated. Based on the extensive research evidence supporting ORT it would be reasonable to assume that it was a cornerstone of the system with well articulated goals, extensive integration with AOD, mainstream and specialist health services and a funding base to reflect its importance. This is not the currently the case. Its role is poorly articulated and understated in policy documents (e.g. *A new blueprint for alcohol and other drug treatment services 2009-2013: client-centred, service-focused,* DHS, 2008). Coordination between ORT specialist and community services is often poor; links between ORT and other AOD services is inadequate; and there is a lack of integration with mainstream services.

Limitations of specialist services

The specialist service system treats a relatively small proportion of the ORT client base (>5%) that resides within 15km of the Melbourne CBD. Some of the SPSs have inadequate links with the hospitals and the associated network of specialist services. The staffing profile of these services often lacks funded Addiction Medicine and other specialists. They don't always provide the full range of ORT medications or necessarily prescribe and dispense on-site. It is assumed that SPS deal with more complex or unstable clients but the evidence for this assertion is lacking. A review of the SPS in 1999 (Hales & Cox, 2000) found that none were providing adequate secondary consultation and support to colleagues in the community component of the ORT system

despite this being a key service requirement. This review also found that 'silting-up' had occurred making access difficult. This was caused by the inability of SPSs to refer stabilised clients to community providers. In turn SPSs are not able to provide easy access for clients in high risk groups (pregnant women, people with co-morbid mental health issues, etc).

Limitations of the primary care/GP system

There are insufficient GP prescribers in total and in some locations (particularly rural areas) to service current ORT demand. Less than 10% of GPs were involved in ORT provision in 2007 (Australian Institute of Health and Welfare, 2010; General Practice Victoria, 2010). Strategies to increase and support GP involvement (Pharmacotherapy Regional Outreach Worker Program: GP Pharmacotherapy training; Pharmacotherapy Development Program) have had only limited success (Connolly, 2009; Swan et al., 2004). As a consequence a small number of GPs are now servicing very large numbers of clients. Potential problems with this development include compromised ORT and general medical care and the considerable risk that if any in this group discontinue practicing (a real risk for a small number of elderly prescribers) alternative treatment places would be very difficult to find. There is also a lack of dispensing points with only 40% of Victorian pharmacies involved in ORT dispensing in 2009 (Anex 2010; Australian Institute of Health and Welfare, 2010). Those that are involved are dealing with greater numbers including some with a range of financial, behavioural and mental health problems. While there may be financial incentives for bigger providers there are many disincentives for others.

Service Quality

Service quality issues are inevitably associated with a system under stress. These include inadequate case management and access to counselling and psychosocial support services; inadequate medical care due to client case load pressure or ORT-only medical service provision. Clients with complex problems are often poorly managed in community settings due to limited access to specialist services (Lord, 2009).

Many other service quality issues arise due the high costs of services experienced by clients, many of whom have very limited capacity to pay. The system in this regard is inequitable with ORT clients placed at considerable financial disadvantage due to the current PBS status of ORT medications. ORT costs (dispensing fees and to a lesser extent travel costs) are a major barrier to treatment engagement and retention. Disrupted ORT has serious, predictable consequences for opioid dependent clients (HRV 2007). There is also a very long history of sub-optimal dosing in Victoria particularly in relation to methadone (Lintzeris et al., 2007). This seems to be due to inadequate prescriber and client education and can lead to poorer therapeutic outcomes. Some clients also express concern about lack of confidentially and discrimination they experience in community pharmacies. This has been a long-standing issue (Lord, 2009; Ritter et al., 2003).

A full list of the limitations can also be found in Appendix 1.

We sought to derive a simple list that summarised these various problems under some general headings, for the purposes of matching the problems to options/solutions.

1. Inadequate specialist system
2. Insufficient treatment places (prescribers and dispensers)
3. Lack of affordability of the program to clients
4. Poor referral and support pathways between specialist and primary care
5. Workforce development and support
6. Quality of care issues

4. Methodology

Development of the options paper

A comprehensive literature review and supplementary information from the Department of Health formed the basis of the Victorian Pharmacotherapy Review options paper. The Drug Policy Modelling Program (DPMP) conducted a comprehensive review of pharmacotherapy programs throughout Australia for the Australian National Council on Drugs resulting in two publications: *Polygon: The many sides to the Australian opioid pharmacotherapy maintenance system* (Ritter & Chalmers, 2009) and *Modelling pharmacotherapy maintenance in Australia: Exploring affordability, availability, accessibility and quality using system dynamics* (Chalmers et al., 2009). The first report, Polygon, entailed significant and comprehensive consultations with key stakeholders throughout Australia to identify the critical issues associated with pharmacotherapy maintenance. Initially a consultative options paper was developed for this project which was based on an examination of the options identified in the Polygon Report and other internal and public documents relating to Victoria's pharmacotherapy model.

Each option/solution addressed the various weaknesses and issues within the system. An additional criterion was that every option had either a supporting evidence-base or had been trialled somewhere in the world. Thus, whilst we included many "blue sky" options, each had some grounding in evidence or experience. We sought to ensure a comprehensive and thorough list of options was generated prior to commencing prioritisation. To that end, Reference Group members were invited to contribute additional options.

Once the full list of options had been developed (a total of 43), we sought to cluster them to make the list more manageable. A synthesis of the literature found that issues could be grouped into the following broad categories:

- Availability of treatment places;
- Workforce development;
- Affordability of treatment to clients;
- Specialist service system;
- Connection with mainstream services; and
- Clinical care standards.

We converted these categories into goals for the Victorian treatment service system. These goals could therefore form the basis of a Victorian ORT program that meets current and emerging needs. These goals, in no particular order are:

1. A sustainable workforce;
2. A high functioning specialist system;
3. Strong and effective connections between the specialist and primary care systems;
4. An accessible program (enough treatment places);
5. High quality clinical care; and
6. An affordable and equitable program for clients.

Each option was placed within the most relevant goal (noting that there was overlap, see later section on the Matrix).

Pre Consultation Checklist

The project team developed a pre consultation options checklist for completion by Reference Group members, service providers, key stakeholders and service users (See

Appendix 2). The checklist was basically an adaptation of the summary list of options and included a three-point scale for respondents to show the level of priority they would attach to each option (high, medium & low). There was also scope for respondents to indicate that items were not an option (i.e., nil priority).

The wording of the options checklist was modified slightly for service users, to avoid jargon and acronyms. For each consultation, potential participants were sent a plain language statement about the research and a copy of the checklist prior to the consultation and asked to complete the checklist and return it to the research team.

Consultation Participants

The table below shows the background and number of participants in each of the project consultations, along with the number that completed the checklist. The list of people consulted is provided in Appendix 3.

Table 5: Details of the consultations

.

Individual Consultations	**Focus Group Consultations**		
Key Stakeholders (n=24)	**Reference group members (n=7)**	**Service providers (n=8)**	**Consumers (n=7)**
Prescribing Doctors (including 8 Addiction Medicine Specialists & 3 Rural Prescribers) (n=13) Service Provider (n=1) Community dispensers (n=2) Community based AOD and community health service worker (n=3) Harm Reduction workers (n=1) Policy maker (n=3) Peak body representatives (n=1)	Pharmaceutical Society of Australia, Victorian Branch (n=2) Royal Australian College of General Practitioners (n=1) General Practice Victoria (n=1) Harm Reduction Victoria Victorian Alcohol and Drug Association (n=1) Victorian Department of Health (n=2)	Metropolitan & regional community based AOD and community health services (n=6) Consumer advocacy organisation (n=1) Specialist Pharmacotherapy Program (n=1)	n/a
Completed checklist			
n=22	**n=8***	**n=6***	**n=7**

**Three participants participated in two different consultation types and completed one checklist, recorded once in the above table.*

Individual Consultations

Key stakeholders were identified on the basis of their expertise and knowledge about ORT in Victoria. These stakeholders were chosen by the project team in consultation with the Department of Health.

Consent was obtained verbally or through participants indicating their willingness to be involved via email. The semi structured interviews focused on the options stakeholders had rated medium or high priority in the pre-consultation checklist. Interviews were conducted over the phone or in person. The interviews were recorded and transcribed.

Focus Group Consultations

Three focus groups were conducted to gain input from project Reference Group members, drug and alcohol service providers and consumers of pharmacotherapy services. For each focus group, notes were taken; the service provider and service user focus group discussions were also recorded. These notes were transcribed.

1. Service users
With the assistance of Harm Reduction Victoria a focus group comprising consumers of specialist and primary care services was convened on July 29th, 2010 at Harm Reduction Victoria. Nine participants agreed to attend and seven were present at the session.

2. Reference Group members
A focus group was conducted on July 12th 2010 at the Department of Health. Seven members were in attendance, including representatives from the Pharmaceutical Society of Australia (Victorian Branch), Royal Australian College of General Practitioners, Harm Reduction Victoria, General Practice Victoria, Victorian Alcohol and Drug Association & the Victorian Department of Health.

3. Service providers
VAADA was asked to identify and approach service providers who could provide a specialist focus on ORT. Service providers were selected to include representation from diverse organisational settings (e.g., SPS, CH) and locations (metropolitan, regional). One participant was from a consumer advocacy organisation. Ten service providers were invited to take part. Eight accepted the invitation and attended the focus group on July 29th, 2010 at Turning Point. Another service provider sent written notes in lieu of attendance.

Data Analysis

As shown in Table 5 above, a total of 43 checklists were completed and returned. Checklist data were analysed to show the level of priority given to each option. Frequencies for 'high' and 'medium' priority were combined and an arbitrary cut-off point of 65% was identified to guide the further exploration of options for Victoria. Where options did not reach 65%, the researchers considered whether their inclusion in the final sample was warranted on the basis of research evidence and key informant comments. Thematic and content analyses were completed on the qualitative data using NVivo 8. This involved text searches based on the options, followed by the identification of themes within these data sets.

Analysis and synthesis

All the above data were analysed by the research team and a draft report was prepared for review by the reference group.

The project was approved by the Eastern Health ethics committee.

5. The original options and their relationship with problems/issues identified

The table below provides a simple list of the options considered, against each of the goals. A detailed table was also prepared (for the consultations) which provided the option itself in addition to benefits of the option, research evidence and concerns about the option. This is provided in Appendix 4.

Table 6: The full list of options

Goal	Options
Goal 1: A sustainable workforce	
Greater number of prescribers	1. Nurse practitioners to prescribe methadone/buprenorphine
	2. Pharmacists to prescribe methadone/buprenorphine
	3. Incentive payments to GPs
Training/accreditation for doctors	4. Revise and redevelop the training requirements and approaches for prescribers
	4 a). Differentiate methadone from buprenorphine: in relation to training, accreditation, prescribing
	4 b). Remove training requirements for buprenorphine-naloxone (i.e. all GPs can prescribe this, but not methadone)
	4 c). Remove all GP training requirements for methadone and buprenorphine
	4 d). Modify the requirements for all GPs to be trained before prescribing, i.e. allow a limited amount of prescribing outside training requirements
	4 e). Continue with compulsory training for GPs but conduct the training on-line only (no face-to-face)
	4 f). Make no substantive changes to training requirements but improve quality and targeting of the training
	4 g). Chapter of Addiction Medicine or RACGP take over the training and/or authorisation of doctors and/or nurse practitioners and/or pharmacists to prescribe methadone and buprenorphine
	5. Introduce pre-packed 'start-up' kits with doses stepped up gradually to maintenance
	6. Revise the permit system - (reduce the amount of paperwork)
Greater number of dispensing points	7. Improve the level of support provided to community pharmacists/pharmacies who dispense methadone/buprenorphine
	8. Make compulsory the dispensing of methadone and buprenorphine as standard part of pharmacy activity
	9. Incentive payments to pharmacists
	10. Vendor machine supply for methadone/buprenorphine
Goal 2: A high functioning specialist system	
	11. Reconsider the role and function of the Specialist Pharmacotherapy Services (SPSs)
	11 a). Replace all SPSs with Drug and Alcohol Addiction Units in teaching hospitals, with mission and brief as per SPS
	11 b). Ensure that all SPS provide specialist services that include

Goal	Options
	methadone, buprenorphine-naloxone and buprenorphine (prescribing and dispensing)
	11 c). Increase funding levels to SPS
	11 d). Ensure all SPS provide secondary consultation
	11 e). SPSs to provide outreach/satellite services in major regional areas
	11 f). All SPS to have 'reserved" treatment places for special needs groups
	12. Advertise and recruit to new Addiction Medicine Specialist position(s) and advertise and recruit to more FAChAM trainee positions
	13. Review the Pharmacotherapy Regional Outreach Workers Program
Goal 3: Strong and effective connection between the specialist and primary care systems	
	14. Strengthen programs designed to encourage and support community/primary care prescribing and dispensing
	14 a). Build referral pathways between generalists and specialists
	14 b). Provide specialist case management support to community programs
	14 c). Specialist services as hub of support for linked community services
	14 d). Shared care programs
	14 e). Review the Pharmacotherapy Development Program
	15. Ensure that the GP super-clinics; one-stop-shop primary health services/"Medicare Locals"/ and CHCs have capacity to treat opioid dependent people (at least one prescriber)
Goal 4: An accessible program (enough treatment places)	
	16. Set up /encourage /incentivise private clinics (as per NSW)
	17. Establish at least one more SPS
	18. Outreach prescriber ('bus') that roves rural regions on set days
	19. Outreach dispensing 'bus': dispenses daily in less accessible locations
	20. Provide transport for (rural) clients
Goal 5: High quality clinical care	
Pharmaceutical opioid dependence	21. Improve approaches for pharmaceutical opioid dependence treatment and for other pharmaceutical dependence (such as benzodiazepine dependence)
	22. Greater knowledge and awareness of pain management in our client group.
	23. Develop clinical guidelines for meth/bup maintenance treatment for those dependent on pharmaceutical opioids
	24. Facilitate multi-disciplinary pain management clinics that include Addiction Medicine Specialists
Optimal dosing	25. Client and practitioner education campaign regarding "optimal doses"
Medication non-adherence & diversion	26. Reduce take-aways
	27. Explore "take-safe" dispensing system
	28. Target supervised dosing only to those that need it.

Goal	Options
	29. All buprenorphine-naloxone delivered as unsupervised treatment (monthly 'script')
Unsupervised treatment model	30. Develop new guidelines for unsupervised treatment (that are independent from take-away dosing policy)
Transfers and client mobility	31. Implement a national permit system
Counselling and psycho-social support services	32. Education for GPs re how to access the new MBBS numbers to fund case management
	33. Better care for complex behavioural needs of clients
	34. Register of psychologists (private) willing to see clients
Privacy and confidentiality (especially in rural regions)	35. Review ways in which privacy and confidentiality can be improved in rural areas
Post-release prisoner maintenance – continuity of care on release	36. Ensure continuity of dispensing at point of release from prison
	37. Improve the peer support provided to clients
Goal 6: An affordable and equitable program for clients	
	38. Reduce financial burden of dispensing fees
	38 a). SPS to provide respite places for those in financial difficulty (dispensing fee-free)
	38 b). State to pay dispensing fees for certain high-risk groups
	38 c). SPS to have no dispensing fees
	38 d). Introduce means testing for client fees
	38 e). State to pay dispensing fee for the first 3-4 weeks for every client
	38 f). State to pay all dispensing fees
	39. Guidelines for pharmacists as to how to manage clients in debt
	40. Divorce the fee payment from the service delivery in community dispensing.
	41. Lobby Commonwealth to have methadone and buprenorphine dispensing costs as part of the PBS funded component
	42. Prohibit pharmacies from charging the same fee for daily dosing and weekly dispensing
	43. Introduce guidelines for 'fair' dispensing fees

The options are not all mutually exclusive (for example changes to patient fees can occur at the same time as changes to prescriber incentives and so on). But in some cases the options are mutually exclusive (for example changing prescriber requirements for both methadone and buprenorphine versus changing prescriber requirements only for buprenorphine).

Matrix matching options to problems

A number of the options address more than one goal. For example, the issue of availability of treatment places is addressed via options that include increasing the numbers of treatment places (via increases in prescriber and dispensing workforce), establishment of new SPS, and better referral pathways. And some options may offset the benefits from others, such as those options that pertain to better quality of treatment and therefore increase the likelihood of clients staying longer in treatment (and hence reducing treatment places for new clients).

Importantly, we sought to ensure that each option addressed the identified problems. Because of the overlap between options and problem domains, we created a matrix that maps each of the options against the summary list of weaknesses/problems/issues:

1. Inadequate specialist system
2. Insufficient treatment places (prescribers and dispensers)
3. Lack of affordability of the program to clients
4. Poor referral and support pathways between specialist and primary care
5. Workforce development and support
6. Quality of care issues

This matrix also identifies where options overlap with each other, as well as where options are mutually exclusive.

Table 7: Matrix: Overlap between options

Option	**Overlap / Related /Synergistic**	**Mutually exclusive**	Insufficient treatment places (prescribers and dispensers)	Unaffordable for clients	Inadequate specialist system	Poor integration, referral and support pathways between	Workforce development and support	Quality of care issues
Goal 1: A sustainable workforce								
1. Nurse practitioners to prescribe methadone/buprenorphine			✓				✓	
2. Pharmacists to prescribe methadone/buprenorphine			✓				✓	
3. Incentive payments to GPs			✓				✓	
4 a). Differentiate methadone from buprenorphine: in relation to training, accreditation, prescribing	4b)	4c)	✓				✓	
4 b). Remove training requirements for buprenorphine-naloxone (i.e. all GPs can prescribe this, but not methadone)			✓				✓	
4 c). Remove all GP training requirements for methadone and buprenorphine		4b) 4e) 4f)	✓				✓	
4 d). Modify the requirements for all GPs to be trained before prescribing, i.e. allow a limited amount of prescribing outside training requirements			✓				✓	
4 e). Continue with compulsory training for GPs to prescribe methadone and buprenorphine but conduct the training on-line only (no face-to-face)		4a) 4b) 4c)	✓				✓	
4 f). Make no substantive changes to training requirements but improve quality and targeting of the training		4a) 4b) 4c) 4e)					✓	
4 g). Chapter of Addiction Medicine or RACGP take over the training and/or authorisation of doctors and/or nurse practitioners and/or pharmacists to prescribe methadone and buprenorphine	14e).		✓		✓		✓	
5. Introduce pre-packed 'start-up' kits with doses stepped up gradually to			✓					✓

Option	**Overlap / Related /Synergistic**	**Mutually exclusive**	Insufficient treatment places (prescribers and dispensers)	Unaffordable for clients	Inadequate specialist system	Poor integration, referral and support pathways between	Workforce development and support	Quality of care issues
maintenance								
6. Revise the permit system - (reduce the amount of paperwork)			✓				✓	
7. Improve the level of support provided to community pharmacists/pharmacies who dispense methadone/buprenorphine	11d) 11f) 14b) 14c) 39		✓			✓	✓	✓
8. Make compulsory the dispensing of methadone and buprenorphine as standard part of pharmacy activity			✓	✓				
9. Incentive payments to pharmacists			✓					
10. Vendor machine supply for methadone/buprenorphine			✓					
Goal 2: A high functioning specialist system								
11 a). Replace all SPSs with Drug and Alcohol Addiction Units in teaching hospitals, with mission and brief as per SPS	12				✓	✓		✓
11 b). Ensure that all SPS provide specialist services that include methadone, buprenorphine-naloxone and buprenorphine (prescribing and dispensing)					✓	✓		✓
11 c). Increase funding levels to SPS					✓			
11 d). Ensure all SPS provide secondary consultation	7		✓		✓	✓	✓	
11 e). SPSs to provide outreach/satellite services in major regional areas	7 14c) 14b) 14a)				✓	✓		
11f). All SPS to have 'reserved" treatment places for special needs groups	38a)		✓		✓	✓		✓
12. Advertise and recruit to new Addiction Medicine Specialist position(s) and advertise and recruit to more FAChAM trainee positions			✓		✓	✓	✓	
13. Review the Pharmacotherapy Regional Outreach Workers			✓			✓	✓	
Goal 3: Strong and effective connection between the specialist and primary								

Option	**Overlap / Related /Synergistic**	**Mutually exclusive**	Insufficient treatment places (prescribers and dispensers)	Unaffordable for clients	Inadequate specialist system	Poor integration, referral and support pathways between	Workforce development and support	Quality of care issues
care systems								
14 a). Build referral pathways between generalists and specialists	14b) 14c) 14d)		✓		✓	✓	✓	✓
14 b). Provide specialist case management support to community programs	7 14a) 14c) 14d)		✓		✓	✓	✓	✓
14 c). Specialist services as hub of support for linked community services	7 14a) 14b) 14d)		✓		✓	✓	✓	✓
14 d). Shared care programs	14a) 14b) 14c)		✓		✓	✓	✓	✓
14e). Review the Pharmacotherapy Development Program	4g).		✓		✓			
15. Ensure that the GP super-clinics; one-stop-shop primary health services/"Medicare Locals"/ and CHCs have capacity to treat opioid dependent people (at least one prescriber)			✓			✓		
Goal 4: An accessible program (enough treatment places)								
16. Set up / encourage /incentivise private clinics (as per NSW)			✓					
17. Establish at least one more SPS	11b) to 11f)		✓		✓			
18. Outreach prescriber (bus) that roves rural regions on set days	35		✓					
19. Outreach dispensing bus: dispenses daily in less accessible locations	35		✓					

Option	**Overlap / Related /Synergistic**	**Mutually exclusive**	Insufficient treatment places (prescribers and dispensers)	Unaffordable for clients	Inadequate specialist system	Poor integration, referral and support pathways between	Workforce development and support	Quality of care issues
20. Provide transport for (rural) clients	35	18, 19	✓					
Goal 5: High quality clinical care								
21. Improve approaches for pharmaceutical opioid dependence treatment and for other pharmaceutical dependence	22, 23, 24						✓	✓
22. Greater knowledge and awareness of pain management in our client group.							✓	✓
23. Develop clinical guidelines for meth/bup maintenance treatment for those dependent on pharmaceutical opioids					✓		✓	✓
24. Facilitate multi-disciplinary pain management clinics that include Addiction Medicine Specialists					✓		✓	✓
25. Client and practitioner education campaign regarding "optimal doses"								✓
26. Reduce take-away provisions		28, 29, 30						✓
27. Explore "take-safe" dispensing system			✓					✓
28. Target supervised dosing only to those that need it	29, 30	26						✓
29. All buprenorphine-naloxone delivered as unsupervised treatment (monthly 'script')	28, 30	26	✓					
30. Develop new guidelines for unsupervised treatment (that are independent from take-away dosing policy)	28, 29	26						✓
31. Implement a national permit system							✓	
32. Education for GPs re how to access the new MBBS numbers to fund case management			✓				✓	
33. Better care for complex behavioural needs of clients	34 11d)				✓	✓		✓

Option	**Overlap / Related /Synergistic**	**Mutually exclusive**	Insufficient treatment places (prescribers and dispensers)	Unaffordable for clients	Inadequate specialist system	Poor integration, referral and support pathways between	Workforce development and support	Quality of care issues
	11g)							
34. Register of psychologists (private) willing to see clients						✓		✓
35. Review ways in which privacy and confidentiality can be improved in rural areas	18, 19, 20							✓
36. Ensure continuity of dispensing at point of release from prison								✓
37. Improve the peer support provided to clients								✓
Goal 6: An affordable and equitable program for clients								
38 a). SPS to provide respite places for those in financial difficulty (dispensing fee-free)	11g)	38c) 38f)		✓	✓	✓		
38 b).State to pay dispensing fees for certain high-risk groups		38c) 38f) 38e)		✓	✓			
38 c). SPS to have no dispensing fees	11c)	38a)		✓				
38 d). Introduce means testing for client fees				✓				
38 e). State to pay dispensing fee for the first 3-4 weeks for every client	38f) 38b)		✓	✓				
38 f). State to pay all dispensing fees		38e)	✓	✓				
39. Guidelines for pharmacists as to how to manage clients in debt			✓	✓			✓	
40. Divorce the fee payment from the service delivery in community dispensing			✓	✓				
41. Lobby Commonwealth to have methadone and buprenorphine dispensing costs as part of the PBS funded component				✓				
42. Prohibit pharmacies from charging the same fee for daily dosing and weekly dispensing		43		✓				
43. Introduce guidelines for 'fair' dispensing fees		42		✓			✓	

6. Prioritising the options for detailed consideration

This chapter provides the results of the polling against each of the options and identifies the options which will be explored in detail in the next Chapter, and the options which are not discussed further.

Stakeholders were asked to rate each option as high, medium or low priority; or to rate it as a nil priority (i.e. not one that they supported). The decision to exclude or include an option was based on consideration of four variables:

- The proportion polled who supported the option (high and medium priority)
- The proportion polled who indicated that it was not an option (Nil ratings)
- The research evidence-base
- Consultations with stakeholders

As a starting point, we took a minimum of 65% or greater in support (high + medium priority) as a somewhat arbitrary cut-off from the poll results. Any option with greater than 65% of respondents in support was automatically retained. In addition, any option with 50% of more respondents indicating a nil priority rating was automatically excluded.

For those options that failed to reach the threshold of 65%, we considered the stakeholder data in addition to the research evidence. Judgements were then made about the inclusion or exclusion of those options from further consideration, based on triangulation of all these sources of data. Those that we have excluded from further analysis in this report could be re-examined at a later stage: notably for those where there was support, but not of a high or medium priority.

The data are reviewed by goal.

Goal 1: A sustainable workforce: excluded options

This goal addressed options regarding increasing the number of prescribers; training and accreditation systems for doctors; and increasing the number of dispensing points. The polling results are given in Table 1. Options that will not be considered further are highlighted in the table.

Table 8: Goal 1 Polling results

	High %	Med %	Low %	Nil %	*H+M %*
Greater number of prescribers					
1. Nurse practitioners to prescribe methadone/buprenorphine	44	17	29	10	*61*
2. Pharmacists to prescribe methadone/buprenorphine	12	29	32	27	*41*
3. Incentive payments to GPs	30	30	28	13	*60*
Training/accreditation for doctors					
4. Revise and redevelop the training requirements and approaches for prescribers	60	30	7	2	*90*
4a). Differentiate methadone from buprenorphine (in relation to training, accreditation, prescribing)	49	21	23	8	*70*
4b). Remove training requirements for buprenorphine-naloxone (i.e. all GPs can prescribe this, but not methadone)	36	17	19	29	*53*
4c). Remove all GP training requirements for methadone and buprenorphine	12	2	26	60	*14*

4d). Modify the requirements for all GPs to be trained before prescribing (i.e. allow a limited amount of prescribing outside training requirements)	29	17	34	20	*46*
4e). Continue with compulsory training for GPs but conduct the training on-line only (no face-to-face)	17	38	26	19	*55*
4f). Make no substantive changes to training requirements but improve quality and targeting of the training	21	28	23	28	*49*
4g). Chapter of Addiction Medicine or RACGP to take over training and/or authorisation (i.e. doctors and/or nurse practitioners and/or pharmacists) to prescribe methadone and buprenorphine	43	35	16	5	*78*
5. Introduce pre-packed 'start-up' kits with doses stepped up gradually to maintenance	20	25	38	18	*45*
6. Revise the permit system (reduce the amount of paperwork)	62	21	12	5	*83*
Greater number of dispensing points					
7. Improve the level of support provided to community pharmacists who dispense methadone/buprenorphine	69	26	5	0	*95*
8. Make compulsory the dispensing of methadone and buprenorphine as a standard part of pharmacy activity	28	28	33	13	*56*
9. Incentive payments to pharmacists	28	30	35	8	*58*
10. Vendor machine supply for methadone/buprenorphine	16	8	27	49	*24*

Three specific options were proposed to increase the number of prescribers: nurse practitioner prescribing (61% support); pharmacists prescribing (42% support) and incentive payments to GPs (60% support). As can be seen from Table 1, none of these three options polled above 65%. In addition a small minority voted that they were not an option at all (10%; 27% and 13% respectively). While we do not consider these three options further, we note that all three could form part of a long-term strategy for DH, particularly the nurse-practitioner model, which we provide some brief comment on in this next paragraph (given that we do not consider it further).

For nurse practitioner prescribing, examination of the interviews would suggest that some lower ratings were associated with a perception that while this option was viable – it may be a longer term option due to delays in establishing new MBS items for NPs and time needed to train a sufficient number of NPs to have an impact on prescribing. In relation to research evidence for NPs, a Cochrane review found that appropriately trained nurses can provide a quality of patient care equivalent to that provided by doctors (Laurant et al., 2006). A report by Reed et al (2008, p. 6) on the role of NPs in Victoria for drug services, concluded that NPs were suitable for residential services but "the capacity of NP roles to be sustainable in community-based, outreach and home-based services, where there was a requirement for the NP to prescribe, was limited unless other arrangements were in place for patients to receive medications at a subsidised cost". Currently, there are approximately 60 NPs in Victoria, with endorsement from the Nurses Board of Victoria. Two are working in the Alcohol and Drugs area. (http://www.health.vic.gov.au/nursing/furthering/practitioner accessed 11/5/10). A number of stakeholders were supportive of NP prescribing, but noted that getting them in place would be challenging. Comments included:

> "I think nurses or nurse practitioners could be utilised to improve prescribing because we're not going to have enough prescribers no matter what carrots we

put on the end of sticks in the foreseeable future, particularly in the outer metropolitan and rural areas" (KI).

"Nurse practitioner prescribing [is] important. Currently it is a long and torturous process [to get] accreditation for prescribing pharmacotherapy. So I think it's a long-term strategy. But it would need a lot of investment" (KI).

Pharmacists prescribing (option 2) did not reach the threshold level of priority, despite international interest in such models of care. Internationally there are models of independent pharmacist prescribers prescribing methadone/buprenorphine though these tend to operate out of clinic models (prescribing in place of doctors) rather than community pharmacy. In a recent review of the international pharmacy literature by Emmerton and colleagues (2005) the increasing acceptance, development and implementation of pharmacist prescribing models internationally were highlighted. It should be noted that many Victorian pharmacists are already tailoring day to day doses within dose ranges.

A paper is currently being developed outlining a possible nationally consistent approach to authorising non-medical practitioner prescribing. The working group overseeing this includes S&Ts and Health Workforce Australia. It is envisaged that a paper outlining the proposal will be presented to the Australian Health Ministers Advisory Council later in the year. This framework would apply equally to pharmacists seeking prescribing rights.

Despite these positive steps, there is currently no incentive for pharmacists to do the course (which is expensive) or to see the clients. Many community pharmacies are not set up for this. Salary/funding for pharmacists needs to be resolved, and Ministerial approval (i.e. legislative change) would be required.

Project respondents expressed some concerns about pharmacist prescribing including:

"I think you begin to mix up the pharmacists' accountabilities if you get them prescribing. I think that's not ideal".

"Pharmacists prescribing I'd rate low. I wonder if pharmacists would want to do it anyway" (KI).

Incentive payments to GP's (Option 3) did not reach the threshold priority rating. No GP incentives schemes currently operate in Australia for ORT (Ritter & Chalmers, 2009), although one KI pointed that that such schemes do operate for other diseases ("They're offering $1300 per annum for each diabetic patient"). At the same time, there are ethical issues associated with incentive payments: "It should be like any other form of illness and shouldn't get paid any more for treating drug dependants than asthma or whatever". There is also no evidence from other countries regarding the benefits of GP financial incentives.

One project respondent implied negative unintended consequences associated with GP incentive payments: "We have enough bad prescribers, we don't need any more" (KI).

Concerns about implementation and adding another layer of paperwork to GPs were noted: "if the red tape bureaucracy that goes into getting payment is too time consuming that it is a little bit counterproductive and won't work" (KI).

There were suggestions that rather than incentive payments per se, billing structures could be improved. "Maybe incentives isn't quite the right word. But the mental health plans have been used, I understand, quite comprehensively for general practitioners. Yes, maybe something like that for drug and alcohol problems could further stimulate interest in the area" (KI). Another KI said "I think that it just would be quite useful if there was almost something tied into a Medicare item about I guess like a methadone treatment plan".

While none of the three specific options to increase the number of prescribers was supported as a priority, we point out that an increase in the number of prescribers could be a secondary benefit associated with a wide range of options outlined in this paper, including the training approaches discussed next.

Option 4b: Remove training requirements for buprenorphine-naloxone (i.e. all GPs can prescribe this, but not methadone) did not receive more than 65% support (29% not an option; 53% in support). Whilst some stakeholders recognised that buprenorphine-naloxone was a significantly less dangerous drug than methadone, some stakeholders did not support the removal of training requirements for this medication.

> "Even if someone's using a very low-risk medication like the buprenorphine naloxone combo, they should still be trained in the concepts of addiction so that they're able to give good advice" (KI).

The final Reference Group meeting highlighted the divergent views of prescribers on this issue. In follow-up feedback one AMS stated 'I again voice my strong opinion that most AOD doctors and the vast majority of Addiction Medicine Physicians are calling for Suboxone to be de-regulated. Even if the uptake by doctors is low (as in NSW) it immediately allows us to build shared-care links and slowly encourage further GP uptake of prescribing'. Another view was put that 'from the RACGP end, there is no push to end training requirements for Suboxone', however 'there is a vast grey area between no training and overly rigorous training'. This KI suggested that other options such as on-line training and mentoring may be appropriate.

There was a suggestion in the reference group that low polling support for this option may have been due to the views of non-prescribers in the project respondent group. A subsequent analysis showed that if all non-prescribers were removed, leaving 16 ORT prescribers, support for the option declined further (53% to 40%).

The advantage of this option largely pertains to increasing the availability of buprenorphine-naloxone treatment beyond the confines of the current accredited system. The parallel with other opioids has been drawn: if doctors can prescribe morphine or oxycodone why not buprenorphine-naloxone given the safety profile. A Reference Group member providing feedback on the draft report noted "Suboxone is not only a much safer drug than other prescribed opioids, it is safer than most prescribed drugs full stop and safer than over the counter pain killers".

The disadvantages of removing the training requirements for buprenorphine-naloxone prescribing:

- It will only be one of three possible medications available (methadone, buprenorphine mono) and hence limit client treatment matching; and
- It may result in more diversion/misuse/inappropriate prescribing.

We believe this issue can be progressed if we focus on the nature of the training required to prescribe various ORT medications with different safety profiles. The project respondents commenting on this option do refer to shared-care, mentoring and on-line training options that might be considered. The nature of the training required is discussed in chapter 7: goal 1, option 4a.

Option 4c: removing all GP training requirements (60% polled that it was not an option). This option was considered in light of the evidence that training may have little impact (see Strang, Hunt et al., 2007). In addition, there was some evidence that training can be a barrier: in Victoria no additional training was required for buprenorphine-naloxone (cf NSW) and the proportion of clients on buprenorphine-naloxone is significantly higher than in NSW, which has a compulsory training program for doctors to prescribe buprenorphine-naloxone. (But: In Victoria, pharmacists apparently refused to dispense

Subutex and this was partially responsible for uptake). Despite these promising notes, stakeholders did not consider that removal of all training requirements was an option. Project respondent comments mainly focussed on the dangerousness of methadone:

> "I think that that has to continue - some sort of methadone training course, some buprenorphine training course"
>
> "Methadone can be dangerous".
>
> "To provide quality care in treatment of addictions - even something that is reasonably straightforward such as pharmacotherapy - a bit of extra training is required".
>
> "This will be a disaster. Just as putting the naltrexone to open slather, which was not an opiate, lead to a whole lot of deaths. This will too, because doctors really do not understand this group of patients, nor how to look after them. So if we're just looking at it as a drug, we're actually forgetting about the fact that we've got a disease entity and a patient at the end of it".

Option 4e: training on-line only (no face-to-face) (19% not an option; 55% support). It was clear that the majority of respondents felt that some face-to-face training was essential as part of prescribing methadone/buprenorphine. We note that the current system and others under discussion all include an on-line component. This option was to have no face-to-face, which we have now eliminated. Despite not receiving sufficiently high priority for further consideration, one KI noted that on-line training may encourage some new prescribers:

> "So it's desirable to have easy access to all methadone training or education system on the net and then people who want to take it further and say become [accredited]".
>
> "I still think there is a place for workshops because it's just that sense of collegiality and other doctors and it gives us a chance to meet people and follow them up".
>
> "I cannot even begin to understand anyhow who suggests that online training in isolation is a meritorious thing to do. It's like an action of desperation to get more prescribers on board at all costs and the duty of care responsibilities are totally dismissed".

Option 4f: making no substantive changes to training requirements but improve quality and targeting of the training (28% not an option; 49% in support). While the above options were not supported, there was also little support for maintaining the status quo.

> "I think the quality is adequate for our constituency, and I think modifications need to be made to increase access".
> "We need to maintain a good standard, but we also need to be innovative in how to do all of that".

Option 4d: modify the requirements for all GPs to be trained before prescribing (i.e. allow a limited amount of prescribing outside training requirements) (20% not an option; 46% in support).

> "No. I can't understand the logic of that. If you're going to let them prescribe for five without training, why not let them prescribe for 50? You could only have one patient and kill them"
>
> "If it goes open slather we've got the same problem as we've got with pain and everything else. It would just be ridiculous".

Option 4a). To differentiate methadone from buprenorphine (in relation to training, accreditation, prescribing) is retained and considered in the next Chapter. Option 4g) to transfer training and/or authorisation to prescribe methadone and buprenorphine to the RACP or RACGP is also retained for full consideration.

The option to introduce pre-packed 'start-up' kits with doses stepped up gradually to maintenance was only supported by a minority of respondents and therefore will not be considered further (45% in support).

Four options were polled regarding increasing the number of dispensing points. The following options polled below 65% in support, and hence will not be considered further:

- Make compulsory the dispensing of methadone and buprenorphine as a standard part of pharmacy activity (Option 8)
- Incentive payments to pharmacists (Option 9)
- Vendor machine supply for methadone/buprenorphine (Option 10)

In relation to Option 8: to make compulsory the dispensing of methadone /buprenorphine, in order to increase the number of dispensing points KI's noted: "I think it's very difficult to make anything compulsory. I think that it's in fact, …absolutely impossible. … a pharmacy could choose not to provide a service. You can't force a private business to provide a service". It was noted that there is a specialist skill set required by pharmacists to deliver the program. There were concerns about the impact of compulsory dispensing on the quality of care: "You're not going to get quality of care by forcing an organisation to provide a service" (KI). "Where you have people who are compelled to do something, particularly in this area, you don't necessarily guarantee good treatment" (KI).

It should be pointed out that if methadone/buprenorphine were made available through the PBS, then there may be a greater obligation on pharmacies to provide the treatment. Importantly, this option was also canvassed in the Commonwealth review of section 100 ("all community pharmacists who claim payments for PBS supply from Medicare Australia be required to participate in the …program") (Department of Health and Ageing, 2010, p. 80).

Incentive payments to pharmacists (Option 9) did not reach our arbitrary threshold of 65% rating it as high/medium priority, despite a number of KIs noting that additional payment to pharmacists would offset the costs associated with participating in the program for pharmacies. NSW and the ACT are examples of jurisdictions that provide incentive payments to pharmacies. In NSW new pharmacies dispensing pharmacotherapies receive a once only incentive payment of $1100 (including GST). Both new and existing pharmacies are eligible to receive an incentive of $110 per client twice a year for clients dosed continuously for two months prior to 30th April and 31st October each year (for a maximum of 20 clients). The lump sum payment for new pharmacies could offset outlay costs. As noted by one KI: "…the first thing that they see as a huge expense is the pump, because that's quite expensive now, it's like $600 or $700. Now, that kind of incentive is what I'm talking about". The ACT government subsidises community pharmacies to the value of $15 per week per client. The Guild /Department funding model study looked at the effect of subsidies for clients and pharmacists and found that compliance was uniformly high (around 93%) and detected no difference between the subsidised and control groups (Healthcare Management Advisors 2007).

At the same time, other KIs expressed concerns about incentive payments to pharmacists:

> "We've had a relatively negative experience around incentive payments to pharmacists, so I'd discourage that. It causes a structural change to the financial

factors involved in dispensing without causing an overall structural change to the pattern of access and distribution" (KI).

A suggestion from one KI that there may be unintended negative consequences associated with incentive payments to pharmacists. As described by this KI:

> "…these situation[s] arise where a lot of the pharmacies were just accepting the government payment, billing the patient, but because they were getting some money in they weren't too worried, until it got to the time to transfer the patient elsewhere... and the pharmacy would say, well, they can't transfer until they pay off their debt. Then you'd check on their debt and they were $500 in debt. And you're going, how do let someone accumulate this? Oh well, we were getting the money from the government so we weren't too worried but really, we reminded them" (KI).

This option is not further pursued.

Regarding the use of vending machines to dispense methadone or buprenorphine, there was very limited support for this option. No other models of medication prescribing operate in this way. KIs did not support the option:

> "The vending machine supply for addiction medicine and buprenorphine - I don't think we could have any support, that we would support that in any way" (KI).

> "Vendor machine supply is just downright dangerous" (KI).

The concern regarding potential for overdose and the need for clinical interaction and assessment at the dosing point was noted:

> "It's always better to have a person...A person can engage someone in conversation, develop that sort of treatment relationship. The person can observe and make comment on; is this person intoxicated, is this person now attending with a friend who looks as though they might be standing over them - all that sort of stuff you miss out on when you've got a vending machine" (KI).

It would also not be legal. "Just as an aside, the section in the Drugs and Poisons Act under section 30, Part II section 30, "Vending machines for poisons or controlled substances. A person shall not, whether on or about his premises or elsewhere install any automatic machine for the sale or supply of any poison or controlled substance, or sell or supply any poison or controlled substance by means of any automatic machine. Allow, commit or suffer any such automatic machine" (KI).

In summary, for Goal 1 (sustainable workforce), of the total of 17 options, 12 did not reach the critical level of priority ratings.

Goal 2: A high functioning specialist system: excluded options

All the options for Goal 2 (11 to 13) polled at more than 65% in support. These will all be considered in the next Chapter.

Table 9: Goal 2 Polling results

	High priority %	Medium priority %	Low priority %	Nil %	*H+M %*
11. Reconsider the role and function of Specialist Pharmacotherapy Services (SPSs)	65	25	5	5	*90*
11a). Replace all SPSs with Drug and	35	43	16	5	*78*

Alcohol Addiction Units in teaching hospitals, with mission and brief as per SPS					
11b). Ensure that all SPSs provide specialist services that include methadone, buprenorphine-naloxone and buprenorphine (prescribing and dispensing)	65	25	8	3	*90*
11c). Increase funding levels to SPSs	76	16	5	3	*92*
11d). Ensure all SPSs provide secondary consultation	78	18	0	5	*96*
11e). SPSs to provide outreach/satellite services in major regional areas	67	28	5	0	*95*
11f). All SPS to have 'reserved' treatment places for special needs groups	55	39	6	0	*94*
12. Advertise and recruit to new Addiction Medicine Specialist position(s)	68	24	7	0	*92*
13. Review the Pharmacotherapy Regional Outreach Workers program	50	37	11	3	*87*

Goal 3: Strong and effective connection between the specialist and primary care systems: excluded options

All the options for Goal 3 (14-15) polled at more than 65% in support. These will all be considered in the next Chapter.

Table 10: Goal 3 Polling results

	High priority %	Medium priority %	Low priority %	Nil %	*H+M %*
14. Strengthen programs designed to encourage and support community/primary care prescribing and dispensing	79	21	0	0	*100*
14a). Build referral pathways between generalists and specialists	67	31	2	0	*98*
14b). Provide specialist case management support to community programs	73	25	3	0	*98*
14c). Specialist services as hub of support for linked community services	62	33	5	0	*95*
14d). Increase / establish shared care programs	57	29	12	2	*86*
14e). Review the Pharmacotherapy Development Program	44	36	16	4	*80*
15. Ensure that the GP super-clinics; one-stop-shop primary health care/"Medicare Locals", have capacity to treat opioid dependent people (at least one prescriber)	71	20	7	2	*91*

Goal 4: An accessible program: excluded options

This goal outlined a range of options to make the ORT program more accessible. The polling results are given in Table 4. Options that will not be considered further are highlighted in the table.

Table 11: Goal 4 Polling results

	High priority %	Medium priority %	Low priority %	Nil %	*H+M %*
16. Set up/encourage/incentivise private clinics (as per NSW)	34	21	29	16	*55*
17. Establish at least one more SPS	64	21	13	3	*85*
18. Outreach prescriber (bus) that roves rural regions on set days	32	29	34	5	*61*
19. Outreach dispensing bus that dispenses daily in less accessible locations (akin to mobile library)	33	31	24	12	*64*
20. Provide transport for rural clients	34	32	29	5	*66*

One of the options proposed under increasing program accessibility was the establishment of private clinics. This option did not meet our arbitrary cut-off of 65% in support (55% were in support). In addition, 16% of respondents considered that it was not an option. There is little research on this topic (only one study which supports the private clinic model (Bell et al., 1995). In addition, the difference between a private clinic model and GP practices is somewhat blurred. As noted by one KI "GPs are private clinics, so that's what we're doing at the moment". The key issue that the option of private clinics could overcome is that of too few treatment places. But, as noted by one KI, the private clinics in NSW are actually smaller in treatment place numbers than some of the larger prescribers in Victoria:

> "So for example, Barkly Street has got, what, 500,000 people on methadone?...None of the private clinics in New South Wales are allowed to have that many patients…The most they're allowed is about 200 to 300. There are more patients at Barkly Street than anywhere else in Australia attending one Service. Yet, they are not considered a private clinic because they don't dispense. If they were dispensing on site, then they become a private clinic" (KI).

Another view expressed was that private clinics will emerge as a result of market forces:

> "I don't think that they're a priority for the sector to jump up and down and try and do things about it. If the market exists and there's folk who are interested in working in that field, they will simply evolve… So I think private clinics are a great idea. I just don't think that they're something that government needs to prioritise" (KI).

A strong view held by the KIs was that in terms of government investment, money would be better spent on enhancing the specialist system; that the specialist system is essential for the community-based system to operate, and hence investment in private clinics would be misplaced. On the basis of the evidence and polling results, the specific option regarding the establishment private clinics will not be considered further.

Regarding the outreach bus options (prescribing and dispensing) research evidence supports these modes of service delivery: for example mobile clinics operate in China, Netherlands (since 1979) and the US (Baltimore, San Francisco, Seattle, Massachusetts). There is evidence of greater retention (x4 times) in treatment compared to fixed sites

(Greenfield et al., 1996). While neither 'outreach bus' option reached the 65% cut-off, in light of the research evidence and project respondent feedback, we have retained both of these options for full consideration. This will be discussed in the next Chapter.

The option to establish at least one more SPS was well supported. We believe that a substantial redevelopment of the specialist system is required. This is discussed in chapter 6; goal 2. A range of recommendations are made that will require additional services and funding, however it is our view that establishing one or more SPSs (as they are currently configured) would not be the best use of limited funding. Therefore this option is not pursued further.

In summary, of the 5 options under Goal 4 (program accessibility) we have retained three for further consideration in the next chapter.

Goal 5: High quality clinical care: excluded options

This goal, high quality clinical care, covered a number of different clinical issues, including pharmaceutical opioid dependence, dosing, take-away provisions, counselling services and so on. As per the intent of this chapter, here we only discuss those options that will not be considered further (the remainder are examined in full in the next Chapter). The polling results are given in Table 5. Options that will not be considered further are highlighted in the table.

Table 12: Goal 5 Polling results

	High priority %	Medium priority %	Low priority %	Nil %	*H+M %*
Pharmaceutical opioid dependence					
21. Improve approaches for pharmaceutical opioid dependence treatment and for other pharmaceutical dependence (such as benzodiazepine dependence)	70	30	0	0	*100*
22. Greater knowledge and awareness of pain management in our client group	74	23	3	0	*97*
23. Develop clinical guidelines for methadone/buprenorphine maintenance treatment for those dependent on pharmaceutical opioids	71	21	8	5	*92*
24. Facilitate multi-disciplinary pain management clinics that include Addiction Medicine Specialists	78	22	0	0	*100*
Optimal dosing					
25. Client and practitioner education campaign regarding "optimal doses"	54	29	15	2	*83*
Medication non-adherence and diversion					
26. Reduce take-aways	10	15	35	40	*25*
27. Explore "take-safe" dispensing system	17	37	31	14	*54*
28. Target supervised dosing only to those that need it	52	14	19	14	*66*
29. All buprenorphine-naloxone delivered as unsupervised treatment (monthly 'script')	29	19	29	24	*48*
Unsupervised treatment model					
30. Develop new guidelines for	46	17	27	10	*63*

unsupervised treatment (that are independent from take-away dosing policy)					
Transfers and client mobility					
31. Implement a national permit system	63	23	13	3	*86*
Counselling and psycho-social support services					
32. Education for GPs regarding how to access the new MBBS numbers to fund case management	40	35	20	5	*75*
33. Better care for complex behavioural needs of clients	68	29	2	0	*98*
34. Register of psychologists (private) willing to see clients	35	48	13	5	*83*
Privacy and confidentiality (especially in rural regions)					
35. Review ways in which privacy and confidentiality can be improved in rural areas	42	39	19	0	*81*
Post-release prisoner maintenance – continuity of care on release					
36. Ensure continuity of dispensing at point of release	93	2	2	2	*95*
37. Improve the peer support provided to clients	51	40	9	0	*91*

Options 26 (reduce take-aways) and 27 ("take-safe") pertained to diversion, neither of which reached threshold polling and will not be considered further.

One option concerned the delivery of buprenorphine-naloxone: making it only available through a monthly script (the unsupervised treatment model, Option 29). Only 48% of the respondents supported this proposition.

> "I think if we move towards a model similar to the sort of thing that is available in other countries, France specifically I suppose, where they just get thrown boxes and boxes of it, we are probably doing them a disservice by not giving them the contact" (KI).

The critical issue seemed to be for the appropriate assessment and matching of clients needs to the appropriate treatment protocol. Buprenorphine-naloxone should be available on monthly scripts "for selected patients". Most stakeholders approved of monthly scripts:

> "I think the capacity for it to be delivered as unsupervised treatment needs to be there" (KI).

But for other clients who require greater supervision, they should also be able to receive buprenorphine-naloxone as a supervised medication. This then rules out this option.

We note that Addiction Medicine Specialists can already apply for a 'minimal supervision' permit which allows up to 28 days unsupervised supply of buprenorphine-naloxone. GPs may also apply for a 'minimal supervision' permit, if endorsed by a specialist. Therefore, this option is already available within Victoria for that proportion of clients assessed as suitable for unsupervised supply. Based on these results, this option will not be considered further.

The only other option (# 30) under this goal to fall below 65% support concerned the development of new guidelines for unsupervised treatment (independent from take-away policy). This polled at 63% in support. Given that it was close to the 65% cut-off and there is research supporting this option (below), we have included this option for further consideration. Research indicates that from a clinical perspective unsupervised treatment

is not significantly different in terms of treatment retention or client outcomes from daily supervised buprenorphine-naloxone (Bell et al., in press). Recent work by Adrian Dunlop in Newcastle also found no adverse effects of initiation into weekly scripting of buprenorphine/naloxone. Given that this model of treatment is common overseas (the USA and French models are largely unsupervised treatment, e.g.: (Auriacombe et al., 2004), the development of clinical guidelines appears to be an important and logical step.

In summary, of the 17 options under Goal 5 (High quality clinical care), we have retained 14 for full consideration.

Goal 6: An affordable and equitable program for clients: excluded options

This goal outlined a range of options that were designed to increase the affordability and equitability of the ORT program. The polling results are given in Table 6. Options that will not be considered further are highlighted in the table.

Table 13: Goal 6 Polling results

	High priority %	Medium priority %	Low priority %	Nil %	*H+M %*
38. Reduce financial burden of dispensing fees	81	14	2	2	*95*
38a). SPS to provide respite places for those in financial difficulty	46	24	15	15	*70*
38b). State to pay dispensing fees for certain high-risk groups	65	13	18	5	*78*
38c). SPS to have no dispensing fees	38	29	17	17	*67*
38d). Introduce means testing for client fees	22	29	17	32	*51*
38e). State to pay dispensing fee for the first 3-4 weeks for every client	43	18	20	20	*61*
38f). State to pay all dispensing fees	48	14	21	17	*62*
39. Guidelines for pharmacists about how to manage clients in debt	50	24	21	5	*74*
40. Divorce the fee payment from the service delivery in community dispensing	53	29	11	8	*82*
41. Lobby Commonwealth to have methadone and buprenorphine dispensing costs as part of the PBS funded component	86	10	2	2	*96*
42. Prohibit pharmacies from charging the same fee for daily dosing and weekly dispensing	55	11	16	18	*66*
43. Introduce guidelines for 'fair' dispensing fees	58	18	13	11	*76*

There were a number of options concerned with reducing the financial burden of dispensing fees. The options that fell below 65% support included the introduction of means testing for dispensing fees (Option 38d, 51% priority support). This option is not considered further.

Three options concerned the State paying dispensing fees: option 38f, the state paying all dispensing fees did not meet our 65% support arbitrary cut-off (62% in support). In any case, based on calculations of the costs involved, this option is unlikely to be feasible. Given the polling results and low feasibility, this option is not considered further. An alternate option was for the State to pay dispensing fees for the first 3-4 weeks for every client. This polled at 61% in support. Stakeholders indicated concerns with unintended consequences of such a policy: noting that clients are likely to cycle in and out of treatment more rapidly (KI comments: "you'll just get people being on for a month and dropping off"; "I've been part of pilots that have tried that. People just drop on and off again"). This option will not be considered further.

Although option 38c), that SPS have no dispensing fees exceeded the 65% support cut-off (67% in support) we are also concerned about unintended consequences with this option. That is, the absence of fees increases the demand for treatment access and reduces incentive to return to a fee paying community program further silting up limited specialist resources. KI feedback on this option included:

> "I think one of the things that SPSs will need to be able to do is transition patients from when they go high priority and their medication is free - given the dearth of options for patients to move out into the community. Many of these patients get stuck at the SPSs. So one of the ways of being able to get the SPSs to move patients out to the community - if they keep providing free methadone forever and ever, patients will never move" (KI).

One way to avoid this 'silting up' problem is to introduce disincentives to remain within the SPS, for example providing no take-away doses (as occurs in other states). However this seems to compromise the integrity of the SPS and tailoring treatment regimens to suit the individual client need. Time-limited fee relief may also be possible, however the majority view was that SPS be designated for specialist services, not for fee-relief per se (See later sections under Goal 6 for further options addressing the dispensing fees).

> "If we're going to have some sort of fee system I do think those fees should also be in the specialist services. Because I know one of the issues is some specialist services charge others don't. When the client is stable it's hard to move them out if you are then going that you're going to have to pay". (KI)

In light of these concerns, the option for all SPS to be fee-free will not be considered further.

Option 42 received 66% support (prohibit pharmacies from charging the same fees for daily and weekly dispensing). However, the option is not feasible because it would be anti-competitive, and pharmacies are small business with a right to determine their own price structuring. Stakeholders also appreciated this: "..there's nothing in the Victorian regulations that allow the state to control what pharmacies charge. They're private businesses and they charge a fee for the service they provide....that's business" (KI). "They're private businesses. You can't prohibit them. The ACCC will be on you if you try to do that" (KI). Therefore this option will not be considered further.

In summary, of the total of 12 options under Goal 6 (an affordable and equitable program) five were not retained.

Summary of excluded options

In this chapter we have systematically reviewed each of the options against the polled results. Options falling below a 65% level of support were reviewed in light of the research evidence and the stakeholder consultations. As a result, a total of 21 options were considered to be of a low or nil priority at this time and will not be considered further. The table below provides the list of those options.

Table 14: Options not being further considered

Goals and options	High priority	Medium priority	Low priority	Nil (not an option)	*H+M %*
	%	%	%	%	
1. Nurse practitioners to prescribe methadone/buprenorphine	44	17	29	10	*61*
2. Pharmacists to prescribe methadone/buprenorphine	12	29	32	27	*41*
3. Incentive payments to GPs	30	30	28	13	*60*
4b). Remove training requirements for buprenorphine-naloxone (i.e. all GPs can prescribe this, but not methadone)	36	17	19	29	*53*
4c). Remove all GP training requirements for methadone and buprenorphine	12	2	26	60	*14*
4d). Modify the requirements for all GPs to be trained before prescribing (i.e. allow a limited amount of prescribing outside training requirements)	29	17	34	20	*46*
4e). Continue with compulsory training for GPs but conduct the training on-line only (no face-to-face)	17	38	26	19	*55*
4f). Make no substantive changes to training requirements but improve quality and targeting of the training	21	28	23	28	*49*
5. Introduce pre-packed 'start-up' kits with doses stepped up gradually to maintenance	20	25	38	18	*45*
8. Make compulsory the dispensing of methadone and buprenorphine as a standard part of pharmacy activity	28	28	33	13	*56*
9. Incentive payments to pharmacists	28	30	35	8	*58*
10. Vendor machine supply for methadone/buprenorphine	16	8	27	49	*24*
16. Set up/encourage/incentivise private clinics (as per NSW)	34	21	29	16	*55*
26. Reduce take-aways	10	15	35	40	*25*
27. Explore "take-safe" dispensing system	18	36	30	15	*54*
29. All buprenorphine-naloxone delivered as unsupervised treatment (monthly 'script')	29	19	29	24	*48*
38c). SPS to have no dispensing fees	38	29	17	17	67
38d). Introduce means testing for	22	29	17	32	*51*

client fees					
38e). State to pay dispensing fee for the first 3-4 weeks for every client	43	18	20	20	*61*
38f). State to pay all dispensing fees	48	14	21	17	*62*
42. Prohibit pharmacies from charging the same fee for daily dosing and weekly dispensing	55	11	16	18	*66*

Three options were subsequently removed after full consideration:

Option 17: establish at least one more SPS (modified/reconfigured)
Option 38a): SPS to provide respite places for those in financial difficulty
Option 43: "fair" dispensing guidelines.

7. Consideration of the options retained

This chapter considers all the retained options. It is structured around the six goals:

1. A sustainable workforce;
2. A high functioning specialist system;
3. Strong and effective connections between the specialist and primary care systems;
4. An accessible program (enough treatment places);
5. High quality clinical care; and
6. An affordable and equitable program for clients.

But we remind readers that the placement of options within each goal is somewhat arbitrary given that many options actually address multiple gaols simultaneously (see Matrix in above chapter). For example the options under goal 1 concerned with workforce development also pertain directly to increasing the number of treatment places (goal 4). For ease of reading however, we have retained the goal structure for this chapter. In the next and final chapter, we consider all the options together.

Goal 1: A sustainable workforce: included options

This goal outlines options designed to develop and sustain the ORT workforce including changes to training, accreditation and permitting for doctors and increasing support for community pharmacists.

The options that were supported were:

> Option 4. Revise and redevelop the training requirements and approaches for prescribers (High or medium level support 90%)
>
> Option 4a). Differentiate methadone from buprenorphine (in relation to training, accreditation, prescribing) (High or medium level support 70%)
>
> Option 4g). Chapter of Addiction Medicine or RACGP to take over training and/or authorisation (i.e. doctors and/or nurse practitioners and/or pharmacists) to prescribe methadone and buprenorphine (High or medium level support 78%)
>
> Option 6. Revise the permit system (reduce the amount of paperwork) (High or medium level support 83%)
>
> Option 7. Improve the level of support provided to community pharmacists who dispense methadone/buprenorphine (High or medium level support 95%)

Revise and redevelop the training requirements and approaches for prescribers
There was a very high level of support for the revision and redevelopment of training for prescribers. ORT prescriber training (for methadone and buprenorphine preparations) is an accreditation requirement in Victoria, as it is in other states in Australia. The training provision is contracted by DH and various organisations responsible for it have developed the content and format over recent years. This includes the addition of an on-line component that is a two module prerequisite to the one-day face-to-face training day. Topic areas for the modules are: Module One - Understanding and working with heroin and heroin dependence; Module Two - Treatment options for heroin and other opioid dependence.

The on-line courses are available via GPlearning (RACGP). Both modules take approximately one hour to complete and attract 2 CPD points each. Approximately 50% of GPs who present to the training day will have completed the on-line modules (K

Connolly 2010, pers. comm., Aug 31). In the three year period from 2006-2009, a total of 122 GPs were trained (84% via the workshops and the remainder in one-to-one training in specialist clinics) (Connolly 2009).

The training is fairly readily available and trainee feedback would suggest that it is a valuable training experience (Connolly, 2009). A NSW policymaker stated:

> "I think Victoria has an outstanding program of methadone and buprenorphine provision, and it's because so much emphasis has been put on training and support in the past" (KI).

The project respondents' support for training was partially due to the perception that doctors were inadequately prepared by undergraduate and postgraduate courses to work in the ORT area. One AMS commented "there needs to be more and better [university] course content around these issues" (KI). Another stated: "I've looked at what happens in medical schools and general practice training. It's not up to scratch ... so bit of extra training is required" (KI). Another reason for the continued support for training provision was the consensus that the risks associated with methadone warranted more caution (see option 4a below).

It should be noted that the call to support the continuation of some form of ORT training is not well supported by research. It is not known to what extent training leads to improved clinical practice and improved outcomes (see Strang, Hunt et al., 2007). Special arrangements for ORT are also inconsistent with arrangements for other S8 drugs such as morphine and oxycodone. The rationale for different arrangements needs to be questioned, particularly when the ORT formulary includes drugs with the safety profile of buprenorphine-naloxone.

Some project respondents were also of the view that the ORT training requirements acted as a barrier to GP involvement in this area. One AMS stated: "I think very strongly that the current requirement of having to do a formal course is a discourager, a disincentive to recruitment" (KI). But this KI did go on to describe the need for a methadone focussed, attenuated course. A pharmacist questioned whether training was the main barrier to ORT involvement stating that "doctors aren't working in the area because they're nervous about treating addicts, they read about overdoses with methadone" (KI).

There is an appreciation that the existing GP pharmacotherapy training program was developed to meet different needs to those that are evident today. We now need to ensure that training arrangements are based on factors such as:

- An increased ORT formulary (with different safety profiles)
- Emerging issues such as pharmaceutical opioid dependence
- Different training and support strategies (on-line, mentoring options etc)
- Changes to GP education to cater for those who are time-poor or isolated

Differentiate methadone from buprenorphine (in relation to training, accreditation, prescribing)

This option was well supported (High/medium priority 70%) and notably only a very small percentage ruled this out altogether (Nil 8%).

There is a precedent and rationale for having different systems for methadone and buprenorphine. This is based on the substantial difference in safety profile between the two medications (Gibson & Degenhardt, 2007; Pirnay et al., 2004). A recent pilot by Dr Adrian Dunlop in Newcastle lends evidence towards a higher safety profile of buprenorphine-naloxone and monthly scripting rather than supervised dispensing. It is also known that client satisfaction is similar between buprenorphine and buprenorphine-naloxone (Daulouède et al., 2010).

Less restrictive systems with buprenorphine have been implemented in France and US. The French approach allows buprenorphine to be prescribed by any GP without approval; without notification to health officials for users undergoing substitution treatment; without stipulating the duration of the prescription; with limited supervision of buprenorphine; and in the absence of biological testing for other substance use (heroin, cocaine, benzodiazepines, etc.; Auriacombe et al., 2004). An AMS stated on interview that:

> "From the French experience with buprenorphine we need to be making it far easier for doctors to prescribe because it is a fairly safe drug. It's not like methadone which you've got to be careful because you can kill people with it. Methadone obviously still needs to be a lot more highly regulated" (KI).

Project respondents were not supportive of removing the training requirements for buprenorphine-naloxone altogether (Option 4b – 53% high/medium support and 29% nil support). This option was not pursued. Subsequent analysis of the views of prescribers-only revealed that the support for this option dropped to 40%.

However, differentiation of medications based on the different safety profiles was a consistent theme. Feedback from AMSs included:

> "It's now clear with Suboxone, that it's a safer drug and the expectations for training, monitoring and permits, needs to reflect that. It's unnecessarily difficult to have patients on Suboxone given that safety profile" (KI).

> "You can't really kill people on buprenorphine. So there is slightly different training required there. But if we want to free up the system with this client group all GPs really should be able to prescribe it" (KI).

> "We should have separate training or split the training, but not have the same onus on training for the prescription of buprenorphine as we do for methadone" (KI).

> "I'd remove the training requirements for buprenorphine/naloxone. I don't agree with remove training requirements for methadone because I think there are risk issues that still need to be managed" (KI).

The assumption here, as briefly mentioned in the previous section, is that the difference in safety profiles requires more thorough training for methadone prescribers but providing greater flexibility regarding training, accreditation and dosing for buprenorphine and buprenorphine-naloxone. That flexibility may result in fewer barriers to GP prescribing (some medications) and greater ORT access for clients. Greater GP engagement that may result from deregulation needs to be weighed against the potential for poorer service quality, as possibly evidenced in France (Guichard et al., 2007).

Differentiating the training requirements for buprenorphine-naloxone and methadone may have the unintended consequence that clients will have more limited ORT options if their GP has opted for limited ORT involvement. One respondent noted:

> "de-linking Suboxone from methadone may be more trouble than it's worth. The patient base is basically the same people with the same problems … and they interchange between methadone and Suboxone. Arguably, these options would best come from the same provider" (KI).

Differentiation may result in some clients needing to find a new prescriber if their medication needs or preferences change. A more positive outcome may be that GPs become engaged in ORT because it is less onerous to do so and with increasing

confidence some decide to undertake further training enabling more comprehensive ORT service provision. On balance, further training differentiation seems justified. As one prescriber noted "there is a vast grey area between no training and over-rigorous training" (KI). One way to address this issue is to further develop the existing training program into a flexible tiered system where the training varies according to the needs of potential GP prescribers and the nature of their engagement in the ORT system.

Redevelopment of the GP prescriber training program should emphasise flexibility, multi-modal training and support strategies, graduated intensity based on the safety profile of medications and the extent of prescriber involvement in ORT. The training and support arrangements need to reflect that this is an on-going process rather than a one-off event.

We propose that tiered training be introduced in Victoria. The below table summarises the proposed differentiated training approaches by methadone or buprenorphine-naloxone.

Table 15: Proposed training arrangements for methadone, buprenorphine and buprenorphine-naloxone

Training and support alternatives	**Prescribing limitations**	**Comments**
1. Shared care. A new prescriber with a mentoring arrangement with an AMS.	Buprenorphine-naloxone prescribing only	Need to specify the nature of this arrangement Supervisory relationship required for 3 month period Further training encouraged Involvement in on-going professional development sessions encouraged
2. On-line training (only). Completion of 2 modules (working with people who are opioid dependent; and buprenorphine-naloxone prescribing issues),	Buprenorphine-naloxone prescribing only	The duration of the on-line component should be approximately 2 hour duration. Mentoring relationship essential Further training encouraged Involvement in on-going professional development sessions encouraged
3. Supervised clinical placement. A new prescriber completes a clinical placement with SPS or specialist hub service with AMS supervision.	All ORT medication prescription	Need to specify the duration of such a placement, and the supervision arrangements. Minimum 4 weeks is recommended. Mentoring relationship

		encouraged Further training encouraged Involvement in on-going professional development sessions essential (must then link to shared care for next 20 patients).
4. Combined training **On-line** Completion of the 2 on-line modules (as above) **PLUS** **Face-to-face** module completion (working with people who are opioid dependent; and prescribing issues with focus on methadone)	All ORT medication prescribing	The face-to face component should be no longer than 2-3 hours duration and scheduled at times that maximise GP access. Mentoring relationship recommended to enhance ORT treatment engagement Involvement in on-going professional development sessions encouraged

It is worth noting that elements of the suggested training and support program for prescribers are already in place. This includes shared-care arrangements between AMS and GPs; supervised clinical placements and an online training component. Between 2006-2009, twelve doctors utilised the clinical supervision pathway to become ORT accredited (Connolly 2009).

Authorisation to prescribe is required for all the training alternatives, that is completion of an assessment to meet DPRG authorisation requirements. This means that DH needs to develop a new accreditation test just for buprenorphine-naloxone alone – given that we recommend that some training options, as outlined in the above table can apply only to buprenorphine-naloxone (shared-care and on-line training).

Changes to the training requirements and the prescribing practices of GPs need to be monitored over a 12 month period to assess quality and identify unintended consequences.

Recommendations

- That the GP pharmacotherapy training and support program is redeveloped as outlined in the previous table: shared care and on-line training are available to accredit prescribers for buprenorphine-naloxone alone. Clinical placement or combination training accredits prescribers for both methadone and buprenorphine.
- That pharmacists are included in the training program and with ongoing professional development activities (see section: 'improve the level of support provided to community pharmacists").
- That the impact of changes to training requirements are monitored and assessed (at 12 months).
- That strategies are implemented to increase AOD course content in undergraduate and postgraduate medical education courses in Victoria.

Chapter of Addiction Medicine or RACGP to take over training and/or authorisation to prescribe methadone and buprenorphine

Project respondent feedback demonstrated that authorisation and training to prescribe should be considered separately. This section relies on respondent feedback in the absence of research demonstrating better outcomes based on the characteristics or practices of the training/accrediting body.

Authorisation

There was consensus that authorisation is the responsibility of government and changes to which body should be responsible for this should not be considered. AMS feedback was clear, for example:

> "Absolutely, no, no, no, no, no. You cannot have a professional group such as a college doing the authorisation. That's a regulatory issue. Medical groups can approve training, or say someone's in a training program. But this is an absolute no. More negative than nil, if that's possible" (KI).

Another stated:

> "The colleges have no desire to regulate and they've got no manpower or resources to regulate. I firmly believe that that needs to be something that's maintained by Department of Health" (KI).

Based on consistent feedback of this kind any changes to the body responsible for ORT prescriber authorisation is not supported.

Training

As mentioned earlier there has been no criticism of the quality of the existing training and KIs had mixed views about the need to make changes to the responsible body. One view was that shifting responsibility to one of the colleges may add kudos to the training program:

> "The only advantage might be that the RACGP or the Chapter of Addiction Medicine might have more kudos in terms of getting people involved".
>
> "The chapter, being part of the College of Physicians has good branding in terms of a go-to organisation for doctors to trust their training. So there are a lot of good reasons to get them involved" (KI).

Others had their reservations about the colleges taking responsibility for training. One AMS stated "I believe there's vested professional interests there (RACP)" (KI). In terms of the potential to broaden training in the future to include non-medical prescribers, a community pharmacist commented:

> "I think if the RACGP took over then we would be much less likely to have the inclusion of pharmacists and nurses, because they would see it as their own thing. I think that kind of exclusion is not going to help" (KI).

A GP prescriber noted "The Chapter of Addiction Medicine, well, they're basically setting themselves up as specialists. We're GPs, not specialists so the training they provide might not actually be appropriate to what we need" (KI). There was also a question about capacity to deliver training with one respondent stating "The Chapter is in the very early stages of getting on their feet. I don't think they have the capabilities to handle anything of that kind" (KI).

Most had a view that it did not matter which organisation was responsible for the training as long as the quality was good. A GP prescriber said

> "I don't necessarily think it matters who provides the training as long as it is of a good quality. I don't see that the College of GPs or the Chapter of Addiction Medicine are necessarily going to be better than anyone else" (KI).

Another AMS stated that it doesn't matter who provides the training "as long as it meets the minimum standards of what's required" (KI).

According to one project respondent, General Practice Victoria (GPV) has extensive experience with GP training for complex and chronic conditions and unrivalled understanding of GPs in all 29 Victorian divisions of general practice. Based on this experience, GPV involvement in various aspects of ORT training development, endorsement, delivery or post-training support would enhance the program.

It seems that a more important point than who has responsibility for the training is ensuring that relevant professional bodies have input into the training program design (content, training delivery methods, assessment etc). An AMS put the view that:

> "from the outset if you're trying to get a quality training program, there is good reasons for it be reviewed and vetted and approved by either or both of those organisations [RACGP and RACP]" (KI).

It was also suggested by an AMS that if training is to be offered "it should be based on a national curriculum and lead to national accreditation as a prescriber" (KI).

Recommendations

- That no change be made to the current DH responsibility for prescriber authorisation
- That DH put the prescriber training program to tender. The first 3 year program would include program redevelopment (as per other recommendations in this section), training program delivery and provision of regular professional development/ networking opportunities for all ORT providers (including pharmacists and nurse practitioners)
- That tendering from the RACGP, RACP and GPV is encouraged but not to the exclusion of other training providers.
- That DH ensure that Victoria is represented in any Commonwealth discussions about consistent ORT training approaches.

Revise the permit system (reduce the amount of paperwork)

There was a high level of support for streamlining what is currently considered to be an administrative burden and a disincentive for engaging in ORT. Project respondents claimed that this has been successfully achieved in other jurisdictions such as NSW without adverse consequences. It was argued by an AMS that the current system was not meeting key goals. "That is, doctors do not comply with it; it does not properly address doctor shopping – leading in some cases to drug related deaths; and does not allow proper regulation of doctors whose treatment is highly questionable. The system needs to be replaced by "some form of prescription monitoring system .... a better risk management system that all doctors have some form of access to" (KI).

An AMS stated:

> "it's just ridiculous in this day and age that we have a very slow permit system of faxing details and waiting hours to get responses when information technology has clearly moved on. If countries like Malaysia can have an online, real time permit system, why can't Australia? It's crazy" (KI).

One AMS noted that:

> "We need to move away from S8 and methadone or buprenorphine being fundamentally different regulatory processes. A doctor should be able to get a permit for methadone or buprenorphine in the same way as you get a permit for a morphine prescription ... you do it, you click it, you got it" (KI).

”There’s absolutely no reason why in this day and age we’re still mucking around with faxing. It’s just nonsense” (KI).

A Reference Group Member commenting on the consultative options paper noted that this perception was not correct.

> “Doctors apply for permits for morphine and other Schedule 8 drugs in the same manner as for permits for ORT... permit applications for ORT are processed as a priority over applications for other Schedule 8 drugs, and if the application form is completed correctly, is usually processed within the same day” (KI).

It is worth noting that the Drugs and Poisons Regulation Group (DPRG) software will be replaced over the next 18-24 months. The database will be web-based, allowing a prescriber to submit an application online, however this does not mean that the permit will be processed on-line. The web-based software will be more streamlined simply because incomplete forms could not be submitted. One AMS welcomed this development but shared frustration that this was taking so long –

> “they say it’s another 18 months before it’s on-line. It shouldn’t be that difficult. They should be doing everything they can to make it as quick as possible” (KI).

DPRG is also participating in a pilot being run by Small Business Victoria. The pilot involves taking current static forms and making them 'smart forms' i.e. drop-downs for responses etc. This is a limited pilot and a discrete number (4) of all DPRG forms will be included in the pilot with testing involving targeted clients for a very short period of time.

Recommendations

- That DH ensure that priority is given to further streamlining the permitting system

Improve the level of support provided to community pharmacists who dispense methadone/buprenorphine

There was a very high level of support expressed for this option in recognition of the important role that community pharmacists play in Victoria’s ORT program. (It should be noted that the option of financial support was not considered a priority and has not been pursued).

There is evidence that many pharmacists experience difficulty servicing some ORT clients. Much of the difficulty relates to payment of fees or problems with permits/prescriptions. Winstock et al (2010) note that in their postal survey, forty one percent of pharmacists had refused to dose a client for any reason the preceding month, due most commonly to expired prescriptions (29%), or missed doses (23%). This study also found that treatment termination by pharmacists was significantly higher in Victoria than NSW. The PAMS annual report 2008-2009 (Lord, 2009) reported that of all calls to the service, more than two thirds (n = 282) concerned pharmacy dispensing and were usually related to dispensing fee and debt management issues. Many of these issues are beyond the control of the pharmacist and the project respondent feedback suggests that pharmacists are concerned when patients struggle with fees.

A reference group member suggested that:

> “pharmacists should not have to count their minimal supervision ORT clients towards client number ceilings, for instance, as these patients are being managed in the same way as ordinary pharmacy customers. Every client who goes onto

> extended take-home dosing will therefore create an opening for a new daily-fee paying ORT patient".

This may facilitate greater uptake of minimal supervision treatment for those clients that meet the criteria.

Other issues that pharmacists experience relate to customer behaviour. One AMS suggested that this is probably not restricted to the ORT client group stating 'I'm not so sure that our client group constitutes such special risk and demands on pharmacists' compared to others, for example, "mentally ill people who come in for their psychiatric medications" (KI).

The consumer focus group spoke extensively of their community pharmacy experience. It included high praise, such as one couple stating "Our current pharmacist treats us with respect – he's gold. It was sheer luck that we stumbled on him. He has respect for human beings no matter what their past and we treat him with respect as well". A number of concerns were raised about lack of confidentiality and what was perceived as discrimination. Examples of such practice included this comment "People who come into the chemist know we are on methadone, because we have to line up and wait to go into this little booth. We don't know about their lives but they know about us". Another stated that "Pharmacists should be reminded of the discrimination we feel, like having to use another door to enter the chemist, or lining up outside".

Overall the KI feedback indicated that community pharmacists do play an important role in ORT and they do require support and ongoing education opportunities to perform their functions to a high standard. One GP prescriber noted that 'in the old days we used to have workshops whereby there would be the counsellors and pharmacists and doctors - all get together and chew over the difficulties that we faced'. But this hasn't happened in the past ten years. "Some ongoing education with all the players would be a very good idea" (KI).

Building on this idea, an experienced ORT pharmacist stated "To think that pharmacists are not in a position to share the same information that the doctors get is ridiculous. If we did train with them we'd start to build some of those bridges that are essential in the treatment of the patients" (KI).

Another pharmacist noted

> "We're in the process of organising an online training program for pharmacists and I think that it's a good thing as a minimum. Having access to training means that there is absolutely no excuse for people not doing the training. It's important now for GPs and pharmacists to have a minimum number of hours' CE, so it's an opportunity for them to get some points" (KI).

Some additional support for pharmacists should be an expected outcome of a redeveloped specialist system (considered under Goal 2 & 3) where secondary consultation and better service linkages are given greater prominence. There also needs to be a range of training and ongoing professional development opportunities provided by the Department in conjunction with the Pharmacy Board, Pharmaceutical Society and/or Guild. A Reference Group member providing feedback on the consultative options paper indicated that the Pharmaceutical Society "is in the process of arranging meetings in the hope that they will help network ORT service providers" (pharmacists and prescribers).

Recommendations

- That DH modify the key service requirements of the GP Pharmacotherapy Training Program to provide opportunities for pharmacists to participate in the

training program and associated professional development/networking forums

- That DH in collaboration with the Pharmaceutical Society/Guild support/fund an ongoing ORT professional development program to complement the on-line pharmacist course currently under development. Content to include client confidentiality; managing 'difficult' clients; and managing client fee payment issues.

Goal 2: A high functioning specialist system: included options

The consultation process identified a very high level of support for the revision or redevelopment of the SPS component of the Victorian ORT system. The following nine options were supported well beyond the 65% arbitrary cut-off point:

> Option 11: Reconsider the role and function of SPSs (90% high/medium priority);
>
> Option 11a): Replace all SPSs with Drug and Alcohol Addiction Units in teaching hospitals, with mission and brief as per SPS (78% high/medium priority);
>
> Option 11b): Ensure that all SPSs provide specialist services that include methadone, buprenorphine-naloxone and buprenorphine (prescribing and dispensing) (90% high/medium priority);
>
> Option 11c): Increase funding levels to SPSs (92% high/medium priority);
>
> Option 11d): Ensure all SPSs provide secondary consultation (96% high/medium priority);
>
> Option 11e): SPSs to provide outreach/satellite services in major regional areas (95% high/medium priority);
>
> Option 11f): All SPS to have 'reserved' treatment places for special needs groups (94% high/medium priority);
>
> Option 12: Advertise and recruit to new Addiction Medicine Specialist position(s) (92% high/medium priority); and
>
> Option 13: Review the Pharmacotherapy Regional Outreach Workers program (87% high/medium priority).

Reconsider the role and function of Specialist Pharmacotherapy Services
Four Specialist Methadone Services (SMS's) (now known as Specialist Pharmacotherapy Services – SPSs) were established in Victoria in 1994 as part of a redevelopment of drug treatment services. SMS's were developed to provide support for those people receiving methadone treatment 'with complex medical, psychiatric or psychosocial problems' (Hales & Cox, 1999). At the time it was envisaged that the SMS would operate in association with a general teaching hospital. The service objectives reflected a dual focus on clinical service provision and support and capacity building for the community component of the treatment model. The objectives were:

- To provide specialist assessment and treatment services to methadone clients with significant medical, psychiatric and/or psychosocial problems.
- To provide consultancy services for health practitioners involved in providing community and hospital-based methadone and other opioid pharmacotherapy.
- To participate in the training of health practitioners involved in providing methadone services (including medical practitioners, pharmacists, nurses and counsellors) (Hales & Cox, 1999).

As indicated in an earlier section, current service provision is not consistent either with this original vision or current demands and emerging needs. One project respondent who has managed SPSs noted that "they've all evolved and developed in different ways and have meandered away from the original intention" (KI). The review of specialist services conducted by Hales and Cox (1999) identified three ways in which the services were not functioning as originally intended:

1. There was a significant 'throughput' issue. That is, access for clients with complex needs was limited due to the difficulty referring stabilised clients back to community based providers.
2. The majority of clients of these services resided within a 5 km radius raising questions of accessibility and equity for others in metropolitan and regional areas.

3. Formal collaboration between SMS providers and others (GPs, Divisions of General Practice, pharmacists, other AOD services and other SPS providers) was lacking.
4. The requirement to provide secondary consultation and training to hospital and community-based ORT program staff was not being met.

Various Victorian AOD service providers raised similar concerns about the functioning of specialist services during the Victorian Government's Blueprint consultation process in 2007. There was a view that these services were overstretched and unable to provide adequate treatment access for complex needs groups or clients in crisis (Anex 2007; City of Yarra 2007; HRV 2007; Turning Point 2007).

The consultation process for this project highlighted a high level of support for the specialist system. This was typified by comments such as one by an experienced GP prescriber "I'm just glad that they are there. Not that I send many people along there, but it's an escape valve really when we can't cope" (KI). An AMS concurred "I do think we need a specialist system because there is always going to be people that don't fit into that community model and that need the case management and the counselling that go with the specialist system" (KI). There was a fairly consistent view that most SPSs were generally meeting the service objective of providing clinical services for complex or unstable clients. One AMS commented "knowing the way a lot of my [SPS] colleagues work, we all do very similar things ... we see the complex medical and psychiatric folk. Anyone who is struggling to continue in treatment in mainstream community-based services gets sent to an SPS for stabilisation….that's what the SPS is doing, that doesn't need revision"(KI).

Although this level of support was common, the adequacy of the system to provide specialist services to the numbers that need them was questioned. An AMS who previously worked in Victoria was supportive of the need for SPSs but questioned the adequacy of the program in light of the considerable expansion of the community component of the ORT program:

> "I think that Victoria has no specialist pharmacotherapy capacity. [The ORT program] has grown at least threefold and the capacity of the specialist pharmacotherapy services hasn't kept up with it at all. So they're not acceptable" (KI).

> "Most specialist treatment is done by GPs, sometimes well, sometimes poorly, out in the community because that's where the patients are. The specialist services are boutique services that a very small number or proportion of patients can access" (KI).

In a similar vein another AMS stated:

> "The specialist pharmacotherapy services really need the capacity to do around 10 to 20 per cent of the [total ORT] population (1,300-2,600 based on current Victorian numbers)… anything less than that and Victoria is kidding itself to say that it actually has specialist trained workers for supporting primary care" (KI).

Recommendation

- That DH reconsider the role and function of Specialist Pharmacotherapy Services as part of a recommended redevelopment of specialist services (see following recommendations)

Replace all SPSs with Drug and Alcohol Addiction Units in teaching hospitals with mission and brief as per SPS

The strength of support for this option was high but lower than that expressed for strengthening the existing SPS model (78% listing it as a high/ medium priority). It is worth remembering that the original intention was that SPSs would operate 'in association with a general teaching hospital' which is consistent with the stipulation that these services cater for clients with 'complex medical, psychiatric or psychosocial problems' (Hales & Cox, 1999). To cater adequately for this client group today there is a need for SPSs to be strongly linked or integrated within with a hospital network and to have the associated links with other specialist services to better address the range of presenting problems that complex clients experience (See 11f regarding special needs groups and Goal 6: complex needs fee-relief).

There are a number of mechanisms by which this could be achieved. Replacement of all SPSs with Drug and Alcohol Addiction Units in teaching hospitals (with mission and brief as per SPS) is one of them. Different relationships are already reflected in existing SPS arrangements including integration with teaching hospitals (Austin and Western) and integration with a health network (Eastern Health).

Project respondents made the following comments about this option:

> An AMS currently working in a SPS stated "I don't think there's any necessity to replace all the SPSs with addiction units in teaching hospitals.... If anything, we should be increasing SPS services within the community" (KI).

A rural AMS with experience in country hospitals stated:

> "I don't really support putting services in hospitals because what hospitals do is siphon-off the funding, [providing] minimal services because they don't think they're important or they don't like those patients hanging around. I think there would be more value in Melbourne in linking them with community-based services ... Community drug and alcohol services generally do better than public hospitals" (KI).

There may be merit in thinking about the nature of the relationships between SPS and the range of hospital and other specialist services located in Area Health Networks. Links with these services are important given the complex needs groups that SPS cater for. It is also important that strong links are established with a range of primary care or community based services.

It should be noted that hospitals, particularly in country regions may have an important role to play in ORT specialist service provision. This issue is considered in relation to option 11e – to provide satellite/outreach services in major rural areas.

Recommendation

- That the option to replace all SPSs with Drug and Alcohol Addiction Units in teaching hospitals is not pursued, but a key service requirement of redeveloped SPSs should specify an auspicing/integration arrangement with an Area Health Network or teaching hospital

Ensure that SPSs provide all specialist services including methadone, buprenorphine and buprenorphine-naloxone prescribing and dispensing

There is good research evidence that methadone, buprenorphine and the combined buprenorphine-naloxone product are all effective ORT medications. Different clinical indicators for use, different safety profiles and client preference would suggest that all

medications have a role to play in specialist services (see Ritter and Chalmers 2009 for review). There is also an expectation that to provide effective advice, support and training to other ORT staff, specialists should have clinical experience with these medications. Project respondents expressed a strong view that to qualify as a specialist service a SPS needs to prescribe the full range of ORT medications and dispense medications on site. An AMS stated "I agree that all SPS should be prescribing all three drugs and I know [one service] only does methadone ... I think that it's self-evident you can't run a service with just half the medications" (KI). Another AMS described this situation as "untenable" (KI). On-site dispensing is not provided at some SPSs prompting a project respondent to note "all of them (SPSs) have to dispense. It's just pointless if they don't dispense" (KI). An important role of specialist services is to be able to provide all levels of back-up support to primary care. "Without a dedicated dosing site, the provision of these back-up services is compromised, particularly for those who have problems accessing community pharmacies" (KI). Difficulty accessing community pharmacists (for whatever reason) was identified as an issue in the 2008/2009 PAMS annual report (Lord, 2009).

A recommendation for this option is contained in consolidated recommendations that appear after the section – 'a reconceptualised specialist system'.

Increase funding levels to SPSs

Ten years ago Hales and Cox (1999) suggested that additional resources may be required to ensure that SPSs achieved their original mission. This particularly related to the provision of a secondary consultation role. They also noted that if SPSs were to provide regional outreach services then funding requirements "would need to be considered." It could be argued that with the expansion of the community component of the program and emerging issues such as pharmaceutical opioid dependence, the need for a well resourced specialist sector is now more important.

One Addiction Medicine Specialist was keen to make the case for a significantly expanded specialist sector stating:

> "You've got four or five small SPSs. The specialist pharmacotherapy services really need the capacity to do around 10 to 20 per cent of the [total ORT] population (1,300-2,600)… anything less than that and Victoria is kidding itself to say that it actually has specialist trained workers for supporting primary care. If you were going to provide outreach satellite services in major regional areas you'd have to be bumping up their funding" (KI).

It is beyond the scope of this project to determine whether the existing funding level is adequate in terms current service delivery against contracted key service requirements. However the funding implications of any recommended changes to the role and function of SPSs will be considered in this report.

Recommendation

- That DH increase the funding provided to the SPS's commensurate with the increased expectations of the redeveloped SPS services (as outlined in other recommendations in this section).

Ensure that all SPSs provide secondary consultation

The SMS evaluation report (Hales & Cox, 1999) found that the provision of secondary consultation and training provided by SMS was 'less than expected' even though it was a 'key service requirement.' The recommendations made in relation to this issue were that SMSs need to achieve a 'better balance between service requirements' (clinical service

provision and secondary consultation) and the Department should do an analysis of the time required to undertake secondary consultation and set targets appropriately (i.e. potentially reduce targets to match funding provided rather than necessarily increasing funding).

A small research project by Longman (unpublished) found that the support and encouragement of medical colleagues is an important positive influence on GP decisions to complete pharmacotherapy training and commence prescribing. A barrier to commencing prescribing is any time delay after completing training. GPs indicated that they became deskilled and lacked confidence after a short period of time. Support and mentoring from AMS and other SPS staff could potentially lead to better engagement and retention in ORT and improved quality of care. An AMS commented that "secondary consultation is a very effective way of providing quality services but also building knowledge and skills in the general sector and it increases access to treatment as well"(KI).

A common theme from the Hales and Cox review (1999), Blueprint submissions and the consultation process for this project was that SPSs provide secondary consultation to some extent, but it is reactive and never prioritised over clinical service provision. A Melbourne based GP prescriber noted "I think they do it. There are not enough of them. They're not resourced to be able to do that" (KI).

A recommendation for this option is contained in consolidated recommendations that appear after the section – 'a reconceptualised specialist system' (p 66).

SPSs to provide outreach/satellite services in major regional areas

There is widespread concern that the SPSs are inaccessible for people residing in rural and remote areas of Victoria. This issue was flagged in the Department of Health EOI document for this project and has been raised by others (Hales & Cox, 1999; Lord, 2009; HRV 2007). The lack of SPS presence in country regions also reduces the likelihood that they are able to effectively support GPs, pharmacists and others involved in ORT in those areas. Given the important role of SPSs in the provision of specialist back-up to support primary care services, this is a serious limitation of the current system.

AMSs and GPs expressed a level of frustration that the services as they are currently configured are irrelevant to clients and other service providers in country regions. A country based GP prescriber stated "for us in the country we very rarely use the specialist pharmacotherapy services at all. I think they're important but let's face it at the moment they're just in the city" (KI).

A Melbourne-based AMS who also works in country areas commented 'I know that other people are going to say, we need more addiction doctors, and yes of course it's true, but boy do we need them specifically outside of Melbourne - where the needs are greatest and the services are least"(KI).

There was a range of suggestions about how rural specialist service coverage could be improved. A country based GP prescriber noted 'I think they [SPSs] could have some [relevance] if they started doing a bit more outreach - not a bad thing. Not necessarily to treat patients but to actually provide support for providers" (KI). An AMS suggested that if the SPSs were functioning well they could be "required to network well with GPs and the community sector in more remote regions like some of the central teaching hospitals do using affiliations or partnership agreements" (KI).

An AMS who works in both the city and country suggested that there is a better way to build rural capacity than develop outreach from city-based SPSs. He stated that "It

would be much smarter to have regional specialist programs [located] within rural Victoria ... it doesn't need to be in every town, but certainly within DHS regions.' This was suggested as an alternative to outreach services where "people come in, do their work and leave, but it doesn't actually leave any infrastructure or knowledge behind" (KI).

He also described a model of service delivery based in a community health service that could be seen as similar to SPS. "The drug and alcohol service takes complex, chaotic and difficult to manage patients in exchange for the doctors who refer to us, agreeing to take them back when they're stable, and do other drug and alcohol work - which they weren't doing previously" (KI). The model utilises a section of the Victorian regulations that allows for an untrained doctor to manage five clients under AMS supervision.

A recommendation for this option is contained in consolidated recommendations that appear after the section – 'a reconceptualised specialist system' (p 66).

Ensure that all SPSs have 'reserved' treatment places for special needs groups

The original intention of the specialist service system was to provide assessment and treatment services to pharmacotherapy clients with significant medical, psychiatric and/or psychosocial problems. This would suggest that all SPS treatment places should be reserved for such clients with the expectation that when/if sufficiently stabilised they would be referred back to community-based ORT providers. This was the expectation of a GP prescriber who stated "specialist centres should really only be treating the ones who are difficult and then passing them back out once they've got them stabilised rather than holding on to them for long periods of time" (KI). The review by Hale and Cox (1999) found that stabilised clients were not being referred back and the authors formed the view that this was due to insufficient community-based ORT places. The result was a 'silting up' of the services whereby some clients no longer needed to be in a specialist program and others who did could not access them.

Three AMSs were of the view that special needs groups already get priority access with comments such as "they already have reserved places for special needs groups" (KI). "That's what happens at the moment. We take the difficult and complex ones" and "although we don't actually have reserved treatment places, even when we're full … we will find a way to fit them in. It's very important that we do that" (KI).

One challenge is to define what constitutes 'special needs', 'complex needs' or 'high risk' groups. There are a number of high risk groups nominated by project respondents as requiring priority access to specialist services:

- Pregnant women
- Prisoners post-release (who have limited community ORT access)
- People with co-morbid mental health issues
- People with significant physical health problems
- HIV positive drug users

Further discussion and definition of high risk groups appears in Goal 6; option 38b.

PAMS (Lord, 2009) has documented the problems experienced by ORT clients who have been terminated from a prescriber or dispenser due to inappropriate behaviour and/or dispensing fee related debt. A safety net is required to ensure that continuity of service provision is not jeopardised. Some project respondents suggested that SPSs may be able to reserve emergency places for clients in these situations. This would not seem to be good use of a limited resource, however other ways to provide a safety net do need to be considered (see Goal 6 regarding fees)

A recommendation for this option is contained in consolidated recommendations that appear after the section – 'a reconceptualised specialist system' (p 66).

Advertise and recruit to new Addiction Medicine Specialist (AMS) position(s) and advertise and recruit to more FAChAM trainee positions

A reasonable expectation of specialist services is that they are staffed by a multidisciplinary team, including AMSs. In Victoria, AMSs have played less of a role in the specialist ORT program compared to states such as NSW. This lack of involvement is primarily due to lack of funded AMS and FAChAM trainee positions in Victoria. This is exacerbated by the current status of Addiction Medicine which is recognised as a specialty but not yet included on Schedule Four of the Health Insurance Regulations (allowing patients to access Medicare rebates).

Project respondents, particularly medical practitioners expressed strong views about the limited opportunities for AMS in Victoria. They noted the lack of funded positions, the lack of trainees and expressed concern about the numbers that are close to retirement. Comments included:

> "It's pathetic that a place like Turning Point couldn't possibly consider employing registrars - there is no funding.... there are no meaningful jobs out there. The only way I have a job as a registrar is that I pay my own way with my Medicare bulk billings [from GP specialisation]. The government really needs to consider this carefully" (KI).
>
> "There is no medical funding at all for SPSs in Victoria. So most of the people who work in SPSs access Medicare…. So if you think that specialist pharmacotherapy services intrinsically need medical input, well that's not what the Victorian Government's funding is for" (KI).
>
> "We have either two or three funded position in the whole of Victoria and we have one and a half full-time trainees. The highest priority is actually creating and funding the positions, not recruiting to them" (KI).
>
> "One of the things that's evident is that there are a number of the FAChAM guys around now that are getting pretty old and we're turning out one [new specialist] a year if we're lucky" (KI).
>
> "I can only think of two specialists that aren't based in Melbourne and one third of the population live in rural Victoria. We could probably get more, except that there are no funded positions for them to go to. How do we expect to be getting GPs on board if we're not supporting them?" (KI).

The situation in Victoria was contrasted with NSW. One AMS commented that "Thirty to forty staff specialist positions [are] funded [by] New South Wales Health". This KI argued that approximately 20 funded positions were required in Victoria to train and skill-up the next generation of doctors to manage addiction issues.

We do need to acknowledge that the Victorian ORT system does differ from that of other states. There is no formula for determining appropriate AMS numbers. However there is good support from experts we consulted for urgently building specialist capacity in the ORT system. We believe that the staffing profiles in specialist services should reflect the complexity of the client presentations. At a minimum, one funded AMS position should be located in each of the four metropolitan SPSs. One position should also be located at specialist services located in three outer metropolitan locations and one based in regional specialist services (one per country region). This is a total of 12 FTE. It will not be easy to fill these positions and some staging may be required. Investment in the FAChAM

trainee scheme will be necessary to increase recruitment to these positions in the medium to long-term.

Recommendations

- That DH strengthen the specialist component of the Victorian ORT system by funding 12 Addiction Medicine Specialist positions attached to specialist services
- That DH in collaboration with the RACP consider the current arrangements for AMS training with a view to better funding and promotion

Review the Pharmacotherapy Regional Outreach Worker Program

In light of the recommended redevelopment of SPS services and the establishment of regional and outer metropolitan specialist hubs (see a reconceptualised specialist system below) the role of the outreach workers needs to be reconsidered. The mixed success and 'moderate' benefits associated with the program that were identified on review (Swan et al., 2004) would suggest that roles might be either reconsidered and linked to the specialist hubs or discontinued with the opportunity to reallocate the funds to support GP and community pharmacy engagement in other ways.

Recommendation

- That DH reconsider the role and function of the PROWP in the context of the redevelopment of the specialist service system (outlined in option 11)

A reconceptualised specialist system

In light of the widespread concern about the functioning of the specialist service system we believe that substantial redevelopment is now required. This section describes what the components of the system should be and provides some guidance on key service requirements. This section addresses issues outlined in options 11a to 11f, 12, 13 and 17 and relates to goal 3 options outlined in the next section that are designed to develop strong and effective connections between the specialist and primary care systems.

It is helpful to think about three separate components that need to be strengthened or established to ensure that Victoria's specialist ORT services can provide high quality clinical care and support other components of the ORT system. The components are (1) strengthened Specialist Pharmacotherapy Services (2) established Specialist Service Hubs in outer metropolitan and rural areas and (3) an investment in Addiction Medicine Specialists (AMS). The first two will be described below. The issue of AMS positions was addressed in the previous section. We will also briefly comment on what we describe as 'specialised' services. These services are GP practices with very large client numbers.

Specialist Pharmacotherapy Services

The SPSs are multi-program specialist AOD sites that cater for complex clients, include links to other specialist services, and incorporate a support/care co-ordination function with links to generalist services as appropriate to client need. Their goal is to provide a highly specialist response to complex clients and move toward shared care arrangements for clients as soon as practical. All SPS should have at least one AMS and links to specialist hubs.

There are a number of key issues that need to be addressed to ensure that SPSs operate as they were originally intended (providing services for the most serious and complex clients and providing advice, support and training for other components of the ORT system) and respond to increased demands for specialist services, including that related to increasing pharmaceutical opioid dependence.

SPSs need to be supported to expand capacity and provide quality services according to the following list of key service requirements:

1. Hospital network auspice/hospital integration
2. Expanded service capacity for special/complex needs clients (to be defined) for specialist assessment, stabilisation and when appropriate referral back to community ORT providers
3. Demonstrated links with other specialist services (mental health, hospitals, allied health) and human services (housing, employment, family services)
4. Pharmacotherapy service provision (AMS, GPs, Nurses/Nurse Practitioners, Pharmacists)
5. Psychosocial services involving psychologists and social workers
6. Support (care co-ordination) provided by appropriately qualified staff
7. Prescribing and on-site dispensing of all approved ORT medications
8. Development of pain management and problematic pharmaceutical use expertise within SPSs (see Goal 5 – options 21-24)
9. Formal links to pain management clinics (e.g., MOU, skills share activities, network arrangements)
10. Established relationships with community ORT providers (GPs, community pharmacists) through a range of formal and informal agreements (e.g., protocols, shared care guidelines and communication strategies) to develop referral relationships (in and out)
11. Provision of an agreed level of secondary consultation, training and support services to specified regions/areas
12. Leadership role in consumer engagement in policy development

Specialist 'hub' services in outer metropolitan and rural areas

The hubs are multi-program sites, which may be a mix of primary care and specialist services (e.g., AOD, Mental Health), AOD focussed, or hospitals, with specialist prescribing capacity. Outposting is a feature of service delivery. Clients are complex, but may be more stable than those typically treated in SPS. Shared care arrangements are used where appropriate/practical. Importantly, the hubs have a role in strengthening community-based services (prescribers, dispensers) - through activities including secondary consultation, skills development etc. These hubs are linked to SPS and include AMS.

It is worth differentiating specialist services (SPS and specialist hubs) from 'specialised' services. This service category refers to the GP practices with very high client loads. Discussion and recommendations regarding this service type are contained in goal 4 - An accessible program.

This service development is based on a very clear message from the consultation process and supported from various service reviews that the current specialist service configuration does not cater well for outer metropolitan and in particular, country regions. One option (# 11e) was that SPS provide outreach or satellite services to major regional areas. There was a high level of support for this option but the potential risk is that these metropolitan SPS-linked services may not be the best way to develop local specialist capacity. Specialist hub services (as detailed in option 14c) may be more effective. This component of the service system would operate in outer metropolitan and

rural regions in a similar way to some existing arrangements (e.g., Goulburn Valley Health Service). Such services would have the following characteristics:

1. Provision of specialist ORT assessment and treatment services for complex needs groups and support for other local ORT providers
2. Operate with a staffing profile appropriate for specialist ORT provision (the exact makeup determined by local preference and availability)
3. Provision of ORT prescription services but not necessarily on-site dispensing
4. Operation from an existing regional service (i.e. no bricks and mortar funding)
5. Service location would be flexible to meet local needs (e.g., Community Health Service; Hospital; AOD service)
6. Specialist staff would use outposting arrangements to increase reach to local towns
7. Linkage to other services (GPs, community pharmacists and other specialist services) through a range of formal and informal agreements (protocols, guidelines, communication strategies) (see connections section below)
8. Linkage to regional hospitals to enable access to pain management expertise
9. Linkage with other regional specialist ORT providers

Recommendations (Option 11a -11f)

- That DH redevelop the SPS system to ensure that it meets current and emerging needs (as outlined above)
- That DH in collaboration with DH regional offices establish specialist hub services in outer metropolitan and rural regions (as outlined above)

Goal 3: Strong and effective connections between the specialist and primary care systems: included options

As noted previously, all options put forward to bolster the connection between specialist and primary care systems have been supported. Two major options are involved:

> Option 14: strengthening programs designed to encourage and support community/primary care prescribing and dispensing, and
>
> Option 15: ensuring that GP super-clinics and one-stop shop primary health care/"Medicare Locals" have capacity to treat opioid dependent people (at least one prescriber).

Strengthen programs

Strong and effective connections between specialist program(s) and community[3]/primary care ORT programs strengthen the capacity for community / primary care services to deliver ORT. Investment in this area aims to increase the number of prescribers (and dispensers) and it may encourage existing prescribers and dispensers to continue this area of work. There is also scope to vary the intensity of services, using stepped and shared care arrangements, according to client need. Options to strengthen program connections need to be considered in conjunction with recommendations in the previous section designed to redevelop and strengthen the specialist ORT system.

A number of studies highlight equal clinical outcomes between specialist and community care settings (Keen et al., 2000; Mintzer et al., 2007; Vignau & Brunelle, 1998). Further, the barriers to GPs taking up prescribing following pharmacotherapy training are operational and structural in nature. That is, they are about practice based issues, many of which are open to resolution (Longman, unpublished).

During consultations there was much discussion about the need to support GPs and that they should not feel isolated and lacking access to specialist assistance. For example, one person suggested the way to extend the system "is to support them (GPs) with better specialist collaboration and cooperation", explaining that, "they're afraid of being unsupported. So having strong support…is strategically and tactically really important" (KI). Another suggested that it would be easier to recruit GPs if better specialist support systems were in place [service provider focus group].

The importance of support from specialist agencies was emphasised in reference to primary care and rural settings, with respondents noting that "we will not seduce GPs into doing this work without that kind of support" and that, "especially in the country, it's the only way it's going to work" (KI).

Support for pharmacists was highlighted in focus group discussion:

> "Complex clients are the reason why pharmacists don't take on pharmacotherapy; SPSs providing support is important" (KI).

Five specific options were put forward to advance these connections:

> 14a) Build referral pathways between generalists and specialists 14b) Provide specialist case management support to community programs 14c) Specialist services as hub of support for linked community services 14d) Shared care programs
>
> 14e) Review the Pharmacotherapy Development Program

[3] Community settings refer to community health centres, primary health care services, GP services, HealthOne clinics, GP super clinics and the newly proposed 'Medicare Locals'.

Build referral pathways between generalists and specialists
Building referral pathways between generalists and specialists (in this case GP and specialist pharmacotherapy prescribers) involves the provision of *perceived* as well as *actual* supports for GPs. In the UK, GPs reported that access to local community drug teams would encourage treatment (Davies & Huxley, 1997). In the 1999 evaluation of the (then) SMS, the holistic approach to MMT was noted as enabling the stabilisation of clients "for a return to less intensive community-based treatment" (Hales & Cox, 1999)

Consultation respondents identified a number of strategies associated with building referral pathways. Put simply, the first step is to increase the number of specialists in Victoria. In order to have pathways "you actually need some specialists. Again, there's almost none…this can only be done by increasing SPS by a factor of 10, you need capacity to treat 1,000-2,000 patients" (KI).

Second, relationships between service providers are important. Referrals are based on "personal contacts", people that "you refer to all the time". These pathways "come through relationships and trust, and experience with each other" (KI).

Third, and particularly in the context of rural settings, building strong referral pathways "would require regionalisation of services" [rural prescriber]. Further, while relationships across locations are important, service delivery should be preserved at local level (KI).

Practical ramifications of these suggestions include the development of local networks of services, including specialist and generalist programs, with formal referral pathways that are supported by regular network development activities.

Provide specialist case management support for community programs
Providing specialist case management support to community programs may also support the uptake of prescribing. In NSW, the Central Coast project involves GP access to immediate phone support from an AOD doctor. In Victoria, the Northern Division of General Practice Outreach Worker is attached to a pharmacotherapy prescribing service to provide capacity to liaise with AOD services and support clients on ORT.

Currently there is a lack of evidence on the effectiveness of specialist case management in community programs, particularly for the AOD population. A recent review examined evidence from 18 studies, on the effectiveness of nurse case management and its impact on health outcomes for people living with long term chronic conditions (diabetes, chronic obstructive pulmonary disease or coronary heart disease). People with these chronic conditions had a high level of health service utilisation and commonly received "unplanned, poorly co-ordinated, ad-hoc care in response to an exacerbation or crisis" (Sutherland & Hayter, 2009). The review found nurse case management had a significant positive effect in a range of areas; objective clinical measurements, quality of life and functionality, patient satisfaction, adherence to treatment and self care and service use (Sutherland & Hayter, 2009).

Some respondents to the current review felt that if clients required specialist case management then hopefully they would already be engaged with primary care services provided within SPS (KI) and that "even with the system where we are, the way it is, they will eventually get case managed" (KI). Others felt that specialist case management could be incorporated into training and mentorship programs, and that this aspect of professional development would be useful for both community and specialist services. One person described a program with three prescribers and a support worker. They noted that the case management model provided through the Medicare initiative on mental health has considerable potential to facilitate linking people into other services (KI).

Clarity around the specialist case management model and role would assist in the efficient utilisation of staff, as explained by one respondent.

> "There are umpteen dozen models of case management versus care coordination and case coordination [whereas we are] looking to develop specific skills in our nurses to implement a case management model … we're funding the NGO sector to provide care coordination which will free up our staff to do the things that we're best at. So we're trying to articulate the different roles that can improve outcomes in the most efficient way and allocate those roles to various parts of the healthcare sector which makes economic sense, if you like, and professional sense" (KI).

Recommendations

- That the ORT program is strengthened by providing support for GPs and community pharmacists.
- That local networks of services, including specialist and generalist programs, which include formal referral pathways and regular activities to build and maintain inter-agency relationships are created.
- That high needs clients have access to specialist case management.
- That the specialist case management model, including appropriate workforce requirements is clarified.
- That the utilisation of Medicare funded mental health services is encouraged, to facilitate linking people into services appropriate to their needs.

Specialist services as hub of support for linked community services

Another way to strengthen programs providing ORT is the use of specialist services as a hub of support for linked community services. Consultation respondents supported the notion, especially if it provides opportunity for "clinical review and to get other opinions and for other specialist input rather than people just working as sole practitioners" (KI).

The 1999 review of SMS noted the need for formal eligibility criteria and referral procedures between SMS and agencies (Hales & Cox, 1999). Innovative program models have developed in the sector; for example the use of 'virtual networks' such as DACAS, to create communities with hubs that include on-line training. The supervised clinical attachment available at the Eastern Health mental health and AOD service is another example.

These services utilise the hub and spoke model, which aims to enable access to appropriate care and ensure the efficient use of specialist resources. Application of the model varies according to local conditions. The central service (hub) may be a designated entry point (e.g., the 'core-shell' model in Ontario; Glaser, 1995), or comprise a coordination function where service relationships are 'two-way'; varying according to the client's stage of treatment and recovery. An example from psychiatric emergency is shown below.

> In the hub-and-spoke model, the psychiatric emergency department acts as a central agency, or hub, with spokes radiating to and from various mental, medical, and social services. The goal is to channel patients to the most efficacious and efficient treatment, depending on the circumstances affecting patients, such as their diagnosis, specific stressors, social circumstances, and phase of life. The spokes are bidirectional, because many patients are referred to the psychiatric emergency department by other services for acute stabilization. The key spokes radiate to all outpatient clinics, day centres, and case management systems and to transitional housing, work therapy, and substance abuse treatment programs (Warren Lee et al., 2003).

Models may vary in terms of organisational settings; "I suppose a teaching hospital is one way to do it, whether it stays as community specialist centres" (KI).
This model has particular application in regional and rural areas; increasing the reach of AOD services (Rush, 1995) and minimising barriers arising from distance and limited service availability. Innovative approaches to service delivery may be utilised in these settings. For example, in northwest Queensland, concerns around service access and high levels of chronic disease led to a model involving mobile teams, which were outposted at communities for 2-3 days each, on a 6-weekly rotation. These teams provided service delivery, training and health promotion activities (Battye & McTaggart, 2003).

Consideration of the service network is also required. As one respondent explained, "it's going to be very region specific and I don't know if it should be community driven or specialist driven or a combination" [metro GP]. The area health service model in NSW was described as one example of regionalisation; "so there's always somewhere in your geographical supply where you can increase, or you can ramp up the level of specialist support you need" [metro prescriber].

Implementation may involve an outreach approach, "to have almost outreach consultants or people that can facilitate those sorts of referrals" (KI). Further, staff in the specialist hubs may require training specific to their advisory role; "the concept of a consultant, so working and supporting others doing their job with your wisdom and expertise, I think that's something that we actually need to foster a bit" [rural prescriber].

Recommendations

- That the hub and spoke model is considered, which may vary in configuration according to local circumstances but will operate according to a common set of principles.
- That this model is utilised, particularly in regional and rural areas.

Shared care programs
Stepped or shared care is regarded as an appropriate option for general practice; "like with any other medical or health issues that requires specialist care. You know we don't ask doctors to be heart surgeons or everything else" [policy maker].

Many different models of shared care exist, the principle being to vary the concentration of care from specialist and primary/community care services according to client status. Some examples are outlined below:

- The Royal Australian College of GPs agree that stepped or shared care is appropriate for general practice, where GPs provide support and care for uncomplicated clients and complicated clients are managed by FAChAM doctors (Ritter & Chalmers, 2009). Shared care guidelines for GP and specialist AOD services identify six elements of a shared care program: clarification of roles; continuum of GP-specialist involvement; clinical protocols and guidelines; communication strategies and referral pathways; educational opportunities; and evaluation and review (Furler, et al 2000).

- PivotWest, in Melbourne's northwest, provides a key anchorage point in linking associated organisations and improving the coordination of care across service systems; from GP practices to community mental health and AOD services. This model involves a psychologist being attached to two GP clinics.

Shared care guidelines for specialist AOD services emphasise two basic steps in setting up a program:

- Identifying broad issues that will affect outcomes (e.g., core services and the interface with GP, possible benefits and concerns about working more closely with GPs, the importance of working with GPs in terms of service activity).
- Exploring organisational attitudes and capacity to establish effective shared care arrangements {e.g., staff skills and attitudes, staff resources, other resources (Furler, et al 2000).

For shared care to be realised, it is important to have sufficient capacity at specialist level to provide the necessary support (Farrell & Gerada, 1997; Strang et al., 1992). Clear, formally documented, relationships between agencies should be established, building and being supported by a foundation of strong communication (Greenwood, 1992; Gruer, 1997). Ongoing investment in service linkages is important; being "worked on and negotiated when things go wrong…to just keep the system going as well as possible for the client and for the doctors and the pharmacists that are participating" (KI). One person felt linkages are a "work in progress" and that as addiction is a relatively new specialty field, the relationship is still evolving. This person felt that more energy could be put into the development of clear pathways on how these relationships evolve (KI).

Consultation respondents suggested educating GPs about the new MBS items, involving case management shared care plans.

Recommendations

- That shared care is incorporated into service operations, supporting program establishment in a manner consistent with guidelines.
- That investment is made into service linkages in an ongoing way.
- That the use of MBS items to fund case management shared care plans is encouraged.

Review the Pharmacotherapy Development Program

The Pharmacotherapy Development Program has a role in supporting and building capacity in the community based system; working directly with GPs and pharmacists. Evidence of effectiveness could not be located for the current review. Anecdotal evidence suggests that it is often peers (i.e., other professionals) who can best encourage new practitioners into the field. While the Pharmacotherapy Development Officers are currently located in DH: Harm Reduction and Pharmacotherapy Services and work in conjunction with DPU, it may be more appropriate to base this role at an external agency (e.g., Pharmacy Guild, RACGP or GPV).

Consultation findings reflect the broader issues impacting community-based ORT in Victoria. In the absence of evidence on program effectiveness, an evaluation was supported.

> "I think the pharmacotherapy development program was always fighting an uphill battle. I mean, they're there to try and get GPs and pharmacists interested in providing the service, and so what they're trying to do is rope in people who are in private businesses, small businesses, to do extra work which is not necessarily lucrative and not necessarily in their best interests, in order to fill a community need. That's a tough portfolio….Does it need to be reviewed? Eventually, but there's no point reviewing it straight away until you start getting the resourcing for some of the other stuff" (KI).

It was noted by a Reference Group member providing feedback on the draft report that "the Pharmacotherapy Development Officers are responsible for adding authorised doctors to the database that in-turn allows the doctors to apply and be granted permits". The extent to which these positions are important to the authorisation/permitting process needs to be considered. We believe that some aspects of the role, including prescriber and community pharmacist recruitment, training, mentoring and developing service networks could be provided if the roles were no longer located within government. Any functions that relate to prescriber or pharmacy authorisation would need to be carefully considered and a decision made about the cost-benefits involved in any changes to the location of these positions.

Recommendations

- That the design and effectiveness of the Pharmacotherapy Development Program is reviewed, in the context of broader system changes.

Ensure that the GP super-clinics; one-stop-shop primary health services/"Medicare Locals"/ and CHCs have capacity to treat opioid dependent people (at least one prescriber)

Benefits of this approach include better primary care access, while the National Healthcare Reform process will need careful monitoring to ensure that pharmacotherapy is one of the services available to clients within GP Super Clinics and Medicare Locals. Service providers contributing to the review noted the practical advantages of a one-stop-shop arrangement. Clients "wouldn't bother going off site to get help they can get on-site" and, in a regional context, "better outcomes have been found for clients attending an on-site dispenser versus a community pharmacy". Extension to other types of healthcare, including dental, child and family services, means that "good care is given to our clients" and community health staff had positive views about working with pharmacotherapy clients (KI).

Diverse views were expressed about ensuring multi-program sites have capacity to treat opioid dependent people, perhaps by engaging of at least one specialist prescriber. A Reference Group member providing feedback on the options paper noted that this arrangement would open up options for other unauthorised doctors in the clinic who have access to medical records to prescribe. Many consultation respondents felt that ORT should be an essential part of service configuration, with one person commenting that the development of multi-program sites is "a real opportunity to make a move" [metro prescriber]. Views include:

- Having an expectation regarding capacity to delivery ORT; "why discriminate against pharmacotherapies? What does a super clinic mean? One stop shop wasn't it?" (KI).

- Making ORT a part of core business; it should be part of the Capital Planning Guidelines…that they also have the capacity to dispense (KI).

- This expectation may be built in to accreditation requirements; "if there was the capacity to tie that [ORT] into one of the guidelines for, you know, maybe accreditation of super clinics" (KI).

- Having super clinics with at least one prescriber would be useful for regional areas; reducing GP concerns about having ORT clients in their waiting rooms and increasing access (KI).

But then, having a single prescriber may be impractical; "what if that particular doctor's not on that day, who's going to cover for him?" (KI). An alternative more advanced approach would see the clinics identifying ORT "as a service need for their clinic" (KI) and ensuring organisational capacity to provide this service.

GP Super Clinics may utilise the hub and spoke model described earlier in this section; typically involving one site "as a principal base providing centralised support or activities to satellite sites which are connected to the principal site" (Department of Health and Ageing, 2009). Variation in the services offered from the hub and the use of collaborative arrangements involving services from hubs and spokes will be the product of local conditions and service needs (Department of Health and Ageing, 2009).
At one super clinic, strategies for ORT are being included to build capacity at the clinic and in the sector. The model will include a pharmacy and part-time pharmacist as well as a nurse; who is available for case management support, including pain management where addiction may be a factor. It is hoped that this resource will "persuade one or more of the GPs in the super clinic to become a prescriber" (KI).

Conversely, some respondents felt that having ORT in these organisational settings may not be realistic. One person described a clinic close by which runs on business principles; "if you force this guy to do it [provide ORT] and he doesn't want to do it because it's not in his business model, he will either do it badly or he'll have one patient so that he can say 'yes, I do it'" (KI). Another talked about a super clinic which refuses to see any AOD patients (KI). A third noted that "it's not necessarily a doctor's decision; it can be the practice manager that says no and that wipes out a dozen potential prescribers" (KI). Others had concerns about incompetency and mismanagement in multi-program sites which may operate; "from the corporate model just in the aim of turning patients over" (KI).

In summary, one-stop shops provide easy access to a range of services and ORT should be considered part of core business. This may be realised by making ORT a requirement of multi-program sites; a feature of accreditation or part of Capital Planning Guidelines. The GP Super Clinics operate from a business model and ORT delivery relies on willingness to engage with this treatment need. Having a sole prescriber at one-stop shops may be impractical (e.g., when the prescriber is not available), although as mentioned earlier current arrangements allow unauthorised doctors some limited prescribing. Ideally, to build capacity would require a team comprising a prescriber, dispenser and nurse. This team may operate from a specialist hub, with links to other agencies.

Finally, it is worth noting that the Medicare Locals and GP Super Clinics are national initiatives and outside the jurisdiction of a state review.

Recommendation

- That one-stop shops, such as GP Super Clinics and Medicare Locals should be required to provide ORT as part of core business. This requirement may be a feature of accreditation or part of Capital Planning Guidelines.

Goal 4: An accessible program: included options

There are no firm estimates of unmet need for the Victorian ORT program. National research (Ritter & Chalmers, 2009) found that there may be up to 50% more patients who had previously sought ORT who may be in need at any one point in time. For Victoria, this translates into about 6,000 more treatment places.

Creating more treatment places is clearly an important priority, and is addressed with increasing the numbers of prescribers and dispensers (see Goal 1), along with reconfiguration of the specialist system (Goal 2) and its connection with primary care services (Goal 3). Various options under Goal 1 (sustainable workforce) relate directly to increasing treatment places, through removing disincentives to provide treatment. In addition, a high functioning specialist system is geared towards ensuring that the community-based workforce is well-supported and hence likely to increase the uptake of services.

Access to the Victorian ORT is usually thought about in relation to three different entry points:

1. SPS
2. GP-primary care
3. Prison/JJ

Service delivery in Victoria is predominantly through the GP system, with 92% of clients being dosed through this service setting. Importantly however, there appear to be two different types of GP programs: those that can be regarded as primary care, with a GP prescribing to a small case load of clients within his/her overall practice, versus GPs that have become specialised in pharmacotherapy maintenance; this work represents a substantial proportion of their practice. These latter services are not 'specialist', rather 'specialised': an important distinction.

There are currently no limits on the numbers of clients any single GP can prescribe for (these limits exist in other jurisdictions). There are 10 GP's who manage approximately one third of all Victoria's ORT clients. There is significant concern about the small number of large GP prescribers on whom the system relies. There is nervousness about what will happen when these prescribers retire:

> "the treatment model is about to collapse within the next five years" (KI)

As a first step in addressing the concern about the small number of large prescribers, this 'specialised' model of service delivery needs to be considered separately from the more typical small GP-based prescribing services. As suggested by one KI:

> "Maybe that should be created as a separate category, separate the general practitioner model, so that there's some way beyond those particular individuals retiring, of having a systematic response…There are economies of scale of treating hundreds of patients under one roof….That's one thing the state government can then do is to accredit those clinics and have a set of procedures and protocols that they can make sure they're being met. So there's some measurement of quality. I think that's a very sensible model that's somewhere between the specialist sector and the primary care sector." (KI)

These large GP practices, while inconsistent with either the specialist model or the primary-care model, deliver a major component of Victoria's services. In some ways this service type is akin to the 'private clinics' that operate in NSW, with the important distinction being that they do not have on-site dispensing. In a study of client outcomes in public and private clinics in New South Wales, Bell, Ward, Mattick et al. (1995) found

that there was no evidence of significantly poorer treatment outcomes in the private clinic model. This suggests that the 'specialised' model of care is effective and should be considered an inherent part of the Victorian system, however there has been no evaluation of the Victorian 'specialised' services.

These 'specialised' services are essential in ensuring access to ORT. An increase in these large GP specialised services would increase ORT access for Victorians. On the other hand, this is a potentially unstable situation, which is highly reliant on this small group of specialised GPs who take on the bulk of the prescribing.

There are a number of options for managing this. The first is do nothing: assume that there will be plans by the providers to transition clients if/when these GPs retire; and that new GPs will take on this specialised role over time.

The second option is to progressively move away from this model and rely more fully on the specialist (SPS) and primary care (GP) systems. This could be achieved by placing caps on the number of clients that any one GP can prescribe for. The consequence of this option would be that new treatment places would need to be found for about 8,000 clients. If taken up by GP's (rather than the specialist system), and given that the average case load of a GP in primary care practice is 10, then 800 more GP prescribers would be required. This is clearly unrealistic.

The third option is to introduce some level of regulation into these large-scale specialised GP programs. Regulation could include some quality assurance measures along with ensuring that measures are in place for continuity of service delivery in the event of the prescriber being no longer able to continue.

The extent to which DH needs to act on this issue is driven by perceptions of:

- Extent of risk associated with reliance on small number of large, specialised programs; and
- Quality assurance concerns.

Recommendations

- That DH acknowledge that in Victoria there are three service types: specialist (SPS); GP primary care (small caseload, integrated with general practice); and 'specialised' services provided by GP who predominantly work in ORT. This third category makes up the bulk of Victoria's ORT.
- Given that the majority of Victorian ORT is provided in these 'specialised' services, that DH consider introducing some regulations around this third service model, including quality assurance mechanisms and insurance regarding continuity of service delivery.
- That an evaluation of the quality of care in these specialised services be conducted. There has been no evaluation to date.

Within goal 4, the options that were included as high/medium priority were:
Option 18. Outreach prescribing bus (61% medium/high priority)
Option 19. Outreach dispensing bus (64% medium/high priority)
Option 20. Transport for rural clients (66% medium/high priority)

Option 17 to set up at least one more SPS was well supported but excluded as a stand-alone option. Discussion and recommendations for the development of the specialist system in its entirety were considered within Goal 2.

Prescribing and dispensing bus

Options 18 and 19 proposed the establishment of an outreach prescribing and dispensing bus. There is research evidence and international experience which supports this option. For example, mobile clinics operate in China, Netherlands (since 1979) and the US (Baltimore, San Francisco, Seattle, Massachusetts). There is evidence of greater retention (x4 times) in treatment compared to fixed sites (Greenfield et al., 1996).

While the options were expressed as a "bus" the basic idea is to provide mobile services, which go to where the clients are located. The notion of a prescriber attending at set times within rural or regional community is not necessarily a new idea; but could be formalised as part of a new mode of service delivery that improves accessibility. The prescriber would not need to attend every day, but have a fixed schedule built around assessment and monitoring/review requirements. The mobile dispensing service, on the other hand, would need to attend daily.

Identification of those areas which would benefit the most is required. We expect that these will mostly be rural towns. Towns that are within driving distance of each other and where dispensing is highly limited could be identified and then a route mapped out. For example Warrnambool, Portland and Colac; or Traralgon, Sale and Bairnsdale. The mobile service could also be an important springboard to assist local GPs to become engaged with the service. If the mobile prescriber had specialist skills, and could provide support and consultation and progressively move to a shared care model with the local GPs this would represent added-value. Indeed, it may even be plausible that after some period of time the mobile service is no longer required as the services become embedded within the local systems.

Obviously considerable thought will be required to develop a detailed implementation plan. This would need to include consideration of the frequency of the mobile prescribers visits; the way in which methadone or buprenorphine is transported; and security arrangements.

It is recommended that the service be piloted in one location and evaluated (including both positive and negative consequences). This could then form the basis of a decision as to whether the service model is worth rolling out across other sites.

Project respondents expressed a number of views about this service model, but were generally supportive.

> "I do quite like the idea of the bus and the dispensing" (KI).

> "The prescriber bus I thought was a good idea….one of the things that country GPs argue is that they feel intimated …- and there have been cases of the doctors being threatened and the person knowing where the doctor lives and they don't want to do it.… if you had a roving bus it's not necessarily a local doctor, so you haven't got that issue of intimidation or standover or using the fact that they live in a local community together. Also I guess if you've got someone who is doing transient work or fruit picking or something it means they could be on the program" (KI).

Some saw it as a practical solution but that it does not address the systemic problem of poor treatment availability:

> "I see that they're sort of band aid approaches to a system that isn't encompassing enough to reach out to prescribers and pharmacists in the area, so we need a bus. If we need a bus of course we have to handle the situation as it presents now, but it's certainly not ideal" (KI).

Some questions about whether it would be a cost-effective treatment modality:

"Outreach can be time consuming, inefficient. Important but it can be inefficient" (KI).

"I like the idea. I said before that we have major problems with patients accessing dispensing in rural areas, and wearing my rural hat, I like the idea of getting dispensing out there. I think economically it would be very expensive per dose dispensed. But the idea of improving dispensing rates is important and would be one way to do it" (KI).

Finally, there were some implementation concerns, notably about security and operating hours.

"There'd definitely be some security concerns" (KI).

Recommendation

- That a pilot prescribing and dispensing "bus" (mobile service) in one rural/regional area is undertaken and an evaluation conducted.

Provide transport for rural clients

Project respondents had mixed views about how to support ORT clients who experience difficulty accessing ORT services. Cost was an important consideration and many options for addressing different local needs were put, including:

"Transport is an issue that we have reported to us all the time but that would cost a bucket load. Because when you talk about pharmacotherapy, you're talking about daily dosing. So that's to-ing and fro-ing someone every day. I can't see it being cost-effective" (KI).

"If all else failed taxi tickets to assist people or something along those lines would be really valuable in the rural areas" (KI).

"It might be better to subsidise their own mechanisms, because the problems are they can't afford the petrol. Or they've lost their license, but they get someone to drive them, but those people can't afford to spend the money. So if you were using that money more wisely it would be to support them in their natural mechanisms of transport" (KI).

With both the above options, a number of KIs noted that if Victoria provided more unsupervised treatment with buprenorphine-naloxone, some of these problems would dissipate:

"Could more stable clients be put on 30 day buprenorphine takeaways, that then requires them not to travel as much? I know perhaps we shouldn't be making judgements around the drugs people are on. But the fact of the matter is, you know, someone can overdose and die on methadone, they can't on buprenorphine" (KI).

Some questioned whether providing transport was the best use of limited funds:

"You know I'd rather see the money tipped in to - because that would cost a lot of money and if you put that money into perhaps part paying dispensing fees for clients or things like that" (KI).

In addition, some KIs noted that better use of technology, such as Skype, could overcome some of the transport problems:

"The way we've actually got around it with Wonthaggi - and this is actually in conjunction with the health … is we actually do it via Skype. They are in with the

pharmacotherapy nurse down at Bass Coast Community Health and I'm here in my clinic and it's only for pharmacotherapy….." (KI)

"I think that's the sort of place where you can utilise local networks, particularly if there's a policy decision that encourages - so the regional transport that are looked after by individual regions, if the pharmacotherapy program at a state level can talk to the people responsible for those state-wide services, then you can get better linkages and you may get volunteers; you may get subsidised funding of transport. There needs to be a flexible way of applying to assist rural people access their pharmacotherapy" (KI).

Recommendation

- That local solutions to rural transport problems are explored (see actions for further details).

Goal 5: High quality clinical care: included options

This section is about options to support high quality clinical care in the provision of ORT. There are nine areas: addressing the provision and quality of care for pharmaceutical opioid dependence; optimal dosing; unsupervised treatment model; medication non-adherence and diversion; client transfers and mobility; counselling and psychosocial support services; privacy and confidentiality (especially in rural regions); continuity of care for prisoners post-release; and peer support. Fourteen options are involved, as explained below.

Pharmaceutical opioid dependence
Four options have been identified to support the provision of high quality clinical care in relation to pharmaceutical opioid dependence. These options comprise:

21. Improve approaches for pharmaceutical opioid dependence treatment and for other pharmaceutical dependence (such as benzodiazepine dependence)
22. Greater knowledge and awareness of pain management in our client group
23. Develop clinical guidelines for methadone/buprenorphine maintenance treatment for those dependent on pharmaceutical opioids
24. Facilitate multi-disciplinary pain management clinics that include Addiction Medicine Specialists

Nielsen (2010, p 107) notes:

> There has been a marked increase in pharmaceutical opioid use in Australia over the past 15 years, in both prescription and over the counter preparations. Much of this opioid use is for the management of chronic pain, defined as persistent pain for more than three months that impairs a patient's function. Chronic pain is a common problem in Australia, and it is estimated that up to 30% of the adult population will experience chronic pain, with severe chronic pain affecting 5-10%.

We currently have limited understandings about people who use pharmaceutical opioids, have associated problems, and don't access AOD treatment. Recent work on drug injection trends among participants in Australian NSPs shows that pharmaceutical opioids were the third most commonly reported drug last injected (behind heroin and amphetamines); with a significant upward trend from 9% in 2005 to 16% in 2009. Figures for Victoria were lower than that for Australia (Iversen, 2010). Experts suggest there is a 'hidden population' of pharmaceutical opioid users that don't access specialist AOD treatment. Defining this 'hidden population' is the topic of current research.

Recent research suggests the majority of pharmaceutical opioid users that do access AOD treatment have similar characteristics to clients that use illicit opioids (Nielsen et al., 2008). Research on pharmaceutical use involving ORT clients with a history of pharmaceutical use shows that 88% of these clients reported using non-medical pharmaceutical opioids and 88% reported using non-medical benzodiazepines (n=305). However these findings do not reflect prevalence among the broader ORT client group as the study sample was convenience based; involving people who had used some kind of pharmaceutical use in the last six months and were willing to take part in the research. Pharmaceutical opioid use among this group significantly reduced as a result of AOD treatment (Nielsen et al., 2008).

Increased knowledge about clinical care for pharmaceutical use problems may result in a service system that is more responsive to new demand, in the context of increasing rates of pharmaceutical opioid use. Conversely, it is not clear whether the 'hidden population' that may be identified in current research will be attracted to traditional AOD services. For example, preliminary data from Nielsen et al (2010) suggests that codeine users do not perceive current ORT as being for them - they are reluctant to enter treatment. Interventions may need to be linked in with primary health services.

Improve approaches for pharmaceutical opioid dependence treatment and for other pharmaceutical dependence (such as benzodiazepine dependence)
Guidelines on pharmaceutical opioid use have been developed by the RACGP and the PSA is in the early stage of developing guidelines that will be complementary to those produced by the RACGP. Strategies to guide the judicious use of pharmaceutical opioid medications may include: training about 'doctor shopping'; online prescription information for doctors and pharmacists to monitor problematic use of pharmaceutical opioids; computer software for initial patient assessments; recall systems; and complex care planning.

Some consultation respondents felt the use of pharmaceutical opioids is an increasing problem. This is evidenced in increasing use of the drugs and contextualised within imperfect systems for monitoring and control. For example, one person noted that,

> "I know how much Endone and MS Contin I have to keep in my safe now, even compared to a couple of years ago, it's five times as much….[and] no one is questioning the clinical correctness of the prescribing" (KI).

There was considerable discussion on the incidence of people with benzodiazepine use problems.

> [It's a] massive issue; we get so many clients who come through here, or maybe 30% who are benzo dependent, it's almost always been started by doctors and maybe [clients] obtain their drugs on the black market now, but prescribing too high for too long" (KI).

Some respondents suggested that people dependent on pharmaceuticals are different from those usually seen in specialist AOD treatment services and they may require different service delivery approaches. For example,

> "It's a different client group - not always - but it can be a different client group. People who haven't got the behavioural issues - well, a lot of people who get involved in street-based drugs have a background of some sort of disengagement from community, of rebellion, of something that gets them to a point where they try an illicit drug….So creating treatment services which are perhaps more mainstream or perhaps more linked in with core health services as opposed to community-based drug and alcohol treatment is really, really important" (KI).

Greater knowledge and awareness of pain management in our client group
The management of chronic pain involves challenges for clients and clinicians. Clients with chronic pain often perceive themselves as under-treated for their pain (Jamison et al., 2000). Health care professionals tend to under-medicate opioid analgesia because of fears of cognitive, respiratory and psychomotor side effects; iatrogenic drug addiction; and prescription drug diversion (Lander, 1990; Savage, 1999). Greater knowledge and awareness of pain management among clients and health care professionals should result in improved clinical care for those with both chronic pain and opioid dependence.

Wodak et al. (2009) highlight challenges faced by prescribers including a lack of concise guidelines, a real-time prescription monitoring system, and insufficient ready access to specialist advice. Recommendations to the Royal Australasian College of Physicians to improve the management of chronic non-malignant pain and reduce problems associated with prescription opioids include:

> Enhancing clinical practice with improved support for GPs and better linkages to relevant specialties, especially pain medicine and addiction medicine.
>
> Improve integration of College training programs in the fields of pain medicine, addiction medicine, psychiatry and general practice (Wodak, et al. 2009, pp. 3-4).

A number of participants in the reference group focus group also commented that pain management and prescription opioid dependence should be "taught better" in general practice training.

Many consultation respondents commented on pain management. Strategies for greater knowledge and awareness about pain management include training sessions, online materials, and provision of pamphlets to doctors and pharmacists. Fliers could be provided to all pain management clinics regarding addiction. Pain management clinics could also be targeted with promotion of the DACAS website.

Recommendations

- That pain management is considered to be part of core business, in terms of staff capacity and treatment expectations, at specialist services.
- That effective linkages between pain management clinics and prescribers and established and supported.

Develop clinical guidelines for methadone/buprenorphine maintenance treatment for those dependent on pharmaceutical opioids

Clinical guidelines are an important tool for improving practice (Strang, 2007) and there is a lack of knowledge regarding the use of methadone and/or buprenorphine as maintenance treatment for those dependent on pharmaceutical opioids. The development and dissemination of clinical treatment guidelines for the treatment of pharmaceutical opioid dependence would assist in strengthening the ORT workforce. Ritter and Chalmers (2009) noted that,

> There is currently no evidence to inform practitioners about the preferred medication regimes for those misusing pharmaceutical opioids, although both methadone and buprenorphine are being used without apparent ill-effect.

The literature available on this patient group suggests they are different from illicit opioid users and this may mean different guidelines are required. Conversely, clinical experience suggests that the ORT client group is heterogeneous; treatment options do not need to vary from those available for the illicit opioid user. However, features of service delivery may require adjustment - supporting access within a 'mainstream' or integrated framework, as noted earlier.

There was some interest in guidelines for benzodiazepine use issues; "at least for prescribers" [metro prescriber]. For some respondents, this extended to information for AOD service providers about dependence on pharmaceuticals in the context of pain management [peak body representative]. One rural respondent supported the development of guidelines, but noted that more fundamental needs should be prioritised in regional settings; "it's more important simply to have somebody who's willing to write a bloody script. We don't have that. So all the other things are icing on an absent cake" (KI).

Recommendation:

- That new clinical guidelines are developed for the management of pharmaceutical opioid dependence with ORT medications

Facilitate multi-disciplinary pain management clinics that include Addiction Medicine Specialists

This option may facilitate the development of better care systems for clients at pain clinics. Beneficial strategies include the provision of expert advice on dependence, development and strengthening of referral pathways, and the articulation and application of shared care models.

Many consultation respondents commented on pain management. Some noted that access to existing pain clinics can be difficult, because of demand for pain management and, in some cases, confusion around which area of health should take the lead. Respondents explained that:

> "Most of it [pain management] is done by us as GPs…at _____ clinic, they're actually asking us not to send people there now. Ring them up, they'll advise us over the phone but 'don't send anyone unless you really need to" (KI).
>
> "Some pain services feel it's not their area. Then the drug and alcohol clinics feel that this is way out of our area of expertise and interest" (KI).
>
> "Pain management specialists by and large just don't see it [opioid dependence], don't want to know about it, and aren't yet ready themselves to integrate the bodies of knowledge and expertise between the two areas" (KI).

There were many suggestions put forward about how to advance health systems capacity in this area:

1. Include addiction specialists in pain management clinics.
    a. If we don't want to increase addiction medicine specialists it would be good to see an addiction medicine specialist connected to all pain management clinics (KI).
    b. Pain management clinics [to] include an addiction nurse…absolutely, a couple of hours a week or something like that. It's an area where the interface of pain and addiction is very much fuzzy. It's not one or the other, so it can be really useful having people linked in with the combined service (KI).
2. Include expertise in pain management as a core feature of SPS.
    a. Prescription drug problems and chronic pain problems are epidemic and increasing…an SPS by definition should be responding to patient needs and community needs (KI).
    b. SPS staff "need to be trained up on pain management and the various options and the various pitfalls that are involved" (KI).
    3. Ensure strong links between AOD, GP and pain management services.
    a. In a number of area health services that we have here, we have people who are prescribers and addiction medicine specialists who go and discuss at the pain clinic (KI).
    b. We're forging very close relationships with both acute and chronic pain management teams in the hospital (KI).
    c. A network of GPs is one possibility; "that provide that support [pain management] and they link together…they may have contact with others for instance addiction specialists" (KI).

And conversely; restrict pain management to designated clinics. One person suggested that, "all pain management in this field should be in a pain management clinic" (KI).

Recommendations

- That a better understanding of the prevalence of problematic pharmaceutical opioid misuse is developed and appropriate treatment and service delivery approaches are implemented

- (See also earlier recommendations).

Optimal dosing

One option was supported in relation to optimal dosing:

25. Client and practitioner education campaign regarding "optimal doses"

The National Clinical Guidelines recommend that optimal doses for methadone should typically exceed 60 mg per day (Henry-Edwards, 2003) with the maximum for buprenorphine being 32 mg per day, with a range from 8-24 mg (Lintzeris, et al., 2006). However research shows that methadone doses are often less than 60 mg. A survey of 195 clients in Victorian community-based services revealed an average dose of 41 mg (Ezard et al., 1999). More recent work suggests the estimated average daily dose in Victoria is around 50mg, with the average definition of a medium dose being 51 mg per day - as identified by prescribers (Lintzeris et al., 2007).

Lintzeris, et al. (2007) suggest that better information for doctors, pharmacist and clients about methadone treatment is required. This information should address how to optimise methadone treatment and include:

> An accessible compilation of the existing evidence about 'what works' to be produced. Important areas to highlight include: long-term treatment outcomes are better than short-term; and the components of effective treatment - such as the role (and determinants) of dose and psychosocial services; the need to identify and respond to mental health comorbidity; and de-bunking 'methadone myths' where appropriate. Consideration should be given as to how existing state, national and international materials could be made more accessible to clients and service providers.

Consultation findings on dosing also focused on education for prescribers. Many respondents spoke about the need to educate prescribers, with under dosing being a problem as "many, many, many doctors under-prescribe, particularly methadone" (KI). For example,

> "We get so many people who come through here that we assess and they've never been on a therapeutic dose and it turns them off treatment and they relapse and it's all in the dose. All they have to do is get them up to 60mg plus usually and the situation will be different, but it doesn't always occur" (KI).

Some noted the importance of a rational, well-informed approach, but questioned the need for a "full-on education campaign" [Addiction Medicine Specialist], or guidelines "saying you can't go above this dose or you can't go - you know - …because everyone is different" (KI).

A few respondents commented on client attitudes regarding dosing. One person felt that patients should "run their own program," (KI) having input into changes in their dosing level in consultation with the GP. Another felt that "where the system lets the kid down… [is where] he just walks in and tell the doctor what he wants, and there isn't enough consultation" (KI). This person provided an interesting perspective on client attitudes about dosing levels:

> "They will measure themselves against somebody else who they know is on methadone and think that if they go on a higher dose than that kid, they must be a worse junkie; they must be in worse shape than he is, so they will almost enforce their own glass ceiling. As well as that, again through lack of education they will have this issue with not going on too high a dose because it's too hard to get off….If we can over time slowly teach them more about the replacement

drugs and the condition of addiction that they have, then we can move towards an optimal dose" (KI).

These findings suggest the need for better information for doctors, pharmacists and clients about methadone treatment, including a focus on long-term rather than short-term treatment outcomes, dosing, psychosocial services, co-morbid mental health issues, and debunking myths (Lintzeris et al., 2007). This could be the basis of an education campaign for prescribers, about discussing optimal doses with patients, for example a 'how to' video on a website showing interactions between doctor and patient. Information for clients could also be developed; about optimal doses, long-term rather than short-term treatment outcomes and the association between dosing levels and reduction regimes. A Reference Group member providing feedback on the options paper suggested that pharmaceutical companies had and role in such education programs.

Recommendation

- That doctors, pharmacists and clients are educated about appropriate dosing levels.

Medication non-adherence and diversion

One option pertaining to medication non-adherence and diversion has been supported:

28. Target supervised dosing only to those that need it

The USA and French models are largely unsupervised treatment, however there is some evidence that supervision in the French system is linked to better retention/treatment outcomes (Auriacombe et al., 2004). Bell, et al. (in press) found no significant difference in treatment retention or client outcomes between daily supervised buprenorphine-naloxone and weekly unsupervised buprenorphine-naloxone. Recent work, by Dr Adrian Dunlop in Newcastle, also found no adverse effects of initiation into weekly scripting of buprenorphine/naloxone.

The RACGP (Vic) Drug & Alcohol Committee has a tentative proposal for a research trial involving a pilot study on a liberalised dosing regimen for Suboxone patients who continue to show low-risk behaviours. This is a variation of the buprenorphine-naloxone waiting list RCT conducted in NSW, by Dunlop et al.

Some respondents felt that unsupervised dosing is appropriate for a proportion of the client group; "it's just an impost to have to make them front up at their chemist twice a week. It's a constant reminder that they're alienated and therefore bad people" (KI). Consumers had a similar view.

> "It can control me. I mean, when I wake up in [the] morning and [I'm] sweating, it's cold and I'm sweating, and the last thing I want to do is go to the chemist and I can't understand why I'm not perceived as adult enough or responsible enough to look after myself. And [I] feel there is no avenue for us to have a voice apart from HRV" (KI).

Consultation respondents noted the need to ensure an appropriate assessment of people's readiness for unsupervised dosing. For example:

> "Perhaps dosing and dispensing should be based more on a risk matrix where the patient and their individual circumstances are assessed and their dosing and dispense is set according to that" (KI).

> "If you are perceived as stable you get take-aways, but some people can fake it. How do they actually determine if you are stable or not?" (KI).

Differences by drug were also identified; with targeted supervised dosing for Suboxone being ok but "if your question is about methadone, I'd have my reservations" (KI). Anticipated benefits of this approach include improved client outcomes and a reduced risk of diversion. Conversely, GPs may have limited capacity to assess stability; it may not be realistic to expect that unsupervised dosing would be appropriately targeted. One respondent noted that "it's very difficult for us GPs to be actually able to do that. You've really got to have some specialist say that it is allright" (KI).

The Australasian Chapter of Addiction Medicine has published a document outlining clinical guidelines for the assessment of stability (Winstock & Bell, 2006). They note a number of important overarching principles for unsupervised dosing:

- Careful client selection
- Ongoing clinical monitoring
- Importance of transparency in treatment decisions and involvement of the client in that process (Winstock & Bell, 2006)

It is worth noting that AOD specialists can already apply for a 'minimal supervision' permit which allows up to 28 days unsupervised supply of buprenorphine-naloxone. That is to say, current policy already includes some allowance for unsupervised dosing. GPs may also apply for a 'minimal supervision' permit, if endorsed by a specialist.

The follow-on effect would be that monthly scripts would remove the need for supervised dosing and thus increase the number of possible dispensing points from which these monthly scripts could be dispensed.

Implementation strategies include continued support for targeted unsupervised dosing for buprenorphine-naloxone and enabling access to specialist advice to support GPs regarding decisions on unsupervised treatment. Consumer input into policy development would also be useful.

Recommendations

- That the use of clinical guidelines to assess stability for unsupervised dosing is actively promoted.
- That the availability of specialist advice to inform the use of unsupervised dosing is actively promoted.

Unsupervised treatment model

The option put forward on unsupervised treatment focuses on the development of guidelines. This option received support from the majority of consultation respondents although it was ranked as a low priority by around one quarter. In the light of research evidence and respondent comments regarding option 29 (above, on unsupervised dosing) and this option, it has been retained. The option is:

> 30. Develop new guidelines for unsupervised treatment (that are independent from take-away dosing policy)

Two respondents voiced specific concerns against this option. One was concerned that large scale use and diversion would result, bringing a risk of destroying the credibility of ORT that has been established in the state. For example:

> "The way I read it, it's suggested to be introduced for a big slice of the clients, and I think it's only relevant for a tiny proportion of clients. Although it could benefit a lot of kids, a lot of other kids are going to get caught up in it that shouldn't be on it, and I think that's just going to spell heaps of diversion" (KI).

Another felt that the guidelines should not be developed independently of a policy on take-away doses.

The majority of respondents that commented on guideline development supported the option. Some respondents noted that unsupervised treatment is appropriate for some clients and having guidelines would be useful. One person noted that guidelines increase the potential for changing practice:

> "I think actually each state, Victoria, New South Wales, South Australia, we have a tendency to become very trapped in this is how our state does it or this is how our country does it and it really is impossible to do it any other way. Despite sometimes even quite hard evidence to the contrary, we just don't change. So I think - I mean, guidelines are a step and an important step" (KI).

And from a service provider perspective:

> "After five takeaways a week on methadone in Victoria there is nowhere to go. That's it, that's as good as it gets unless you leave the country and go overseas on a holiday, and even that's hard. That depends on your doctor and your pharmacist and whether they're willing to be nice to you on that day. That's not okay and there's no consistency" (KI).

Some respondents noted that unsupervised treatment would increase reach and decrease costs. In an environment where many people go untreated, guidelines for the appropriate use of unsupervised treatment would be welcome as a tool to increase service availability. "In a world of limited resources, how do we get as much treatment to as many patients of a high quality with as low risk as possible" (KI).

Recommendation

- That guidelines for unsupervised treatment are developed.

Transfers and client mobility

Option 31 is to implement a national permit system and this was given high / medium priority by 85% of respondents. While clearly important, this issue is beyond the scope of a state review. Further work is required to address this area.

Counselling and psycho-social support services

Three options have been supported to advance counselling and psycho-social support services:

> 32. Education for GPs re how to access the new MBBS numbers to fund case management
> 33. Better care for complex behavioural needs of clients
> 34. Register of psychologists (private) willing to see clients

Education for GPs re how to access the new MBBS numbers to fund case management

Better remuneration is currently achievable for AOD work using Medicare complex care GP item numbers (i.e., management plans, team care arrangements, mental health treatment plans etc; plus reviews thereof). Consultation respondents felt that utilisation

of these items made good sense; some felt that clinicians are already aware of these options while others thought education was a good idea.

"Having the options is a useful means of incentivisation. Benefits result for clients, in that services become available where they were not previously" (KI). However, a common perception among professionals is that AOD work is not worth the effort. Practical resources may assist in challenging this perception.

In NSW, resources have been prepared to support GPs working with other professionals and clients to develop combined care and business plans for the management of opioid dependent patients. These resources provide hyperlinks to link to additional online resources (websites, documents, presentations) and represent a user friendly, practical approach. They comprise:

> The Patient Journey Kit 1: Transfer of stable public clinic opioid dependent patients to GP prescribers
>
> The Patient Journey Kit 2: Supporting GPs to manage comorbidity in the community (Winstock, 2007)

Better care for complex behavioural needs of clients

The need for GP support and access to specialist care has been highlighted in this review (cf. section on goal 3). Similarly, consultation respondents explained that prescribers need access to specialist advice and support services as "they will have patients they cannot handle or they'll have doses they aren't sure about and need to discuss" (KI). The GP mental health care plans discussed elsewhere facilitate access to specialist psychosocial resources and the utilisation of specialist services according to client need.

The current pressure on prescribers limits their ability to provide comprehensive health care to the patient and address clients' other healthcare needs or practice preventative health practices, "there just isn't the time". One respondent noted that the GP at their centre takes a very holistic approach to patients however this means an increased load for him. A respondent working at an SPS commented that half their hours are made up of secondary consultation; almost all of these consultations involving prescribers.

In addition, GPs want back-up support for behavioural problems. Respondents in the service provider focus group emphasised the efficiency and effectiveness of utilising support staff when complex clients are involved; supporting the clients, providing administrative support for permits, freeing up doctors to "focus on the purely clinical/medical component of treatment". Further, more can be done for clients, addressing their other health and social issues.

Respondents in the consumer focus group described coordinated approaches to care and useful sources of health and social services support. For example:

> "I've got onto the Enhanced Primary Care system where I have a team of people helping me - GP, psychologist and chemist. The GP recommended it and I get 12 free visits to a psychologist, get dental through it as well" (KI).
> "[Centrelink] were actually really good and offered to put us in contact with lots of services" (KI).
> "[The AOD service] has general workers and they ask how you are going, and if you need anything; the Hep C helpline is really good" (KI).

There were concerns, among these respondents, about having to "retell your story all the time" when engaged with multiple services. One person noted that, [the] GP doesn't ask how I am, he just prints out the script and I'm out of there in five minutes. If you

want or need more help you have to find other services yourself. If I want general medical care I go to another doctor" (KI).

Information about referral pathways, strengthening these links, and ensuring access to specialist services are all important for GP prescribers. Having staff with a support and coordination role can facilitate access to needed, non-specialist AOD services.

Register of psychologists (private) willing to see clients

There is research evidence on improved outcomes associated with the provision of counselling with pharmacotherapy (Amato et al., 2004; Gossop et al., 2006; Rowan-Szal et al., 2004), when it is made available but not compulsory. Similarly, consultation respondents felt that having access to capable and interested psychologists would be helpful; people with appropriate training, skills and understanding to work with clients. There was some emphasis on engaging psychologists that work with this client group on a regular basis and, similar to other findings on referral pathways, acknowledgement that linkages between addiction services and psychologists rely on personal contacts and trust in the quality of psychology services.

One person noted that there is already a register; the Australasian Psychological Society has a register of psychologists that may elect alcohol and drug related addiction as an area of interest. They explained that, "it's not whether or not you have a register - it's whether you have anyone interested….the problem isn't the register" (KI). In the rural context, the reality is "there are no private providers in most of the state" (KI).

While the MBS psychology has seen good uptake and high demand, anecdotal evidence suggests that services may not be reaching pharmacotherapy clients. Further, the limited number of sessions available (i.e., sets of six) may not be a good match to the needs of pharmacotherapy clients. In addition, private psychologists expect a substantial co-payment which is not realistic for many people in ORT.

Establishing a weblink to the register may raise awareness about available services, for example via the DACAS website (http://www.dacas.org.au/). Links to specialist mental health services should be strengthened, including information about referral pathways. As noted elsewhere in this document, increased support available to GPs, including access to specialist advice and clinical support (e.g. nursing and/or administration support) would facilitate better care for the complex behavioural needs of clients.

Recommendations

- That client access to counselling and psycho-social support services is supported by promoting MBBS items, using strategies for service co-ordination, and highlighting existing psychological services.

Privacy and confidentiality (especially in rural regions)

One option was put forward (and supported) for ORT in relation to privacy and confidentiality. This option is:

> 35. Review ways in which privacy and confidentiality can be improved in rural areas

While we could not access evidence specific to privacy and confidentiality for ORT in rural areas, respondents provided a pragmatic view on the salience and inevitability of these issues in rural environments. Some respondents felt there is little opportunity to maintain client privacy in country areas, with one person explaining that:

"I mean, it's rural areas. That's kind of what rural areas do. Everyone knows everyone" (KI).

Others reflected a similar perspective, noting that privacy and confidentiality are concerns for rural clients, however the focus of change may need to be the public mindset regarding pharmacotherapy [community dispenser], or an increase in the number of places that will prescribe and dispense to improve anonymity (KI). Stigmatisation of treatment is a concern, "people are afraid – and I think particularly the professionals – but people are afraid to access drug and alcohol services because of the risk of confidentiality" (KI).

In rural pharmacies, privacy and confidentiality "are the biggest issues…because a lot of pharmacies are dosing in the middle of their store… [whereas] if that became more normal, that the patient went off to a separate room when the pharmacist was counselling [about methadone or other medications], no one would realise that some of them were getting methadone and Suboxone" (KI). However, participants in the consumer focus group commented on some pharmacies that have a "a little room where you have to wait for your dose, but the door is still left open so everyone can still see you in there, and you see them looking down at you".

The consumer focus group highlighted that confidentiality concerns in community pharmacies were also an issue in metropolitan areas. Consumer feedback to this effect was included in goal 1: Option 7 (Improving the level of support to community pharmacists).

Strategies such as unsupervised treatment (where appropriate to client need) mean that clients are not easily identifiable. Practical remedies, such as unsupervised treatment (where appropriate to client need) and an outreach dispensing bus, may also assist.

Recommendation

- That concerns about confidentiality are minimised through strategies designed to support access (e.g. GP Super Clinics) and reach (e.g., unsupervised dosing, where appropriate).

Post-release prisoner maintenance - continuity of care on release

One option addressing continuity and support for prisoners post-release has been identified and supported in this review:

36. Ensure continuity of dispensing at point of release from prison

The efficacy and cost-effectiveness of prison pharmacotherapy maintenance is beyond doubt (Dolan et al., 2005; Dolan et al., 1998; Haig, 2003; Shearer et al., 2004). Further, point of release is a high risk time for prisoners in relation to drug use and overdose (Bird & Hutchinson, 2003; Darke et al., 2000; Dolan et al., 1996). Continuity of dispensing is vitally important.

On leaving prison, Corrections Victoria pays for dosing fees at pharmacies approved to provide the services for the first four weeks after the prisoner is released (at a cost of $140). The Moreland Hall 'Blueprint' submission notes that the prisoner post release pharmacotherapy pilot had an 80% retention rate.

Project respondents reflected this context. For example:

> "It's really important that treatment continues at that juncture because we know that on release that's one of the highest rates of overdose, whether it's release from gaol or rehab or detox. That's the highest rate of overdose so yes that linkage is definitely life-saving" (KI).

And from another rural vantage point,

> "When someone has been in gaol for a while, and it doesn't have to be that long, they have extreme levels of anxiety when they come out and for a long time the way they have dealt with their anxiety is to take drugs. So if we leave a gap, it's a problem" (KI).

Researchers at the Burnet Institute are currently conducting an evaluation of the methadone and buprenorphine dispensing subsidy program for Victorian prisoners ("hit and miss" study). Preliminary findings suggest that one month may not be long enough. Some respondents commented that people released on bail from the court [i.e. post remand] also require a tailored response. "They then rock up to us and we have no information about when they had their last dose, what dose they're on, anything like that. Now we do get that information when they're released from gaol, but not released from the court" (KI).

Benefits for clients are clear; retention, safety, continuity. It is worth noting that a large amount of follow-up is required; it can take three months for payments to be finalised. There are also resource implications. The reader is also directed to information on the options put forward in relation to dispensing fees, which is included later in this chapter. The post-prison payment of pharmacotherapy fees may require extension, with anecdotal evidence suggesting a period of up to three months may be more appropriate.

While outside the scope of this review, it is worth exploring the needs of people on remand who are released from court into the community, regarding seamless engagement with treatment and payment of fees. Finally, the timeliness of fee payments to dispensers would support their ongoing engagement.

Recommendations

- That financial support for post-prison ORT is maintained and consideration be given to whether the period of support should be extended.
- That continuity in ORT for clients released from court after being on remand is considered.

Peer support

The option on peer support has been supported in this review:

> 37. Improve the peer support provided to clients

Clients with experience of peer support and peer-led education hold positive views, "valuing the non-judgmental, strengths-based and empowering aspects of peer approaches" (Holt, et al., 2007). Benefits are mainly about treatment retention which, in turn, supports improved treatment outcomes.

Victoria's Pharmacotherapy Advocacy and Medication Service (PAMS) is a peer-based telephone based advocacy, information, mediation, referral and support service for pharmacotherapy consumers, prescribers and pharmacists in relation to consumer issues and pharmacotherapy programs. Consumers self-refer or they are referred via

community, welfare and other service providers. Pharmacists and prescribers are encouraged to phone PAMS regarding consumer related concerns. Lord (undated presentation) explained that,

> PAMS is peer based. In practice this means that any pharmacotherapy consumer who calls the service can be guaranteed that the worker they speak to will have had an experience of being on an opioid substitution therapy program personally or may still be at present. This has been a great relief to many consumers who have, in the most part been incredibly grateful that they are talking to somebody who "knows what it is like" and thus understands the inconvenience of daily supervised dispensing along with the degree of suffering experienced from the abrupt cessation of a pharmacotherapy program. In turn, PAMS workers are able to represent the consumer perspective to service providers.

Demand for the service has increased steadily since 2005-06. At that time, there were 352 cases and an average per month of 29.3. In 2008-09 there were 542 cases and a monthly average of 45.2 (Harm Reduction Victoria, 2010).

Information from the 2009 PAMS annual report provides insights on the people using the PAMS and the services they receive. In 2008-2009:

> The PAMS received 542 calls; the majority were consumers (79%), from Melbourne metropolitan areas and Geelong (89%) followed by inner regional (9%) and outer regional areas (2%).
>
> The most common reasons for the call were fees (38%), requests for information about pharmacotherapies (17.5%), and problems relating to TADs (8%).
>
> The most commonly recorded service outcomes were 'information provision' (80%), 'debriefing and/or support' (51%), and advocacy (45%).

Comparable models from other locations were highlighted and supported by respondents (e.g., Methadone Advice and Conciliation Service; peer support as part of the Ethos Project]. One respondent explained that, "what clients need is access to information and education and support" and some mentioned that access to hepatitis B and C treatment is facilitated through peer support services [harm reduction worker, policy maker].

Some respondents spoke about the need to increase capacity for peer support. The SPS should be encouraged to demonstrate leadership in this area and resourced accordingly. Specialist services should be encouraged to maintain strong links with human services that can provide practical supports to clients in need (e.g., around housing, family relationship problems, welfare benefits).

Alongside these developments in peer support, it would be useful to establish straightforward measures of activity and effectiveness to build the evidence on these interventions.

Recommendations

- That DH and SPS providers continue to engage with and support peer support services in recognition of the important role they play in the Victorian ORT system.

Goal 6: An affordable and equitable program for clients: included options

Seven options to increase affordability and equity for clients were supported:

> 38. Reduce financial burden of dispensing fees (95% medium / high priority)
>
> 38a). SPS to provide respite places for those in financial difficulty (70% medium / high priority)
>
> 38b). State to pay dispensing fees for certain high-risk groups (78% medium / high priority)
>
> 39. Guidelines for pharmacists about how to manage clients in debt (74% medium / high priority)
>
> 40. Divorce the fee payment from the service delivery in community dispensing (82% medium / high priority)
>
> 41. Lobby Commonwealth to have methadone and buprenorphine dispensing costs as part of the PBS funded component (96% medium / high priority)
>
> 43. Introduce guidelines for 'fair' dispensing fees (76% medium / high priority)

Reduce financial burden of dispensing fees

The dispensing fees associated with the ORT have been consistently raised as a critical problem for Victorian pharmacotherapy maintenance clients. There is substantial anecdotal evidence that the dispensing fees are a significant problem for clients. The Salvation Army and RMIT report entitled *A Raw Deal* was based on research involving clients of primary health services for injecting drug users. It explored the issue of dispensing fees amongst this sample of ORT clients. Rowe (Rowe, 2007) reports that "difficulty meeting the financial obligations of OST often contributes to the deterioration of the relationship between dispensing pharmacist and client. This is an obstacle to retention in treatment and involuntary treatment termination is invariably followed by problematic heroin use".

The Pharmacotherapy Advocacy and Support (PAMS) Service Annual Report 2008/2009 reported that 'difficulty with the payment of dispensing fees' is the most common reason for consumer contact with PAMS. Many clients on income support are unable to pay (84% of those contacting the PAMS service in 2008/09).

Additionally, it is inequitable.

> "we have this pathetic fee system that discriminates against these people and placing a massive burden on them and just impedes their treatment and their progress, for what, a couple of bucks? It's just ludicrous; false economy; it's terrible, it's not right, it shouldn't happen" (KI).

Potential improvements in outcomes associated with reducing the financial burden to clients include:

- Increased treatment uptake
- Reduced financial burden on clients
- Lower program drop-out
- Equity (with other medicines and with other drug treatment types)

This well-recognised problem of dispensing fees has been the subject of investigation by the Pharmacy Guild. Funding model options were compared in a study funded by the Commonwealth in association with the Pharmacy Guild (2007). The three options were minimally different (one involved no client fee, another involvement subsidy to the pharmacy and a third an enhanced care model). They found no significant differences between the models in treatment retention but all three models improved satisfaction and improvements were reported in well-being, social and health status associated with having more money (positive client outcomes in terms of reduced financial stress, reduced conflict with partners or spouses and other benefits as a consequence of subsidising dispensing fees). In addition, this study examined the average costs to pharmacies of dispensing. The Pharmacy Guild calculated the average cost of dispensing a daily dose as $3.27 ($1.61-$7.37) for methadone, based on 10 pharmacies, and $3.29 ($1.03 - $8.18) for buprenorphine, based on 8 pharmacies (Pharmacy Guild of Australia, 2007). Eight of the ten pharmacies were making some positive financial return with the average annual return per pharmacy being $15,424 (the median was $16,850).

In 2008, the Commonwealth Government, in concert with the Pharmacy Guild of Australia, funded NDARC and Price Waterhouse Coopers to explore the repercussions of dispensing fees for treatment retention, health outcomes, missed doses and patient satisfaction, among other things. Pharmacies were randomised into an intervention group (pharmacist incentive payment plus $15.00 per week reduction in client fees for clients of that pharmacy) and a control group (pharmacist incentive payment of $30.00 per month). There was no significant difference in client outcomes in the intervention group compared to the control group. Indeed, retention and health outcomes overall were universally high. There were high levels of satisfaction (both from pharmacists and clients) across both groups. The authors do report that those clients paying higher fees were less likely to be compliant with their dosing regimen.

Finally, the issue of dispensing fees is conflated with the emerging misuse of pharmaceutical opioids. As noted by KI's:

> "it's cheaper for them to go and get a script of prescribed opioids from a GP with their Health Care Card, than to go and pick up daily" (KI).

> "Different to what it used to be when heroin was the drug of choice" (same KI).

SPSs to provide respite places for those in financial difficulty

Project respondents seemed to appreciate the complexities associated with providing treatment places based on financial difficulty alone:

> "I don't think the SPS role is to provide respite if someone's in financial difficulty... it did lead to the problem that we could never get them off the program then because they knew if they went out to the community, they had to pay" (KI).

> "It would be great if SPSs could provide respite places for those in crisis but financial difficulty – low [priority]. I think these people can find the finances when they really need to... But certainly when you are in crisis or unsafe or suicidal or at risk - there are no places currently for that" (KI).

One factor that significantly mitigates against this option is the option regarding fee-relief for 'high risk' groups (see below). If the high risk groups were implemented, then there is likely to be less need for fee-relief respite places within the SPS.

Another additional option is a fund held by PAMS (or some other body) to use for those in financial crisis. This option would be significantly less disruptive to the client's care (and would not involve transfer to a specialist service).

In conclusion, we are of the view that the option of SPS providing fee-relief places not be considered further, given the arguments for ensuring that the specialist services are retained for those with serious and complex problems; implementation of fee-relief for high risk groups; the disruption associated with client transfer for financial reasons only; and implementation of a new fund specifically designed to assist with financial difficulties only.

Project respondents were in support of the notion of a newly established fund:

> "I support the notion of a fee-assistance fund administered by PAMS, or a similar organisation" (KI)

This would be a feasible way of providing much needed dispensing fee and debt relief to clients experiencing financial hardship and who otherwise would experience program termination or some other serious harm. There is a great deal of logic in making a unified funding source available to PAMS for fee relief. PAMS has systems and relationships with providers that could efficiently facilitate the assessment of clients and arrange for payment to the pharmacies, in the context of negotiated agreements with pharmacists and client support to prevent future problems. Administration of such a fund would not be without challenges, and demand for such a service would need to be closely monitored. The fund holder would also require financial support to provide such a service (staffing and infrastructure support).

Recommendation

- That SPS not be used to provide fee-relief alone in light of other recommendations regarding fee-relief for high risk groups
- That a new fund be established and administered by an independent body (ideally PAMS) designed to assist clients with financial difficulties.

State to pay for high risk groups

There was strong support for a priority focus on fee-relief for "high risk" groups (78% rated it as high/medium priority). Unfortunately there is no research evidence to directly inform this option. There is little research on the impact of fees themselves, and we could not identify any research that specifically examined the impact of fees on high risk groups. The two critical issues for this option are:

1. Definition of "high risk"; and
2. Implementation processes.

Definition of 'high risk'

If this option were to be implemented, there needs to be agreement on what constitutes 'high risk'. Project respondents appreciated that this was complicated:

> "Everyone should get it. They're all at high risk of overdose. They're high risk of having accidents under the influence of intoxicating - they're all high risk" (KI).

> "How you would define the high-risk groups would be tricky. Because everyone would want to be in a high-risk group" (KI).

The descriptors of "high risk", taken from the national clinical guideline documents for pharmacotherapy treatment include the following:

- Acute psychosis, severe depression
- Frequent abuse of other sedatives including alcohol, benzodiazepines, heroin or other opioids
- Intoxicated presentations to the pharmacy or medical practitioner
- Recent history of overdose
- Recent history of self-harm
- Chaotic lifestyle

- HIV positive
- Having children in patient's care who may be at risk of physical abuse, neglect.
- Unstable accommodation and living arrangements
- Diversion of medication
- Opioid users who are chronic carriers of hepatitis B
- Pregnant opioid users
- Newly released prisoners who have been undergoing buprenorphine or methadone treatment while in custody or individuals recently released from a correction setting and not in treatment.

"People are said to be in continued high-risk drug use when there are frequent presentations while intoxicated or overdoses of heroin or other substances, frequent missed doses, chaotic drug-related behaviours, or deteriorating medical or mental states due to drug use". (National clinical guidelines and procedures for the use of buprenorphine in the treatment of opioid dependence. http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/9011C92D2F6E1FC5CA2575B4001353B6/$File/bupren.pdf; accessed 25/8/10; page 25).

Another approach to defining "high risk" groups is to examine the criteria for stability that are associated with unsupervised dosing. The Royal Australasian College of Physicians, Australasian Chapter of Addiction Medicine developed clinical guidelines for 'assessing the suitability for unsupervised medication doses in the treatment of opioid dependency'. These guidelines note the following criteria for instability:

- Recent diversion of doses
- Ongoing illicit drug use
- Regular injecting drug use
- Erratic/threatening behaviour
- Irregular attendance for pick-up
- Refused dosing
- Risky substance use
- Recent overdose/attempts at self-harm
- Unstable accommodation
- Steady dose less than 4 weeks
- Significant mental health problems
- Significant physical health problems
- Child protection/risk issues

These guidelines suggest multi-modal assessment including:

- Clinical assessment
- Client self-report
- Physical exam
- Urine testing
- Review of attendance
- Review of compliance with dosing schedule.
- Mental health assessment

Examination of these two lists of patient behaviours and diagnoses suggests that a significant number of current Victorian ORT clients would meet these criteria for "high risk". Indeed, one KI listed the high risk groups and then said "well, you know, so we just cover pretty much everybody" (KI).

Given the financial constraints, we sought to refine the list to a more manageable number of criteria, and ones that were supported by the project respondents and the literature. If we define "high risk" as clients who are at risk of mortality or significant morbidity should they fail to enter or to cease pharmacotherapy maintenance, we therefore propose the following inclusions within the "high risk" category:

1. Under 19 years of age (an existing category for fee-relief in Victoria)

2. Juvenile Justice clients (an existing category for fee-relief in Victoria)
3. Individuals recently released from prison (an existing category for fee-relief in Victoria)
4. HIV positive clients
5. Pregnant women
6. Single women or men with one or more children in their care, where the children are at risk
7. Women who are breast feeding
8. Serious current comorbid mental health disorders (active symptoms of psychosis, major depression, anxiety) or disabling physical conditions

There is strong support for these criteria in the project respondent interviews, as demonstrated by the following sample quotes:

> "I would say no dispensing fees only for [complex] clients - HIV, pregnant women, maybe mental health, people with mental health issues, such that they're completely chaotic and disorganised, they're the kinds of people who should probably not pay anything..." (KI).
>
> "Perhaps more patients with more complex needs like co-morbidity, things like that". (KI)

The Salvation Army, in a submission to the Department and based on Rowe's report proposed that pharmacotherapy dispensing fees be funded by the state for the following specific populations:

- women who are pregnant and mothers in the first 18 months post partum
- PLWHA (people living with HIV /AIDS)
- people who are homeless with complex co-morbidity.

These are consistent with the proposed eight criteria listed above.

It may be worth considering whether only those clients within SPSs are eligible for fee-relief within this 'high risk' group definition. There is some logic to this: the specialist services are managing the most severe and complex presentations; clients would receive appropriate specialist support for their mental health, physical health and other comorbid conditions if placed within an SPS. However, this would not apply to prisoners post-release, those under 19 years of age, pregnant women, women who are breastfeeding or necessarily to those with uncomplicated HIV. This then suggests a two-tiered system for fee-relief in 'high risk' groups as discussed under implementation.

Implementation

Prior to discussing how fee subsidisation might work for this group, it is important to note that Victoria currently subsidises fees for three client groups:

- Under 19 years of age
- Youth justice clients on Community Orders
- Recently released from prison (up to 4 weeks post-release)

Current implementation

When a doctor applies for a permit for a client under 19 years old, it is flagged on the Drugs and Poisons Information System (DAPIS) and the pharmacy is sent a fax to advise that DH will pay until a specified date (in this case, the day before the 19th birthday). Pharmacists send an account and are paid $5 per day plus GST. Invoices go to DH and payments are organised in the Operations Unit. For Youth Justice clients, YJ informs Drugs and Poisons of client eligibility and the pharmacy is sent a fax as before. (The faxes are the same as for under 19, and the pharmacist is not informed whether it is an under 19 or YJ client). Payments are processed every four weeks. The prison release clients have payments made by the Justice Department for 4 weeks after release. Workers at the prisons organise doctors and pharmacists prior to release.

On this basis, it appears that there is a system in place that could encompass the payments to 'high risk' groups, in the same manner as operates now. The doctor (prescriber) would need to flag it on the permit application, and then DPU send through a fax advising that they will pay (for a set period). According to an expert, initially the reporting requirements were very onerous and pharmacists were reluctant to participate. But now they are paid without all the reporting requirements and it runs more smoothly. This will need to be borne in mind with implementation of the 'high risks' groups fee-relief.

Proposed criteria (as outlined earlier)

1. Under 19 years of age (an existing category for fee-relief in Victoria)
2. Juvenile Justice clients (an existing category for fee-relief in Victoria)
3. Individuals recently released from prison (an existing category for fee-relief in Victoria)
4. HIV positive clients
5. Pregnant women
6. Single women or men with one or more children in their care, where the children are at risk
7. Women who are breast feeding
8. Serious current comorbid mental health disorders (active symptoms of psychosis, major depression, anxiety) or disabling physical conditions

Two-tiered system: SPS versus community programs

For ease of implementation, those criteria that are 'objective' and do not necessarily require specialist management, can receive fee-relief in the community-based ORT services. This would include those that meet criteria 1, 2, 3, 5, 7.
For criteria 4, 6 and 8, clients would preferably be managed within a specialist service to be eligible for the fee-relief.

Other practicalities

There are likely to be a number of practical issues in implementation that will require consideration. For example, when would fee-relief stop for any one client? For some conditions (such as pregnancy; breastfeeding) it can be based on observable criteria. Other groups are defined by time (four weeks post-release). Criteria for length of fee-relief would need to be established for those with serious current comorbid mental health disorders. Most sensibly it would be easiest to define a time period initially (for example 4 weeks) with a subsequent review. Another practicality concerns how many times within one year a client can receive fee-relief. As noted by one project respondent: "It should even be multiple times in a year, unlike the NRT. It should be two or three times a year" (KI).

Recommendation

- That DH pursue the option of establishing a fee-relief program for clients who meet agreed-upon 'high risk' criteria.

Guidelines for pharmacists as to how to manage clients in debt
While there was strong support for the development of debt management guidelines for pharmacists (72% nominated it as a priority) there were also comments against this option:

> "Guidelines for pharmacists on how to manage clients in debt? Forget it. No, absolutely not. Let the pharmacists do their jobs for pharmacists rather than as financial planner" (KI).

> "If they pay me, they pay me. If they don't well, I give them a certain amount of leeway and then we come to a conclusion and so be it. That's between me and the patient" (KI).

These comments appear to suggest that respondents thought that the guidelines would be 'compulsory'. That was not the intent. The option concerned developing and making available a resource for pharmacist, should they wish to have suggestions regarding how to minimise problems associated with clients' fees. The above comments reinforce the importance of the guidelines being a resource, and not prescriptive. The guidelines would not specify the amount of the client fee.

It would be hoped that having some suggestions and guidelines available for pharmacists, that some of the problems may be averted from the start. The PAMS service gets actively involved in mediating/sorting out strategies for debt management – but this is after the fact (relationship breakdown has already occurred) and is resource intensive. Additionally, it has been suggested that pharmacist being debt collectors may act as a disincentive to participate in the program. If guidelines were available, more pharmacists may feel less reluctant to participate.

Recommendation

- That DH facilitate a process for the development of (voluntary) guidelines to assist pharmacists in managing client debt.

Divorce the fee payment from the service delivery in community dispensing
When a relationship between client and pharmacist breaks down due to failure to pay fees, clients may experience difficulty transferring to another pharmacist due to lack of availability. This difficulty may also result from the need to provide a letter of reference from the original pharmacist and sometimes the requirement to pay dispensing fees a week in advance'

Data shows that pharmacists struggle with the fees and that it's a disincentive to their participation in the program. In a review of client fees, pharmacists noted that fee subsidisation led to improved staff-client relationships (Health Care Management Advisors, 2007).

This option proposes a basic model whereby pharmacists are paid by the state and the state collects the fees directly from clients. The potential downsides of this model include the impact on client perception of how confidential their treatment is as a result of a 3rd party (the state) collecting the money. Introducing a complex system of payment may also be inefficient. Project respondents offered diverse views:

> "what does that mean? Oh, to have the state run as a fund holder. I think that just adds another area of bureaucracy that would actually make things more expensive to actually deliver. Ambivalent to that one" (KI).

"I think ...is really important. Because a lot of the pharmacists get caught up in terrible issues around payment. Clients don't pay and it becomes a real issue and they have to kick them off. It's really pretty stressful and if the two could be separated, I think that would be a lot better. They still pay something but not directly to the pharmacist" (KI).

Recommendations

- That a review of other models where state collects fees from clients is undertaken
- That an assessment of feasibility is conducted

Lobby the Commonwealth to have methadone and buprenorphine dispensing costs as part of the PBS funded component

This is not a new idea. The IGCD has had it on their agenda since 2007. The ORT dispensing fees are inconsistent with Australia's approach to funding essential medicines. Current funding arrangements contravene the fundamentals of the PBS… "access to life saving drugs for all the Australian population at an affordable price". The price is determined by the Commonwealth and the use of the standard patient co-payments would eliminate differences between pharmacies in rates of charging.

It is worthwhile to first outline the PBS system, in broad terms, for medicines in Australia. Australia has universal access to medicines through the Commonwealth Pharmaceutical Benefits Scheme (PBS). Medicines are registered with the PBS once efficacy and cost-effectiveness have been demonstrated (by the drug company). An agreed price for the medicine is negotiated, and the PBS then makes these medicines available at subsidised cost to the Australian community – that is the patient pays a co-payment (the amount determined by ability to pay based on benefit entitlements) which is less than the amount that would be paid if the medicine was not subsidised by the PBS. The PBS subsidy applies to the drug itself and there are not PBS subsidies to Pharmacies for dispensing or recording as the medications are listed under Section 100. (Note: the Commonwealth does pay dispensing fees under the National Health Act for Section 85 medicines ($6.42 dispensing fee; and $2.71 dangerous drug fee).

There are two categories of patient co-payments: general and concessional (concession card holders). Each category has its own patient co-payment amount and a corresponding safety net amount, meaning a maximum amount that is paid per year by the patient. Per PBS unit of medicine/medication the general patient co-payment is $33.30; and the concessional patient co-payment is $5.40. The safety net thresholds are $1,281.30 for general patients and $324.00 for concessional patients (http://www.pbs.gov.au/html/consumer/pbs/about). Given that approximately 75% of ORT patients are concession card holders, we focus on their typical arrangements for access to medicines. Under the PBS, ORT patients would pay a patient co-payment of $5.40 for every unit (a script) of PBS medicines received. Once they reach the safety net amount of $324.00 (i.e. they spend $324.00 in total on co-payments) the remaining medicines are provided at no cost, for the rest of the calendar year. (Patients are responsible for maintaining their own records regarding the safety net).

To apply these standard PBS arrangements to ORT, there would need to be agreement about what constituted a "unit" in PBS terms. A single dose is unlikely to be a unit, as units are usually scripts, defining a course of treatment. The PBS format for regular, ongoing medicines to treat chronic disease is one month's supply. If one month's supply were taken as the 'unit', concession card holders would pay $5.40 per month for their ORT medication. Incidentally, this amount would not reach the annual safety net (unless they purchased other medications throughout the year). If the PBS unit were defined as one week's supply, patients would pay $5.40 per week. If the PBS unit were defined as a

daily dose, patients who are concession card holders would pay $5.40 per day until they reached the safety net – which would occur after approximately 8-9 weeks of treatment. However, if the unit were defined as a daily dose, non-concession card holders would be paying over $230 per week (until they reached their cap of $1,281.30). Irrespective of the definition of the PBS unit (whether a month, week or daily dose) the maximum amount a concession card holder would pay per annum would be the safety net amount of $324.00.

Having described in simple terms how a PBS subsidy might work in the case of ORT medications, there are some other complications. Methadone and buprenorphine for opioid dependence have been listed as PBS drugs. As such they are judged to be necessary and cost-effective medicines. However they are listed under Section 100 of the PBS (not Section 85 where other medications are listed). Section 100 was designed for medications that are dispensed through hospitals and largely not made available through a 'script' (hence there is no 'unit' specified). Under Section 100, the PBS supplies the medication free of charge to wholesalers and accredited pharmacies at no cost to the pharmacies. There is no subsidy to dispense these drugs, nor to record the dispensing under the various necessary regulatory requirements. The cost to pharmacies of both the actual dispensing and the recording is therefore not covered, and hence the introduction of dispensing fees to patients across Australia where ORT is provided outside hospital settings.

For the PBS system to be implemented, the medicines could be moved to Section 85, requiring both an agreed price negotiated with the drug companies, and an agreed 'unit'. Alternately, the medicines could stay under Section 100 and be subject to the patient co-payment and safety net scheme (it would still require specification of a 'unit'). We understand that other medicines available through Section 100 are subject to the usual PBS subsidy arrangements. For example, consideration of the Highly Specialised Drugs program may be useful. The Highly Specialised Drugs are medicines for the treatment of chronic conditions which, because of their clinical use or other special features, are restricted to supply through public and private hospitals having access to appropriate specialist facilities. To prescribe these drugs as pharmaceutical benefit items, medical practitioners are required to be affiliated with these specialist hospital units. A general practitioner or non-specialist hospital doctor may only prescribe Highly Specialised Drugs to provide maintenance therapy under the guidance of the treating specialist. (http://www.pbs.gov.au/html/healthpro/browseby/section100?subbook=HS: accessed 25/8/10). The principles of Commonwealth pricing of PBS drugs could be applied by the Victorian government. For example, medications funded under the PBS Highly Specialised Drugs Program are only subsidised by the Commonwealth for community patients. The cost of medications for inpatients remains the responsibility of the treating hospital (i.e. State governments). The same could apply here, but we note that the option of the State paying all dispensing fees did not receive a sufficiently high priority rating at this time.

There are other arrangements that the Commonwealth has in place for medications to treat chronic conditions. For example bupropion (Zyban) is limited to a single course of treatment (no repeats; 9 weeks) with only one course of PBS-subsidised bupropion hydrochloride authorised per 12 months. Varenicline (Champix) is another example, with only one course (12 weeks) of PBS-subsidised varenicline authorised per year. Notably, given both these medications treat nicotine dependence, there is also provision for the relationship between the two drugs (The period between commencing a course of varenicline tartrate and bupropion hydrochloride must be at least 6 months). Such a provision may also be required for methadone and buprenorphine. At its most recent meeting in July, the PBAC recommended that Nicorette, Nicabate and Nicotinell transdermal patches be PBS listed for 12 weeks of therapy a year as an aid to smoking cessation. While further exploration of these particular options for methadone and buprenorphine is beyond the scope of this report, these examples provide evidence of

the ways in which the Commonwealth currently manages medications for chronic conditions.

There has been a recent review of remuneration for Section 100 drugs, with a report released with findings from the review and recommendations (available at http://www.health.gov.au/internet/main/publishing.nsf/Content/pharmacy-4cpa-reviews). In the specific chapter on ORT (referred to in the report as ODT: Opiate Dependence Treatment Program), the issue of Section 85 versus Section 100 for these medications is explored. The report notes that workshop participants were all in support of a shift to S85 for these medicines. There was also discussion of "Staged Supply" payment which would cover the additional administrative and recording costs associated with dispensing methadone/buprenorphine.

Another avenue that may be worth further exploration is instalment dispensing. 'Dispensing in instalments' (DII) describes the practice of dispensing a single prescription in multiple instalments (e.g. daily, biweekly, or weekly) (http://www.guild.org.au/uploadedfiles/Research_and_Development_Grants_Program/Projects/2004-534%20Final%20Report.pdf, accessed 25/8/10 page 14). A project was undertaken with the aim "to develop dispensing and counselling protocols for unit dose medication to patients who may be at risk from drugs with dependency properties (S4 and S8) and to identify an appropriate level of remuneration for this service" (page 8). It should be noted that methadone and buprenorphine supervised dispensing were regarded as outside the scope of this report. Nonetheless, this work suggests that Dispensing in Instalments (DII) may be worth further investigation.

One project respondent noted:

> "Instalment dispensing is where the pharmacist gets paid for the act of dispensing, not for the prescription. So there's a separate fee for the prescription and then just the process of dispensing, the pharmacist would get paid for that by the government" (KI).

To summarise, there are a number of aspects to the potential for the Commonwealth to cover the costs associated with dispensing methadone and buprenorphine. There are options to consider scheduling both medications under S85; there are also options to cover the dispensing fees under the existing S100.

The positive features and advantages to the PBS subsidy arrangement are the following:

- Patients still pay a co-payment, regarded by stakeholders to the Victorian ORT as important ("I think paying for a service is really important for these people"; "They've got to contribute. You can't get it for nothing" (KI).
- ORT medicines contribute to the Victorian patients' overall safety net for all medicines (as they should)
- The system in Australia under the PBS is demonstrably fair and equitable, meeting principles of horizontal and vertical equity. It reduces the stigma and marginalisation of ORT clients through providing the same system for them to access these medicines as any other medicines for the general public
- It removes the need for pharmacies to negotiate dispensing fees
- It may encourage more pharmacies to participate in the scheme, indeed it has been suggested that if ORT medicines were made available under Section 85, pharmacies would have a greater obligation to supply them (under Section 92 of the National Health Act)

However there are some major caveats:

1. First and foremost, this is not an option that Victoria could implement per se. The option is to lobby the Commonwealth.
2. The issue of 'unit' which includes duration of prescriptions; plus the issue of associated pharmacy costs for recording need to be managed.

3. Drug company involvement would be essential.
4. There may be different considerations between methadone and buprenorphine. Buprenorphine seems more amenable to being listed under S85. According to one project respondent: "It will only make sense for Suboxone. It doesn't make sense for methadone which is largely a supervised drug" (KI). However, we point out that the supervision arrangements are not linked to Schedule 100 per se. There does not seem to be any *a priori* reason not to consider methadone as well under S85, if a "unit" can be ascertained and agreed to. In addition, as noted above, there are alternatives to the S85 option that should also be thoroughly considered.

Recommendations

- That DH actively pursue the issue of the current Commonwealth medicines funding schemes as they can be applied to pharmacotherapy medications. While DH Victoria cannot force the Commonwealth or drug companies to change the funding arrangements, strong lobbying is required.

Introduce guidelines for 'fair' dispensing fees

Pharmacists argue that the fees are currently too low. The same fee ($30 per week) has applied since the 1980's. It has been argued that the true value of the service is more than $9 per day (Pharm Funding Model PGA / Dept Health study 2010). This same study found 93% compliance for 700 clients over 6 months for collecting doses (also demonstrating just how successful the program actually is).

Project respondents who supported this option made comments such as:

> "It would be good if there could be some sort of consensus amongst, you know, the Pharmaceutical Society, Pharmacy Guild, whatever, around making it - you know, putting some minimums and maximums on the types of fees that could be charged for pharmacotherapy" (KI).

However, there is a fundamental problem with introducing "fair" dispensing prices – as this would be anti-competitive. It is possible, however, that the guidelines could identify high level principles, and not make any comments on price per se. For example one principle might be that doses are less expensive for people who have paid for a week up front or a month up front.

Not all were in support of guidelines; there was a suggestion that it may create new barriers:

> "So I would like pharmacists to be on board, and ideally I would like them to not rip clients off. But more importantly, I would like pharmacists to be on board. The more prohibitions and compulsions we put on them, the less likely they are to be on board" (KI).

Perhaps more importantly, there is significant tension between the ORT dispensing as a private business versus a government service. As noted by one project respondent "...Keep it as private programs and away we go. Leave it there and let the patient make up their mind".

Recommendation

- That no further action is taken on this option.

8. Pulling it all together

This chapter aims to integrate the various findings across problems, goals, and the prioritised options. This chapter also deals with implementation: actions required; resource implications and staging.

We used three resource categories:

Nil: no direct resources to implement required (aside from time of DH staff)
Minimal: less than $50,000
Moderate: >$50,000 and <$300,000
High: >$300,000

We also identify where the costs are non-recurrent (NR) and recurrent (R).
These are ball-park estimates only[4].

Staging: We have also provided a guide to implementing various options (staging). The categories are:
I = Immediate (within the next few months)
M = Medium term (within 12 months)
L = Long term (within 3 years)

Originally we conceived six goals:

1. A sustainable workforce;
2. A high functioning specialist system;
3. Strong and effective connections between the specialist and primary care systems;
4. An accessible program (enough treatment places);
5. High quality clinical care; and
6. An affordable and equitable program for clients.

We identified a total of 43 options to address these goals. Of the 43 options, 21 were not retained as priority options and a further three were subsequently removed after full consideration, leaving 19 different options.

The 19 options, as discussed in detail in the preceding chapter, have been modified to be consistent with key stakeholder views, research evidence, and with each other (i.e. internal consistency).

The result is a reconfiguration away from the 6 goals and into two categories of options for the Victorian ORT. The first category concerns the specialist system and its connection with the community/generalist services. We found we were not able to deal with the various options (previously under Goals 2 and 3, options 11 to 14, plus option 17) independently. The second category of options concern individual components of treatment, such as affordability to clients, quality care issues and workforce development. While obviously they all relate to the specialist-generalist system, the options for this latter category can all be dealt with independently, as will be seen below.

Therefore this chapter is structured into two parts:
a). Specialist system redevelopment and connection between specialist and primary care services;
b). Service improvements (workforce development, accessibility, quality care and affordability).

[4] There is some overlap across actions and, thus, resource implications.

Specialist system redevelopment

Overall we have recommended a major redevelopment of the specialist services, including the establishment of new AMS positions, the redevelopment of the SPS, and the establishment of specialist hubs. The reconceptualisation of the specialist service system and supporting recommendations were outlined in Chapter 7; goal 2.

This chapter is concerned with implementation strategies including, for each recommendation, actions, resources and staging.

Table 16: Specialist system redevelopment: recommendations, actions, resources and staging

Recommendations	Actions	Resources	Staging
• That DH reconsider the role and function of SPS as part of a recommended redevelopment of specialist services to better meet current and emerging needs (11)	Revise the key service requirements for SPSs (as on p 65) Implement a process for aligning current SPS practice with key service requirements via contract renegotiation with existing providers or service re-tendering	**Nil** **Nil**	**M** **M**
• That DH increase the funding provided to the SPS's commensurate with the increased expectations of the redeveloped SPS services (as outlined in recommendations and key service requirements outlined in this section) (11c).	Review the capacity required across the specialist service system to treat greater numbers of serious and complex clients (KI estimates that this would apply to 10-20% of the total ORT client group – 1,300 -2,600 in total) Define 'complex/specialist needs' and 'stability' to provide guidance on admission to and discharge from SPSs (See goal 2 and Goal 6 - An affordable and equitable program for clients' for further details) Determine the capacity required in each SPS based on local/regional demand Review other SPS functions (secondary consults/advice, training) and set episodes/performance expectations and adjust funding accordingly	**High R** **Nil** **Nil** **Moderate (per SPS and in addition to current funding provision) R**	**M** **M** **M** **M**

Recommendations	Actions	Resources	Staging
	Determine an appropriate staffing profile and funding for specialist service provision (according to the listed key service requirements). Determine whether capital works or minor works funding is required to assist SPSs to establish a comprehensive service	**Moderate (additional to current) R** **Minimal - Moderate (variable) mostly NR**	**M** **M- L**
• That the option to replace all SPSs with Drug and Alcohol Addiction Units in teaching hospitals is not pursued, but a key service requirement of redeveloped SPSs should specify an auspicing/integration arrangement with an Area Health Network or teaching hospital (11a).	Revise the key service requirements to include auspicing arrangements	**Minimal NR**	**M**
• That DH in collaboration with regional offices establish specialist hub services in outer metropolitan and rural regions (11e).	Develop the key service requirements for specialist hub services in collaboration with DH regional offices (as detailed on p 65 -66) Determine where greatest service needs are and the extent of service coverage required (based on a the recommendation to locate (1) one specialist hub in each country region and out-posting arrangements to service a broader area and(2) up to 3 specialist hub services in outer metropolitan regions) Determine the most appropriate service model to meet local need (region by region) Review the capacity required for treatment places and secondary consultation for each location Cost service provision Tender and provide ongoing funding	**Nil** **Nil** **Nil** **Nil** **Nil** **Moderate**	**M** **M** **M** **M** **M** **L**

Recommendations	Actions	Resources	Staging
	for the services	**(per service) R**	
• That DH strengthen the specialist component of the Victorian ORT system by funding 12 Addiction Medicine Specialist positions to be attached to specialist services (12).	Engage the DH regional offices in discussions about AMS recruitment with a view to determining a prioritised, phased recruitment strategy Engage the RACP in discussions about AMS the recruitment strategy. Develop position descriptions & recruitment Recruitment to positions associated with the SPSs should be prioritised (but this should be subject to the process for SPS redevelopment/alignment with revised key service requirements outlined above. Further recruitment will be determined by the timing of the specialist hub service development process.	**Nil** **Nil** **Nil** **High R**	**M** **M** **M** **M-L**
• That DH in collaboration with the RACP consider the current arrangements for AMS training with a view to better funding and promotion (12).	In discussions with the RACP, determine the yearly training place requirements to meet the needs of an expanding ORT system and AMS attrition Set training targets with the RACP Review current arrangements for system administration and funding Provide recurrent funding for the agreed number of trainee positions	**Nil** **Nil** **Nil** **Moderate R**	**M** **M** **M** **M- L**
• That DH reconsider the role and function of the PROWP in the context of the redevelopment of the specialist service system (13).	Engage DH regional offices in discussions about the merits of continued PROWP funding to determine whether funds can be consolidated as part of a regional specialist hub service or redirected to support ORT service provision in other ways. The decision to be made on region by region assessment of needs and the performance of this program Determine the most appropriate service model to meet local need (region by region)	**Nil** **Nil**	**M** **M**

Recommendations	Actions	Resources	Staging
	In the context of the establishment of the specialist hub services in outer metropolitan and regional areas, reconsider the need for these positions on a region by region basis and determine whether positions could be integrated with specialist services or the funding redirected to support prescriber and pharmacist involvement in other ways	**Moderate R**	**M**

Connection between the specialist and primary care system(s)

The connections between the reconceptualised specialist service system (SPS and specialist hubs) and primary care services was detailed in Chapter 7: Goal 3. Implementation strategies including recommendations, actions, resources and staging are outlined in the table below.

Table 17: Connections between specialist and generalist services: recommendations, actions, resources and staging

Recommendations	Actions	Resources	Staging
• That the ORT program is strengthened by providing support for GPs and community pharmacists (14).	*Implement actions detailed below*		
• That local networks of services, including specialist and generalist programs, which include formal referral pathways and regular activities to build and maintain inter-agency relationships, are created (14).	Allocate staff resources for local network development. Commence discussions with DH regional offices to develop a detailed implementation plan and action same. Establish formal referral pathways and information sharing activities to build and maintain inter-agency relationships	**Moderate R**	**M**
• That high needs clients have access to specialist case management (14).	Include specialist case management as a core feature of specialist services and hubs.	**Minimal NR**	**M**
• That the specialist case management model, including appropriate workforce requirements is	Detail features of the model and identify workforce requirements (qualifications, experience, specialist training).	**Minimal NR**	**M**

Recommendations	Actions	Resources	Staging
clarified (14b).			
• That the utilisation of Medicare funded mental health services is encouraged, to facilitate linking people into services appropriate to their needs (14). • That the use of MBS items to fund case management shared care plans is encouraged (32).	Promote use of the Medicare funded mental health services as part of specialist case management, including service linkages.	**Minimal** **NR**	**I**
• That the hub and spoke model is considered, which may vary in configuration according to local circumstances but will operate according to a common set of principles. (14c) • That this model is utilised, particularly in regional and rural areas.	Establish common set of principles for hub and spoke model. Develop implementation plan for hub and spoke model, involving regional discussions, including variation by location, and considering existing arrangements.	**Moderate** **NR**	**M**
• That shared care is incorporated into service operations, supporting program establishment in a manner consistent with guidelines (14d). • That investment is made into service linkages in an ongoing way.	Develop shared care guidelines for ORT. Support service linkages through dedicated resources (see item on local networks). Utilise Medicare items to support shared care plans (as for specialist case management).	**Minimal** **NR** **Minimal** **R** **Minimal** **R**	**M** **M** **M**
• That the design and effectiveness of the Pharmacotherapy Development Program is reviewed, in the context of broader system changes (14e).	Following the implementation of actions cited above, review the appropriateness and effectiveness of the pharmacotherapy development program.	**Moderate**	**M-L**

Service improvements

The following table outlines the options, recommendations, actions required, indication of resource requirements and staging for those options concerned with workforce development, accessibility, quality of care and affordability.

Table 18: Service improvements: recommendations, actions, resources and staging

Recommendations	Actions	Resources	Staging
WORKFORCE DEVELOPMENT			
• That strategies are implemented to increase AOD course content in undergraduate and postgraduate medical education courses in Victoria (4)	Instigate discussions with Victorian medical school course coordinators, GP training program coordinators to maximise the likelihood that AOD & ORT content is incorporated in courses. This needs to be a collaborative initiative - DH facilitated and involving the RACP, RACGP and other relevant stakeholders	**Nil**	**M- L**
• That the GP pharmacotherapy training and support program is redeveloped as outlined in Table 15 (4a)	DH to consider recommendations for the revised training program (p 50-51) Develop the specifications for training program redevelopment as outlined in the Table 15. Other actions include: • Reduce the duration and emphasis of the face-to-face component of the training to be consistent with other GP training scheduling (after hours and not exceeding 2 hours). • Continue to supplement face-to-face training with on-line content • Focus the training on (1) working with people who are opioid dependent and (2) methadone prescription. • Emphasise the role of shared care and supervised clinical placement alternatives or supplements to on-line and face-to-face training • Develop new assessment to meet DPRG authorisation requirements for buprenorphine-naloxone alone	**Nil** **Nil**	**I** **M**

Recommendations	Actions	Resources	Staging
• That pharmacists are included in the training program and with ongoing professional development activities (see section: 'improve the level of support provided to community pharmacists") (4)	In the development of the key service requirements, incorporate pharmacy involvement (potentially as participants of co-facilitators) Provide opportunities for pharmacists to be engaged in the on-going professional development activities (forums) that would be a key service requirement of this training contract	**Nil** **Nil**	**M** **M**
• That the impact of changes to training requirements are monitored and assessed (at 12 months) (4).	In addition to the normal monitoring and reporting requirements of the contractor, this redeveloped program should also be evaluated 12 months after commencing training delivery.	**Minimal NR**	**L**
• That no change be made to the current DH responsibility for prescriber authorisation (4g)	The option to change the responsible body for prescriber authorisation was not recommended - no action required	**-**	**-**
• That DH to put the prescriber training program to tender. (4g) • That tendering from the RACGP, RACP and GPV is encouraged but not to the exclusion of other training providers (4g)	The first 3 year program would include program redevelopment (as outlined above) and include training program delivery and provision of regular professional development/ networking opportunities for all ORT providers (including pharmacists and nurse practitioners) That a key service requirement for the training tender is developed stipulating that the RACP, RACGP and GPV need to be engaged in and endorse the training program redevelopment	**Moderate R** **Nil**	**L**
• That DH ensure that Victoria is represented in any Commonwealth discussions about consistent ORT training approaches (4).	There is merit in considering uniform national training requirements and Victoria should continue to contribute to or lead these discussions in appropriate forums	**Nil**	**M- L**
• That DH ensure that priority is given to further streamlining	Implement the new online permit system as a matter of urgency	**Nil – Minimal NR**	**M**

Recommendations	Actions	Resources	Staging
the permitting system (6)	System developments should allow 'prescription monitoring' to enhance ORT program safety and effectiveness Engage the medical and pharmacy colleges/peak bodies in the redevelopment of the permitting/authorisation system and in ongoing review processes.	**Nil**	
• That DH modify the key service requirements of the GP Pharmacotherapy Training Program to provide opportunities for pharmacists to participate in the training program and associated professional development/networking forums (7).	Modify KSR to include pharmacists in the training program	**Nil-Minimal NR**	
• That DH in collaboration with the Pharmaceutical Society/Guild support/fund an ongoing ORT professional development program to complement the on-line pharmacist course currently under development. (7)	Establish new pharmacists Ort professional development program Content to include client confidentiality; managing 'difficult' clients; and managing client fee payment issues.	**Moderate R**	**I**
ACCESSIBILITY			
• That DH acknowledge that in Victoria there are three service types: specialist (SPS); GP primary care (small caseload, integrated with general practice); and 'specialised' services provided by GP who predominantly work in ORT. This third category makes up the bulk of Victoria's	Formally document the role that 'specialised' services play in the Victorian ORT system Introduce regulation covering: quality assurance mechanisms and insurance regarding continuity of service delivery Commission an evaluation of the quality of care in these services.	**Minimal NR**	**M**

Recommendations	Actions	Resources	Staging
ORT. • Given that the majority of Victorian ORT is provided in these 'specialised' services, that DH consider introducing some regulations around this third service model • That an evaluation of the quality of care in these specialised services be conducted (16).			
• That one-stop shops, such as GP Super Clinics and Medicare Locals should be required to provide ORT as part of core business (15).	Practical issues need to be addressed if ORT is included in GP Super Clinics; willingness to provide ORT; core of ORT expertise. Strategies may include: a) ORT as part of Capital Planning Guidelines for GP Super Clinics; part of accreditation; b)multi-disciplinary teams (prescriber, dispenser, addictions nurse) and including capacity building orientation Develop list of all the new health clinics and prepare generic letter of approach regarding ORT prescribing Site visits to newly established services	**Minimal**	**L**
• That a pilot prescribing and dispensing "bus" (mobile service) in one rural/regional area is undertaken and an evaluation conducted (18 and 19).	Establish areas of need for a pilot of dispensing bus Establish pilot program Commission evaluation	**High** **NR initially**	**L**
• That local solutions to improve rural transport are explored (20).	Work with individual local providers to identify transport needs. Explore strategies tailored to site including: • the use of technology	**Minimal** **NR**	**I**

Recommendations	Actions	Resources	Staging
	(Skype) for prescribing; • volunteers (for assisting with transport to dispensing sites); • vouchers for public transport (where applicable/available); and • greater use of unsupervised dosing where clients meet the criteria for this form of treatment		
QUALITY CARE	**Actions**	**Resources**	**Staging**
• That a better understanding of the prevalence of problematic pharmaceutical opioid misuse and appropriate treatment and service delivery approaches is undertaken (21).	Strategies for greater knowledge and awareness about pain management include training sessions, online materials, and provision of pamphlets to doctors and pharmacists. Fliers could be provided to all pain management clinics regarding addiction. Pain management clinics could also be targeted with promotion of the DACAS website. Develop interventions for delivery in primary health settings / linked in with same	**Moderate** **NR**	**M**
• That pain management is part of core business, in terms of staff capacity and treatment expectations, at specialist services (22).	Include expertise in pain management as a core feature of SPS Develop service networks (including prescribers, pain management and addiction medicine specialists) with specialists to be utilised on a case by case basis (see goal 3) Training sessions, online materials, and provision of pamphlets on pain management to GPs and pharmacists Fliers to all pain management clinics re addiction/dependency, DACAS promotion etc	**Minimal** **NR** **Moderate, then minimal**[5] **NR** **Moderate,** **NR** **Minimal,** **NR**	**L** **L** **M** **M**
• That new clinical guidelines are developed for the management of pharmaceutical opioid dependence with ORT	Establish a clinical guidelines working committee and commission them to produce interim clinical treatment guidelines on methadone/buprenorphine maintenance treatment for clients	**Moderate** **NR**	**M**

[5] During establishment there will be a greater cost however established links should require less resources to be maintained.

Recommendations	Actions	Resources	Staging
medications (23)	dependent on pharmaceutical opioids, pending further research		
• That effective linkages between pain management clinics and prescribers are established and supported (24).	Pain management clinics to have links to an addiction medicine specialist and / or include an AOD nurse Support strong links between AOD, GP and pain management services (e.g., AOD and pain management teams in regional hospital; secondary consult to pain management clinics; networked services; presentations by prescribers and addiction medicine specialists at pain clinics)	**Minimal NR** **Moderate R**	**L** **L**
• That doctors, pharmacists and clients are educated about appropriate dosing levels (25).	Develop and disseminate quality information for doctors, pharmacists and clients about methadone treatment, including a focus on long-term rather than short-term treatment outcomes, dosing, psychosocial services, co-morbid mental health issues, and debunking myths Develop and publish 'how to' video on-line; showing interactions between doctor and patient, to guide dosing and changes in same Develop and disseminate information for clients about optimal doses, long-term rather than short-term treatment outcomes and the association between dosing levels and reduction regimes	**Moderate NR** **Minimal NR** **Minimal NR**	**M** **M** **M**
• That the use of clinical guidelines to assess stability for unsupervised dosing is actively promoted (28).	Promote the use of clinical guidelines to assess stability for unsupervised dosing. Promote the availability of specialist advice to inform the use of unsupervised dosing.	**Nil** **Nil**	**I** **I**
• That the availability of specialist advice to inform the use of unsupervised dosing is actively promoted (28).	Support unsupervised dosing [buprenorphine-naloxone; Suboxone] where appropriate to client stability Develop risk matrix to assess appropriateness of unsupervised dosing	**Minimal NR**	**M**

Recommendations	Actions	Resources	Staging
	Enable access to specialist advice to support GPs regarding decisions on unsupervised dosing Support consumer involvement in policy development		
• That guidelines for unsupervised treatment are developed (30).	Develop guidelines	**Moderate** **NR**	**M**
• That client access to counselling and psycho-social support services is supported by promoting MBBS items, using strategies for service co-ordination, and highlighting existing psychological services (32, 33, 34).	Encourage the use of MBBS items for management plans, team care arrangements, mental health treatment plans etc, as well as reviews thereof. Strengthen links to specialist mental health services Support staff to administer permits, address other health and welfare issues that clients may have (care coordination role) Co-ordination mechanism to ensure available information about referral pathways, strengthening these links, and ensuring access to specialist services (e.g., DACAS resources supported by network development role). Promote link to APS register of psychologists interested in providing AOD related service (e.g., via DACAS, other relevant websites) Ensure information about referral pathways is readily accessible	**Minimal** **NR** **Moderate** **R** **Minimal** **R** **Moderate** **NR** **Nil** **NR** **Minimal** **NR**	**I** **I** **I** **I** **I** **I**
• That concerns about confidentiality are minimised (35).	Strategies designed to support access (e.g. GP Super Clinics) and reach (e.g., unsupervised dosing, where appropriate)	**Minimal** **NR**	**M**
• That financial support for post-prison ORT is maintained and explore whether the period of support should be extended. • That continuity in ORT for clients released from court	Maintain post-prison payment of pharmacotherapy fees and examine whether a one month subsidy is sufficient Explore needs of people on remand who are released from court into the community, regarding seamless engagement with treatment and	**Moderate** **R**	**M**

Recommendations	Actions	Resources	Staging
after being on remand is considered (36).	payment of fees		
• That DH and SPS providers continue to engage with and support peer support services in recognition of the important role they play in the Victorian ORT system.	Increase staff resources for peer support SPS to provide leadership in peer support, with concomitant resourcing Establish straightforward measures of activity and outcomes of peer support activities to build evidence on effectiveness	**Minimal R** **Minimal NR**	**M**
AFFORDABILITY	**Actions**	**Resources**	**Staging**
• That a new fund be established and administered by an independent body (ideally PAMS) designed to assist clients with financial difficulties (38) • That DH evaluate the operation of the discretionary funding program after a period of operation, using agreed outcome measures.	Establish a discretionary fund to enable practical supports to ORT clients who would otherwise miss out on their dose due to non-payment of fees Contract the service provider Establish ongoing monitoring mechanisms re implementation	**High R**	**M**
• That DH pursue the option of establishing a fee-relief program for clients who meet agreed-upon 'high risk' criteria (38b).	Agree on the criteria for 'high risk', commencing with the proposed 8 suggested above; Establish assessment approaches Establish payment mechanisms	**High R**	**M**
• That DH facilitate a process for the development of (voluntary) guidelines to assist pharmacists in managing client debt (39).	Further discussion with pharmacists about the nature of guidelines; what content would be most useful etc. Discussion with PAMS about possible strategies to include in the guidelines Draft guidelines and review Distribute guidelines as "suggestions" to assist pharmacists with this issue	**Minimal NR**	**I**
• That a review of other models where state collects fees from clients is	Review of other models where state collects fees from clients Assessment of feasibility	**Minimal**	**L**

Recommendations	Actions	Resources	Staging
undertaken; and • That an assessment of feasibility is conducted (40)			
• That DH actively pursue the issue of the current Commonwealth medicines funding schemes as they can be applied to pharmacotherapy medications. While DH Victoria cannot force the Commonwealth or drug companies to change the funding arrangements, strong lobbying is required (41).	Establish working group Liaise with drug companies Form alliance across jurisdictions Develop an advocacy package	**Minimal**	**I**

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Appendix 1: Limitations

Summary of the limitations of the Victorian Pharmacotherapy System

Overarching Issues

- Program goals are not well articulated (abstinence or reduced drug use/harm)
- The benefits of pharmacotherapy are not well understood (by those working in the program)
- The importance of pharmacotherapy treatment in the Victorian service system is understated (as represented in the Blueprint)
- The service system was designed when methadone was the only treatment option and pharmaceutical opioid misuse was not an identified problem – the adequacy of the service model is now under question
- There is limited opportunity for consumer involvement
- There is inadequate coordination between the various components of the service system (between SPSs; between SPSs and primary care providers; between pharmacotherapy and other AOD services; between pharmacotherapy services and other health and welfare services)
- There is a lack of integration with mainstream health services
- Diversion is an ongoing issue that needs to be managed (potential to threaten the viability of the program)
- Equity is an issue – fees for this service type compared to other chronic diseases. Argument for PBS inclusion
- There is a significant number of opioid users who are between treatment or yet to be engaged in treatment who would benefit from it and may engage in it if it was more affordable/accessible/better tailored to specific needs (we don't know why they are currently out of treatment)
- There is inadequate targeting of high risk groups through fee waivers (pregnant women; prisoners on release; complex needs groups)
- The regulatory requirements may need to be reviewed to reduce red tape and disincentive for GP and pharmacist engagement in the program
- Data collection, analysis and reporting needs to be improved

Program quality Issues

- Access to counselling and psychosocial support services is not adequate for those that seek them
- Case management is not adequate (underutilised by GPs)
- The pressure on a small group of GPs prescribing to large numbers compromises care (including general medical care)
- Continuity of care can be compromised for clients in crisis as a result of sudden program termination
- Sub-optimal dosing is an ongoing issue that compromises the effectiveness of the Victorian program (prescriber knowledge and client preference issues)
- Clients with complex problems are often poorly managed (limited access to specialist services)
- Stigma and discrimination are ongoing problems (more acute in some community pharmacies)

Limitations of the primary care/GP system

- There are insufficient GP prescribers in total and in some locations (particularly rural areas)
- Strategies to promote and support GP engagement (PROWP; GP Pharmacotherapy training; Pharmacotherapy Development Program) have had only limited success
- There are insufficient dispensers/dispensing points
- There is no current strategy to broaden prescribing to include nurse practitioners and/or pharmacists
- Privacy and confidentiality are difficult to maintain (particularly in community pharmacies)
- The training requirements for GPs may be a disincentive for engagement in the program
- Client costs (dispensing fees and to a lesser extent travel) are significant and are a major factor in attracting and retaining many in treatment

Limitations of specialist services

- SPSs provide only limited access for clients with complex needs
- Affordability of SPSs is an issue for clients
- SPSs experience difficulties referring stabilised clients to primary care/GP programs (insufficient GPs and client preference to stay in a familiar environment)
- SPSs have failed to provide adequate secondary consultation, support and education for primary care/GPs
- SPSs are too metro focussed – no service provision for rural clients
- Dispensing functions are a problem for some (non existent or limited hours)
- SPSs have insufficient flexibility to provide crisis prescribing and dispensing services
- The potential for Addiction Medicine Specialists to bolster the Victorian system is largely unrealised (inadequate funded positions and absence of Medicare item numbers)

Appendix 2: Pre-consultation check-list for polling

Victorian Pharmacotherapy Review
Summary of Options – Pre Consultation Checklist

This checklist is designed to streamline our consultation with you. It contains the summary of options put forward in the full paper along with a scale for you to indicated what level of priority you would attach to each option

It would be helpful if you could complete and return the checklist at least one day prior to your scheduled interview time. We will then concentrate on options that you consider to have a medium / high priority for pharmacotherapy service provision in Victoria.

We want to know how you rate each of the options below in terms of priority level. Please respond to each of the options listed by selecting the priority level in the right hand column that you think best applies to the option described.

Goals and options	**Priority Level [please select one]**
Goal 1: A sustainable workforce	
1.1 Greater number of prescribers	High Medium Low Nil
a) Nurse practitioners to prescribe methadone/buprenorphine	High Medium Low Nil
b) Pharmacists to prescribe methadone/buprenorphine	High Medium Low Nil
c) Incentive payments to GPs	High Medium Low Nil
1.2 Training/accreditation for doctors	High Medium Low Nil
a) Revise and redevelop the training requirements and approaches for prescribers	High Medium Low Nil
b) Differentiate methadone from buprenorphine (in relation to training, accreditation, prescribing)	High Medium Low Nil
c) Remove training requirements for buprenorphine-naloxone (i.e. all GPs can prescribe this, but not methadone)	High Medium Low Nil
d) Remove all GP training requirements for methadone and buprenorphine	High Medium Low Nil
e) Modify the requirements for all GPs to be trained before prescribing (i.e. allow a limited amount of prescribing outside training requirements)	High Medium Low Nil
f) Continue with compulsory training for GPs but conduct the training on-line only (no face-to-face)	High Medium Low Nil
g) Make no substantive changes to training requirements but improve quality and targeting of the training	High Medium Low Nil
h) Chapter of Addiction Medicine or RACGP to take over training and/or authorisation (i.e. doctors and/or nurse practitioners and/or pharmacists) to prescribe methadone and buprenorphine	High Medium Low Nil
1.3 'Start up kits'	High Medium Low Nil
a) Introduce pre-packed 'start-up' kits with doses stepped up gradually to maintenance	High Medium Low Nil
1.4 Revision of the permit system	High Medium Low Nil
a) Revise the permit system (reduce the amount of paperwork)	High Medium Low Nil
1.5 Greater number of dispensing points	High Medium Low Nil

Goals and options	Priority Level [please select one]
a) Improve the level of support provided to community pharmacists who dispense methadone/buprenorphine	High Medium Low Nil
b) Make compulsory the dispensing of methadone and buprenorphine as a standard part of pharmacy activity	High Medium Low Nil
c) Incentive payments to pharmacists	High Medium Low Nil
d) Vendor machine supply for methadone/buprenorphine	High Medium Low Nil
Goal 2: A high functioning specialist system	
2.1 Address Specialist Pharmacotherapy Services (SPSs)	High Medium Low Nil
a) Reconsider the role and function of Specialist Pharmacotherapy Services (SPSs)	High Medium Low Nil
b) Replace all SPSs with Drug and Alcohol Addiction Units in teaching hospitals, with mission and brief as per SPS	High Medium Low Nil
c) Ensure that all SPSs provide specialist services that include methadone, buprenorphine-naloxone and buprenorphine (prescribing and dispensing)	High Medium Low Nil
d) Increase funding levels to SPSs	High Medium Low Nil
e) Ensure all SPSs provide secondary consultation	High Medium Low Nil
f) SPSs to provide outreach/satellite services in major regional areas	High Medium Low Nil
2.2 Addiction Medicine Specialists & FACAM Trainees	High Medium Low Nil
a) Advertise and recruit to new Addiction Medicine Specialist position(s)	High Medium Low Nil
2.3 Review of Pharmacotherapy Regional Outreach	High Medium Low Nil
a) Review the Pharmacotherapy Regional Outreach Workers program	High Medium Low Nil
Goal 3: Strong and effective connection between the specialist and primary care systems	
3.1 Strengthen programs and linkages	High Medium Low Nil
a) Strengthen programs designed to encourage and support community/primary care prescribing and dispensing	High Medium Low Nil
b) Build referral pathways between generalists and specialists	High Medium Low Nil
c) Provide specialist case management support to community programs	High Medium Low Nil
d) Specialist services as hub of support for linked community services	High Medium Low Nil
e) Increase / establish shared care programs	High Medium Low Nil
3.2 Service capacity	High Medium Low Nil
a) Ensure that the GP super-clinics; one-stop-shop primary health care/"Medicare Locals", have capacity to treat opioid dependent people (at least one prescriber)	High Medium Low Nil
Goal 4: An accessible program (enough treatment places)	
4.1 Private Clinics	High Medium Low Nil
a) Set up/encourage/incentivise private clinics (as per NSW)	High Medium Low Nil
4.2 Specialist Prescriber Service	High Medium Low Nil
a) Establish at least one more SPS	High Medium Low Nil
4.3 Outreach	High Medium Low Nil
a) Outreach prescriber (bus) that roves rural regions on set days	High Medium Low Nil
b) Outreach dispensing bus that dispenses daily in less	High Medium Low Nil

Goals and options	Priority Level [please select one]
accessible locations (akin to mobile library)	
4.4 Transport provided	High Medium Low Nil
a) Provide transport for rural clients	High Medium Low Nil
Goal 5: High quality clinical care	
5.1 Address pharmaceutical opioid dependence	High Medium Low Nil
a) Information to opioid replacement therapy (ORT) providers about dependence on pharmaceutical opioids; and about pain management	High Medium Low Nil
b) Greater knowledge and awareness of pain management in our client group	High Medium Low Nil
c) Develop clinical guidelines for methadone/buprenorphine maintenance treatment for those dependent on pharmaceutical opioids	High Medium Low Nil
d) Facilitate multi-disciplinary pain management clinics that include Addiction Medicine Specialists	High Medium Low Nil
5.2 Optimal dosing	High Medium Low Nil
a) Client and practitioner education campaign regarding "optimal doses"	High Medium Low Nil
5.3 Medication non-adherence and diversion	High Medium Low Nil
a) Reduce take-aways	High Medium Low Nil
b) Target supervised dosing only to those that need it	High Medium Low Nil
c) All buprenorphine-naloxone delivered as unsupervised treatment (monthly 'script')	High Medium Low Nil
5.4 Unsupervised treatment model	High Medium Low Nil
a) Develop new guidelines for unsupervised treatment (that are independent from take-away dosing policy)	High Medium Low Nil
5.5 Transfers and client mobility	High Medium Low Nil
a) Implement a national permit system	High Medium Low Nil
5.6 Counselling and psycho-social support services	High Medium Low Nil
a) Education for GPs regarding how to access the new MBBS numbers to fund case management	High Medium Low Nil
b) Better referral pathways between SPS and GP practices for complex behavioural needs of clients	High Medium Low Nil
c) Establish register of psychologists (private) willing to see clients	High Medium Low Nil
5.7 Privacy and confidentiality (especially in rural regions)	High Medium Low Nil
a) Review ways in which privacy and confidentiality can be improved in rural areas	High Medium Low Nil
5.8 Post-release prisoner maintenance – continuity of care on release	High Medium Low Nil
a) Ensure continuity of dispensing at point of release	High Medium Low Nil
Goal 6: An affordable and equitable program for clients	
6 .1 Address dispensing fees	High Medium Low Nil
a) Reduce financial burden of dispensing fees	High Medium Low Nil
b) SPS to provide respite places for those in financial difficulty	High Medium Low Nil
c) State to pay dispensing fees for certain high-risk groups	High Medium Low Nil
d) SPS to have no dispensing fees	High Medium Low Nil

Goals and options	Priority Level [please select one]
e) Introduce means testing for client fees	High Medium Low Nil
f) State to pay dispensing fee for the first 3-4 weeks for every client	High Medium Low Nil
g) State to pay all dispensing fees	High Medium Low Nil
h) Divorce the fee payment from the service delivery in community dispensing	High Medium Low Nil
i) Lobby Commonwealth to have methadone and buprenorphine dispensing costs as part of the PBS funded component	High Medium Low Nil
6.2 Guidelines	High Medium Low Nil
a) Guidelines for pharmacists about how to manage clients in debt	High Medium Low Nil
b) Prohibit pharmacies from charging the same fee for daily dosing and weekly dispensing	High Medium Low Nil
c) Introduce guidelines for 'fair' dispensing fees	High Medium Low Nil

Thank you for taking the time to complete this checklist.

Please return your completed checklist to Heidi Strickland as soon as possible via email: heidis@turningpoint.org.au or fax: 03 9416 3420

Appendix 3: Key Stakeholder Consultations

Reference Group Members (Focus group and checklist)

1. Irvine Newton
2. David Nolte
3. Dr Malcolm McRae
4. Damon Brogan
5. Sonya Tremellen
6. Sam Biondo
7. Barbara Taylor
8. Roland Jaernig
9. Mathew McCrone
10. John Ryan
11. Dr Martyn-Lloyd Jones
12. Dr Matthew Frei
13. Dr Mike McDonough
14. Derek Chilton
15. Pier Decarlo (or Martin Turnbull who took his place at focus group)
16. Sarah Lord

Key stakeholders: (Individual consultations & checklist)

1 Angelo Pricolo
2 Dr Nick Lintzeris
3 Dr Adrian Dunlop
4 Belinda McNair
5 Cameron McGregor
6 Dr Andy Lovett
7 Dr Rob Weiss
8 John Silveri
9 Dr John Sherman
10 Dr Adrian Reynolds
11 Sharon O'Reilly
12 Dr Michael Aufgang
13 David McGrath
14 Anna Keato
15 Anne Lawrance
16 Sarah Lord
17 Mal Doriean
18 Dr Christine Longman
19 Dr Benny Monheit
20 Rose McCrohan
21 Dr John O'Donoghue
22 Dr Tracey Soh
23 Dr Mike McDonough

Service Providers (Focus group & checklist)

1 Scott Withy
2 Sharon O'Reilly
3 Cheryl Delalande
4 Cheryl Sobczyk
5 Danny Jeffcote
6 Damon Brogan
7 Sharon Read
8 Mary Bassi

Consumers x 7 (Focus group & checklist)

Appendix 4: All options/solutions with benefits, research evidence and concerns

This table provides a summary of the various options that are available for Victoria. The options are not all mutually exclusive (for example changes to patient fees can occur at the same time as changes to prescriber incentives and so on). But in some cases the options are mutually exclusive (for example changing prescriber requirements for both methadone and buprenorphine versus changing prescriber requirements only for buprenorphine).

A number of the options address more than one goal. For example, the issue of availability of treatment places is addressed via options that include increasing the numbers of treatment places (via increases in prescriber and dispensing workforce), establishment of new SPS, and better referral pathways. And some options may offset the benefits from others, such as those options that pertain to better quality of treatment and therefore increase the likelihood of clients staying longer in treatment (and hence reducing treatment places for new clients).

The table provides summary points for each option, including the main benefits of the option; research evidence of relevance to the option and concerns for each option.

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
Goal 1: A sustainable workforce				
Greater number of prescribers	1. Nurse practitioners to prescribe methadone/ buprenorphine	Reduce the burden on GPs Increase treatment places Improve accessibility of the program	Evidence: Cochrane Review indicating that appropriately trained nurses can provide a quality of patient care equivalent to that provided by doctors (Laurant et al., 2006). 50 nurse practitioners currently in Victoria, currently 3 NPs endorsed by the NBV in A&D. (http://www.health.vic.gov.au/nursing/furthering/practitioner accessed 11/5/10) Report by Reed et al (Reed et al., 2008)) on role of NPs in Victoria for drug services, concluded that NPs were suitable for residential services but "The	Implementation issues Quality of care may be questioned Shortage of nurses; few potential nursing candidates in the system and extensive study

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			capacity of NP roles to be sustainable in community-based, outreach and home-based services, where there was a requirement for the NP to prescribe, was limited unless other arrangements were in place for patients to receive medications at a subsidised cost". (p.6). Report also noted that NPs would have role in pharmacotherapy maintenance by way of "developing and implementing treatment plans for people with drug and alcohol addictions" (p. 8). But NPs should also prescribe (to meet the identified issue here for Vic ORT). At a state level, legislation allows for NPs to write prescriptions under the Drugs, Poisons and Controlled Substances Act 1981 (Vic) and they can refer patients to other health care professionals. The Victorian Nurses Board has outlined medications that can be prescribed by a NP – but this is limited by their 'scope of practice' which may vary. Methadone, naltrexone and buprenorphine are listed as potentially part of their formulary. The legislative approval relates to 'categories' of Nurse Practitioner. Currently, there are 22 separate categories, of which A&D is one. With the move to national registration, these 22 categories will be collapsed into 8. A&D is the only current category which will go into two of the new categories, namely 'mental health' and 'primary care'. Effectively, this means that substantially more NPs in Victoria will have legislative approval to prescribe pharmacotherapy, as long as employers have the necessary frameworks in place. To that end, ten sites in Victoria are currently developing models to facilitate NP prescribing of pharmacotherapy.	is needed to gain the NP qualification. Employment arrangements need to be considered. (but build into "Medicare Locals"/CHC etc.) Query whether NP prescribing would be an efficient way to deal with the "bottleneck" at prescribers level (i.e. investment in this option may produce minimal return in relation to patient access to prescribers)

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			Recent announcement (Roxon) of new MBBS items for NP's. May want to consider NP prescribing only for buprenorphine (because better safety profile). Potential role for DACAS in supporting NP's.	
	2. Pharmacists to prescribe methadone/ buprenorphine	Reduce the burden on GPs Increase treatment places Improve accessibility of the program	Evidence: http://www.psa.org.au/site.php?id=1565 "In a recent review of the international pharmacy literature by Emmerton, et al., the increasing acceptance, development and implementation of pharmacist prescribing models internationally were apparent". Already many pharmacists are tailoring day to day doses within dose ranges. Precedent for pharmacist prescribing around the world. New grad pharmacists well suited to post grad training would relish the opportunity. Internationally there are models of independent pharmacist prescribers prescribing methadone/buprenorphine though these tend to operate out of clinic models (prescribing in place of doctors) rather than community pharmacy. Occurs in the UK ('supplementary prescribing' and 'independent prescriber' models) There is currently no incentive for pharmacists to do the course (which is expensive) or to see the clients. Many community pharmacies are not set up for this. Could work in a community health hub type place	Requires new post-graduate qualification Salary/funding for pharmacists needs to be resolved (?Medicare) Ministerial approval (i.e. legislative change) required Some other concerns (from doctor) include: patient safety; time and space for confidential conversations; rotating pharmacists; insurance costs; provision of

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			('Medicare Local'). A paper is currently being developed outlining a possible nationally consistent approach to authorising non-medical practitioner prescribing. The working group overseeing this includes S&Ts and Health Workforce Australia. It is envisaged that a paper outlining the proposal will be presented to AHMAC later in the year. This framework would apply equally to pharmacists seeking prescribing rights. May want to consider pharmacist prescribing only for buprenorphine (because better safety profile). Potential role for DACAS in supporting pharmacists who prescribe.	other medical services; co-existing medication intake; monitoring especially urinary drug screens; takeaway provision. BUT all of these apply equally to medical prescribing bar the co-occurring medical treatment. Query whether pharmacists prescribing would be an efficient way to deal with the "bottleneck" at prescribers level (i.e. investment in this option may produce minimal return in relation to patient access to prescribers)

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
	3. Incentive payments to GPs	Increase likelihood that GPs remain in the program Increase likelihood that new GPs will join the program	Evidence: No incentives schemes currently in operation in Australia (Ritter & Chalmers, 2009). No evidence from other countries re financial incentives located to date. Differentiate between encouraging new prescribers; versus rewarding existing prescribers (may improve situation for GPs currently prescribing; not sure if will be an incentive for new GPs to take up patients). See also option 32 re GPs being smarter at accessing additional MBBS items.	Funding required May require some ceiling on number of clients per GP to ensure quality of care.
Training/accreditation requirements for doctors	4. Revise and redevelop the training requirements and approaches for prescribers		The training (and accreditation) of prescribers is perceived to be one of the barriers/blockage points in the ORT system. The rationale for why these medicines require such "special" arrangements needs to be questioned. The appropriate comparison for ORT should arguably be the prescribing of morphine and oxycodone (for example); there is little rationale for having different requirements for eligibility to prescribe from these other opioids. Training requirements/accreditation should be based on likelihood of harm/risk to clients. On that basis other opioids and benzodiazepines create more harm (ref). There are a number of different options to revise the medical/prescriber training/accreditation processes,	

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			as detailed in Options 4a to 4g. 4a). differentiate methadone from buprenorphine 4b). remove training requirements for buprenorphine-naloxone alone 4c). remove all training requirements for both methadone and buprenorphine 4d). allow limited prescribing for non-accredited doctors 4e).provide training on-line only 4f). no change to training/accreditation requirements but improve quality of training 4g). Chapter of Addiction Medicine or RACGP take over authorisation role	
	4 a). Differentiate methadone from buprenorphine: in relation to training, accreditation, prescribing	Allows greater flexibility with policies regarding training, accreditation and dosing policies	Evidence: There is a precedent and rationale for having different systems for methadone from buprenorphine. This is the model in the US and France. The substantial difference in safety profile between the two drugs would warrant this (e.g. (Gibson & Degenhardt, 2007; Pirnay et al., 2004). The assumption here is that the difference in safety profiles requires more thorough training for methadone prescribers.	ChAM attempting to do this now May reduce client options (i.e. choice between methadone and buprenorphine), but buprenorphine as first-line treatment has rationale (and ?currently operates like this to some extent in Tasmania).

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
	4 b). Remove training requirements for buprenorphine-naloxone (i.e. all GPs can prescribe this, but not methadone)	May encourage greater GP participation Better treatment access	Evidence: Safety of buprenorphine-naloxone relative to either methadone or buprenorphine alone is well-documented (Mammen & Bell, 2009) and client satisfaction similar between bup and bup-naloxone (Daulouède et al., 2010). See option 4 – evidence suggests training is a barrier and not necessarily associated with better outcomes. Less restricted system with buprenorphine has been implemented in France and US. The French approach: buprenorphine can be prescribed by any GP without approval; no notification to health officials for users undergoing substitution treatment; the duration of the prescription; limited supervision of buprenorphine ; the absence of biological testing for uses of other substances (heroin, cocaine, benzodiazepines, etc.) (Auriacombe et al., 2004) Recent pilot by Dr Dunlop (Newcastle) lends evidence towards higher safety profile of buprenorphine-naloxone and monthly scripting rather than supervised dispensing (see Option 29: unsupervised treatment).	Requires regulatory change Risks of poorer service quality, as possibly evidenced in France (Guichard et al., 2007)
	4 c). Remove all GP training requirements for methadone and buprenorphine	Increase likelihood of new GPs entering the program	Evidence: Observational studies of training suggest that it has little impact (see (Strang, Hunt et al., 2007). Evidence that training is a barrier: In Victoria no	Training would need to occur as part of mainstream medical

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			additional training was required for buprenorphine-naloxone (cf NSW) and the proportion of clients on buprenorphine-naloxone is significantly higher than in NSW, which has a compulsory training program for doctors to prescribe buprenorphine-naloxone. (But: In Victoria, pharmacists apparently refused to dispense Subutex and this was partially responsible for uptake) Evidence to the contrary: Training is beneficial: Research by Lintzeris, Ritter, Dunlop et al. (2002) demonstrated improvements in knowledge with training and subsequent uptake of buprenorphine prescribing, but clinical outcomes were not assessed. Not all those who do attend training become a prescriber therefore removal of training may not have the strong intended benefits. One of the reasons GPs attend training is that they can satisfy their obligations to undertake continual professional development (therefore if training no longer offered, no incentive).	education at undergraduate level (?some recent initiatives to improve addiction training in undergrad med courses). Potential concerns regarding quality of care, risk management (but see option 5: induction kits). The risk of methadone toxicity occurring in patients is greater when prescriber skill is lacking (work by Olaf Drummer, Mike McDonough & others does show that doctor/prescriber factors are apparent in

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
				a significant number of methadone detected deaths.
	4 d). Modify the requirements for all GPs to be trained before prescribing, i.e. allow a limited amount of prescribing outside training requirements	May encourage greater GP participation Facilitates better continuity of care when GP prescribers is on holidays/unavailable. (already possible for maximum 1 week of prescribing)	Evidence: Precedent in other jurisdictions, e.g. in NSW a GP can prescribe to up to 5 patients without training although few exercise this option. In the ACT, changes introduced December 2009 included the option for a doctor to prescribe (without training) if within a practice with at least one trained ('endorsed') prescriber. "If a practice has only one endorsed prescriber of methadone/buprenorphine, other doctors in that practice will be able to prescribe methadone/ buprenorphine for patients with a current approval". Section 3 of the Victorian Policy allows a 'deputising' GP (non approved) to prescribe for up to a week. Limitations include no dose increase or take-aways, contact DACAS if advice needed and notify Drugs and Poisons Regulation Group. <u>Note:</u> Drugs and Poisons Regulation Group amended policy on 'deputising' in March 2009. The new requirements are such that once a medical practitioner at a certain practice obtains a permit to prescribe pharmacotherapy, any practitioner at that same practice may prescribe for the length of the permit. Increase/improve the role of DACAS to provide clinical back-up (in WA, prescribers cannot start a	Low uptake in NSW demonstrated, hence may not be worth the regulatory investment?

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			new patient without consulting their version of DACAS – check).	
	4 e). Continue with compulsory training for GPs to prescribe methadone and buprenorphine but conduct the training on-line only (no face-to-face)	Will save resources May encourage existing GPs to do on-line refresher course. May encourage new GPs to enter the program	Evidence: Increasing utilisation of online training amongst health professions more generally Prescribers in rural/regional areas may be more greatly impacted by distances to training sites therefore may have greater impact on these high need areas Preliminary work has started on this.	Sole online training may be insufficient for quality care.
	4 f). Make no substantive changes to training requirements but improve quality and targeting of the training		Improved professional development strategy for prescribers could include: • Differentiation of training needs of new prescribers, existing prescribers and non-prescribing GPs • Targeting GPs using data local and/or general practice population need data • Content and training methods that align with the service system – builds awareness, relationships (local, regional, statewide, private, public, medical specialist, pharmacy, allied health etc) • Professional development activities available at the local level to meet identified needs which may include seminar / workshop / practice audit / clinical attachment / small learning group / visits to local services / on line or other self directed learning materials • Training provided to pharmacists and doctors in the same forum	Does not address the training/accreditation barrier

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			• A monthly forum open to practitioners comprised of 45 minutes guest speaker (e.g.: coroner, police drug squad, addiction medicine specialist, etc) and 15 minutes current local issues/regulation changes • Use podcasts and other technologies to improve reach of training • Provide GP registrars with placement experiences at existing A&D clinics	
	4 g). Chapter of Addiction Medicine or RACGP take over the training and/or authorisation of doctors and/or nurse practitioners and/or pharmacists to prescribe methadone and buprenorphine		Evidence: Professional societies have an important role in accreditation/authorisation. The approval for accreditation to prescribe could be shifted from the Department of Health to the professional society – Chapter of Addiction Medicine	
	5. Introduce pre-packed 'start-up' kits with doses stepped up gradually to maintenance	May encourage greater GP participation (less complicated to prescribe) Potentially reduce risk of early-in-treatment overdose/under dose	Evidence: Initiation of treatment a high-risk time for potential overdose (insert ref's) Have GPs follow a clearly defined protocol for commencing pharmacotherapy which includes mandatory engagement with DACAS when prescribing outside of said protocol. Could be implemented in conjunction with reduced training options (Options $a, b, c, d; to reduce risks). Precedent with 'start up' kits of other medications	Requires pharmaceutical industry support Assumes one med regime suits all. But there is much variation in human response to any medication

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			that require an increasing dose over the first week or two. Under-dosing with buprenorphine in the induction phase has previously been associated with early attrition from treatment (e.g. Petitjean 2001). But under-dosing is a prescriber training problem. May be more applicable to buprenorphine than methadone.	
	6. Revise the permit system - (reduce the amount of paperwork)	Streamline the administrative burden of the program	Evidence: Some prescribers charge an $80.00 fee over and above the Medicare rebate (presumably to cover administrative costs); if streamlining eliminates this charge (a huge barrier to treatment) it would be a good thing. Other jurisdictions have a permit system whereby bureaucrats have access to real-time dispensing data. Such a system provides complete information on clients' prior pharmacotherapy history which ensures safer oversight of treatment. For noting: the software used by Drugs and Poisons Regulation Group will be replaced in the next 18-24 months which will include an online application facility. The DPU paperwork for permits should be fully computerized. NB This is currently available on an ad hoc basis. An encrypted email option should be made available, as well as faxing.	This is in train now - ?check when it will be fully implemented and email options available.

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			Ultimate goal: an online real-time transfer of permits.	
Greater number of dispensing points	7. Improve the level of support provided to community pharmacists/pharmacies who dispense methadone/buprenorphine	Increase the number of pharmacies that dispense methadone/buprenorphine Improve quality of services delivered by pharmacists	Evidence: Winstock et al (2010) note that in their postal survey, 41% of pharmacists had refused to dose a client for any reason the preceding month, due most commonly to expired prescriptions (29%), or missed doses (23%). This study also found that treatment termination by pharmacists was significantly higher in Victoria than NSW (Winstock et al., 2010). These data suggest that greater support to community pharmacists is required. Improve the skills base of dispensing pharmacists: ensure that pharmacists are provided with ongoing training (at least one session per year) that covers the following: dealing with difficult clients, understanding mental health issues, collecting fees from clients, understanding drug dependence, harm reduction and how it relates to pharmacotherapy, drug pharmacology etc.	Need appropriate training for pharmacy staff to deal with difficult patients
	8. Make compulsory the dispensing of methadone and buprenorphine as standard part of pharmacy activity	Increase the number of dispensing locations	Evidence: Currently only 1/3 of Victorian pharmacies participate in the program (evidence of considerable untapped capacity). Pharmacy Guild may support such a recommendation whereby all pharmacies should dispense methadone/buprenorphine (personnel communication).	Requires regulatory review Concern that this may by default therefore include "disinterested"

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			Equity issue: pharmacies are not able to selectively choose which drugs they stock, and which not – under regulations pharmacies must carry all relevant medicines (problem arises because methadone/buprenorphine under Section 100 and so not covered by usual pharmacy regulations. Would overcome the emerging tendency of 'franchise' pharmacy chains to decide not to dispense. Stigma/discrimination may be an issue: (i.e. making pharmacists that don't like this group provide a service might negatively impact on the clients). Positive pharmacist attitudes are associated with greater service provision to injecting drug users (Matheson et al., 1999). Pharmacy Boards could refuse to register premises that don't provide ORT.	pharmacists who provide poor service.
	9. Incentive payments to pharmacists	Increase pharmacy involvement with the program	Evidence: "Pharmacists believe their services are undervalued and insufficiently compensated". NSW experience: new pharmacies dispensing pharmacotherapies receive a once only incentive payment of $1100 (including GST). Both new and existing pharmacies are eligible to receive an incentive of $110 per client twice a year for clients dosed continuously for two months prior to 30th April and 31st October each year (for a maximum of 20 clients).	Requires resources Payments from government to pharmacists should be per treatment c.f. per dose.

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			The ACT government subsidises community pharmacies to the value of $15 per week per client. Tasmania also provides pharmacy incentives. Data on effectiveness of this strategy not clear (sample sizes too small?). The guild /dept funding model study looked at the effect of subsidies for clients and pharmacists but compliance so good (both subsidized and control groups) @ around 93% so no difference detected.	
	10. Vendor machine supply for methadone/buprenorphine	Improved access to dispensing	Evidence: Secure dosing booths that are similar to ATMs (the walk-in' ATM that is fully enclosed) whereby a card system ('smart card') is used that contains all the dose and client information and that when the smart card (like an ATM card) is inserted into a machine (similar to an ATM) a dose is automatically dispensed for the client. The 'ATMs' could be contained in self locking booths that can only be opened and closed with the smart card, they can be filled with cameras to minimise diversion and they can have 24 hour access to a telephone support service in case something goes wrong. These 'ATMs' could be located state-wide, they would dramatically reduce the need for TADs when travelling intra-state (interstate if other states had them too), they would reduce the need for pharmacies to have to dose to a large bulk of the pharmacotherapy client group, they would give greater confidentiality to the client group, they would increase the possibility of a 'normal life' for the client; they would reduce the concern that some pharmacists have in terms of storing	No other models of medication prescribing operate in this way. Public perception issues Security risks

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			methadone on their premises (concern about break-ins), they would increase access to the program in rural and regional areas and in the long term they would most likely be highly cost effective.	
Goal 2: A high functioning specialist system				
	11. Reconsider the role and function of the Specialist Pharmacotherapy Services (SPSs)	Ensure specialist support is available and accessible	Evidence: The original intent of the SPS was a comprehensive specialist service that provided prescribing, dispensing, specialist training and support, back-up services and secondary consultation. It appears that the existing SPS are not all providing this array of functions (for example Austin SPS only prescribes/dispenses methadone; not dedicated dispensing sites at 3 SPS). Assuming the original model was evidence-based, option is to reconfigure all SPS in accordance with original 'vision'. The review of SMS in Victoria (Hales & Cox, 1999) concluded that the services were of high quality and very well regarded by the clients who use them. They noted that the service model was unique in its goal to provide holistic treatment to stabilise clients prior to referral on to less intensive community-based treatment. There are a number of potential options for SPS services in Victoria, as explored in 11a to 11f. 11a). replace all SPS with units in teaching hospitals 11b). ensure all SPS provide specialist services 11c). increase funding to SPS	May require resources May require service contract changes

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			11d). ensure all SPS provide secondary consultation 11e). all SPS to provide outreach/satellite services 11f). "reserved" treatment places for special needs groups	
	11 a). Replace all SPSs with Drug and Alcohol Addiction Units in teaching hospitals, with mission and brief as per SPS	Some advantages: Would operate like other medical specialities; Provides better career pathways; May attract more doctors; May improve referral pathways.	Evidence: May be timely given national health reform agenda New State Government Primary Care Partnerships are being formed with hospitals being the hubs of the new organisations gives ideal time for forming D&A units. Need to ensure that hospitals are supportive of addiction medicine and our clientele. See also option re Addiction Medicine Specialist (# 12).	Requires reconfiguration of services.
	11 b). Ensure that all SPS provide specialist services that include methadone, buprenorphine-naloxone and buprenorphine (prescribing and dispensing)	Effective specialist system	Evidence: Dosing points are limited at present (data), and represent significant strain on the Victorian program. Role of specialist service is to be able to provide all levels of back-up support to primary care, post-release prisoners etc. Without dedicated dosing site, the provision of these back-up services is compromised. The lack of dedicated dispensing capacity for those who are unable to access community pharmacists (for whatever reason) was identified as an issue in the PAMS annual report (Lord, 2009). PAMS noted that the limited capacity of SPS to	May require a re-tendering of the SPS in Victoria. And/or re-configuration of the SPS system. Austin has dosing capability even though only methadone DASWest has some dosing

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			dispense pharmacotherapies on-site was a problem (p39) At present, only the TP SPS has a dedicated dosing site. If all SPS had dedicated dosing site, then they could take clients from GPs for stabilisation/dosing and then refer back.	
	11 c). Increase funding levels to SPS	Given central role of SPS in supporting the primary care system, adequate funding levels will ensure the SPS role in referral, support for GPs	Evidence: Consistent with SPS achieving their original mission, greater resources may be required: The HOI review noted that if SMS were to provide regional outreach services then funding requirements 'would need to be considered' but otherwise funding was not addressed – rather the emphasis was on providers balancing focus on key service requirements and funder setting appropriate service targets for the funding provided	Resources required
	11 d). Ensure all SPS provide secondary consultation	Improve level of support to primary care services	Evidence: The SPS evaluation report (Hales 2000) found that the "Provision of secondary consultation and training provided by SMS was 'less than expected' even though it was a 'key service requirement.' The recommendations made in relation to this issue were that SMS need to achieve a 'better balance between service requirements' (focus on doing what is required with funding provided) and the Department should do an analysis of the time required to undertake secondary consultation and set targets appropriately (i.e. potentially reduce targets to match funding provided)	Training may be required
	11 e). SPSs to provide	Improve rural/regional	Evidence: As per previous, importance of a specialist back-up	Resources may be required

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
	outreach/satellite services in major regional areas	services, including quality and back-up support	system to support primary care services. Each SPS needs to operate one or more satellite clinics (e.g. Sessional at community health service/GP super Clinic/Regional Hospital) Link each SPS with one major rural region. Use of telemedicine could be pursued. See also option 14c re outreach support (network of services) more generally, i.e. not limited to rural/regional areas.	Need to ensure SPS have treatment places to take up potential clients from their satellite services.
	11f). All SPS to have 'reserved" treatment places for special needs groups	Improve access for high risk clients	Evidence: Existing ORT clients can fall through the gaps when life gets complicated (e.g. run out of money and can't afford dispensing fee; experiencing mental health issues and so on). All SPS services would have to have a certain number of places reserved, for up to a 3 month period, for the following client groups: a) those recently released from prison or police custody who were not able to return to their previous prescribing or dispensing service (see option 36), b) those who have been terminated from a prescriber or dispenser due to inappropriate behaviour and/or dispensing fee related debt (see option 38a) c) those who are trying to access the program who are not able to find a place in a community prescribing or dispensing service in the community.	Resources may be required and a reconfiguration of how SPS operate their services.
	12. Advertise and	Improve quality of	Evidence:	Resources

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
	recruit to new Addiction Medicine Specialist position(s) and advertise and recruit to more FAChAM trainee positions	services Encourage more GP participation (with better specialist support)	Stakeholders to Polygon project (Ritter & Chalmers, 2009) reported the importance of a specialist system to provide secondary consultation and support to GPs. It is well established in medical culture that doctors/GPs need to communicate with/seek support from "specialist practitioners" (indeed, arguably a standard practise) however, not many GP's have heard of Addiction Medicine, let alone, know whom/where to refer to. There are approximately 200 FAChAM specialists in Australia, with xx% in Victoria (compared to yy% in NSW). This indicates that Victoria is lagging behind other states in having such positions. More trainee positions are vital to achieve this goal.	required for new positions Recruitment strategy required Need to consider location of new specialists: SPS or one in each major teaching hospital. A minority of FAChAM's work exclusively in addiction medicine, many are for example psychiatrists (with an interest). Need to accommodate this (e.g.: part-time status)
	13. Review the Pharmacotherapy Regional Outreach Workers	Improve service delivery in rural areas	Evidence: The Evaluation of Victorian Methadone Regional Outreach Worker Programs (Swan et al., 2004) suggested that dedicated workers in rural areas could increase the number of prescribing GPs, dispensing pharmacists and clients in the program.	

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			Better use of the role: Pharmacotherapy outreach workers should have well described position descriptions commensurate with their expertise – if they are well trained professionals it is a waste of time for them to be accompanying patients to doctor / pharmacy. See also options 18, 19 re outreach bus services.	
Goal 3: Strong and effective connection between the specialist and primary care systems				
	14. Strengthen programs designed to encourage and support community/primary care prescribing and dispensing	Will increase the number prescribers (& dispensers) May encourage existing group to continue prescribing and dispensing	Evidence: Equivalent clinical outcomes between specialist and community care settings: (e.g. (Keen et al., 2000; Mintzer et al., 2007; Vignau & Brunelle, 1998). Community settings here refer to: community health centres (CHC's); primary health care services; GP services; HealthOne clinics; GP super clinics and the newly proposed "Medicare Locals". GPs who decide to complete pharmacotherapy training often do this in response to the need for a prescriber within their practices and local communities. The support and encouragement of medical colleagues is an important positive influence in GPs' decisions to complete training and subsequently commence prescribing. NB A revised system of medical support in the first months could be crucial. The barriers to GPs' commencement of prescribing after pharmacotherapy training are operational and structural in nature, mainly related to practice based issues, many of which are open to resolution. Part of	Requires investment and judgement about cost-benefit (i.e. does a modest increased engagement in the program justify the funding?)

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			key findings from "Influences on Opioid Pharmacotherapy Programs in General Practice in Victoria" a Master of Medicine thesis by Christine Longman. There are a number of ways in which the connections between the specialist program(s) and community/primary care ORT programs can be strengthened: 14a). build referral pathways 14b). provide case management support to community programs (from specialist sector) 14c). Network hub between SPS and primary care prescribers/dispensers 14d). shared care programs 14e). review the Pharmacotherapy Development Program	
	14 a). Build referral pathways between generalists and specialists	Better service system Greater support for GPs	Evidence: UK research: GPs reported that access to local community drug teams would encourage treatment (Davies & Huxley, 1997). See also Strang et al., 1992. Evidence that 'perceived support' is the key, knowing there is someone to refer people to if required is the main thing, does not mean there will be referrals but the perceived support can increase treatment participation for prescribers The SMS evaluation (Hales, 2000) reported that: 'The SMS model is unique, as it enables an holistic approach to methadone maintenance treatment, by	

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			incorporating medical, counselling and case management services in order to stabilise clients for a return to less intensive community-based treatment' (p v1)	
	14 b). Provide specialist case management support to community programs		Example projects – The Central Coast GP Project (GP's having immediate phone support by AOD doctor support) Shared Care Guidelines (Furler, J., Patterson, S., Clark, C., King, T. & Roeg, S., 2000). GP Methadone Liaison Officer Case example: Northern Division of GP – Outreach worker attached to pharmacotherapy prescribing service to provide capacity to liaise with AOD services and support clients on ORT	
	14 c). Specialist services as hub of support for linked community services	Better linkages between services Greater support in regional/rural areas	Evidence: The HOI review of Victorian SMS in 1999 recommended that 'formal eligibility criteria and referral procedures should be developed between SMS and agencies 'with a referral relationship' (GPs) Case example: Greater Eastern Primary Health (Knox Division of GP) – Model of GP engagement and education whereby GPs complete a 10 hour face-to-face supervised clinical attachment with Eastern Health MH and AOD service Use of virtual networks (e.g. DACAS) to create communities with hubs, including online training as part of the virtual network	Requires funded positions to facilitate this co-ordination. Need buy in from all services to make this work

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			Each GP to have an identified specialist service that they relate to. Each SPS convenes a network of generalist services for their region	
	14 d). Shared care programs	Better client outcomes	Evidence: Shared care guidelines (Furler et al 2000) Polygon report notes that the Royal Australian College of GPs agree that stepped or shared care is appropriate for general practice: general practice will provide support and care for uncomplicated cases while complicated cases will be managed by FAChAM doctors. (Ritter & Chalmers, 2009) Case example: PivotWest - represented a key anchorage point in terms of linking associated organisations and improving the coordination of care across the service systems, from GP practice to community mental health and drug/alcohol services. Psychologist attached to 2 GP clinics	"Shared care seems to be a great idea with lots of funded projects but never really works that well"
	14e). review the Pharmacotherapy Development Program	Improved formal support to community prescribers and dispensers. Improved data systems	Evidence: The Pharmacotherapy Development Program (located within DPU) has a role in supporting and building the capacity of the community based system. Evidence of effectiveness could not be located. Noted that often it's peers (other professionals) who can best encourage new practitioners into the field. Systematic approaches to data collection and analysis are required. Transparency back to practitioners and stakeholders	

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			could be enhanced (e.g.: reporting systems, engagement with stakeholders). See also option 6 (revise permit system) The Pharmacotherapy Development Officers may also be more appropriately located within an **agency external to the department** (organisation such as the Pharmacy Guild or RACGP).	
	15. Ensure that the GP super-clinics; one-stop-shop primary health services/"Medicare Locals"/ and CHCs have capacity to treat opioid dependent people (at least one prescriber)	Better primary care access	Evidence: Research demonstrates better outcomes in primary health care settings than in specialist settings for ORT: (Wittchen et al., 2008) compared outcomes (retention and drug use) in primary care settings versus specialist centres and found better outcomes in the primary care settings. A number of other researchers have documented equivalent clinical outcomes between specialist and primary care settings (see for example Keen, Rowse, Mathers et al., 2000; Mintzer et al., 2007; Vignau & Brunelle, 1998). A greater number of mid-sized clinic sites in widely dispersed locations reduces the unpopular, large clinic model (that the neighbours don't like etc, so less community impact). Medical Boards could refuse to register premises that don't provide ORT.	Will need to watch the Healthcare reform process carefully, link with new 'Medicare Locals' development.
Goal 4: An accessible program (enough treatment places)				

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
	16. Set up/ encourage /incentivise private clinics (as per NSW)	Improve access for clients	Evidence: No research to support differential outcomes. In a study of client outcomes in public and private clinics in New South Wales, Bell, Ward, Mattick et al. (Bell et al., 1995) found that differences in outcomes (as measured by retention in treatment and heroin use) between clinics within each sector were greater than differences between the sectors. In a version of the private clinic model: GPs may be interested in a collaborative approach to work with Addiction Medicine Specialists in local private D&A clinics. Small D&A centres already exist in an uncoordinated manner e.g. Croydon, Geelong, some CHC's. Drop-in consultations often have advantages to the usual appointment system.	May not be attractive to clients
	17. Establish at least one more SPS	Better access for clients with serious and complex needs.	Evidence: The Victorian SMS (now SPS) were evaluated by Health Outcomes International. "There is a general consensus that the SMS are providing high quality and valuable services to their target population…." (p. v; Hales, 2000). Hales (2000) evaluation also found that 'Clients display a high level of satisfaction with the model of service delivery, intensity of services available and the staff employed by the SMS. The majority of clients involved in the consultative process had been involved in other methadone treatment programs in the past and all clients reported the SMS as suiting them best' (p. v)	Resources required Concern that SPS only cater to local clients:" Geocentric" client distribution around SMS sites (HOI, 1999)

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			PAMS 2008-2009 annual report recommended the establishment of adequately resourced SMS in each region to improve access. See also option 11 (reconsider role and function of SPS)	
	18. Outreach prescriber (bus) that roves rural regions on set days	Improve rural/regional prescribing accessibility	Evidence: SMS evaluation recommended that provision of mobile or outreach services should be considered (Hales, 2000) See http://www.pivotwest.org.au/index.php?action=view&view=35830 for bus-operated health service in City of Maribyrnong.	Resources required Provides improved access but may not be sufficient for good case management
	19. Outreach dispensing bus: dispenses daily in less accessible locations (akin to mobile library)	Improve rural/regional dispensing accessibility	Evidence: Mobile clinics operating in China, Netherlands (since 1979) and the US (Baltimore, San Francisco, Seattle, Massachusetts) – to address NIMBY and rural access. Evidence of greater retention (x4 times) in treatment compared to fixed sites (Greenfield et al., 1996).	Resources required May require pharmacy legislation review May create an "occasion" upon arrival. May be privacy concerns.
	20. Provide transport for (rural) clients	Improve dispensing accessibility	Instead of an outreach bus (prescribing/dispensing) provide bus for clients to travel for prescribing/dispensing. And/or cover transport costs for clients located a minimum distance from ORT	Resources required

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			services (public transport passes).	
Goal 5: High quality clinical care				
Pharmaceutical opioid dependence	21. Improve approaches for pharmaceutical opioid dependence treatment and for other pharmaceutical dependence (such as benzodiazepine dependence)	Service system able to be responsive to potential new demand	Evidence: Currently we have limited knowledge about those using pharmaceuticals that don't currently access AOD treatment. Recent research suggests that the majority of pharmaceutical opioid users that access AOD treatment are a similar population to traditional illicit opioid using samples. Key Experts suggest there are 'hidden populations' of pharmaceutical opioid users that don't access current AOD treatment. Defining this 'hidden population' is the topic of current research. Research on rates of use of pharmaceuticals amongst ORT clients showed that 88% reported using nonmedical pharmaceutical opioids, and 88% reported using non-medical benzodiazepines (n = 305). However, this does not reflect prevalence for two reasons, 1. it was a convenience sample and 2, people had to have used some kind of pharmaceutical in the last 6 months to be eligible. Use in last 4 weeks was 25% of the sample, using an average of 6/28 days for pharmaceutical opioids. PO use significantly reduced as a result of treatment (Nielsen et al., 2008). RACGP has developed guidelines on this issue. PSA is in the early stages of doing the same (and complementary to what RACGP has). Reducing access to these medications Is important through strategies such as training about "doctor	Resource neutral Unclear whether the "hidden population" will be attracted to traditional D&A services. Nielsen et al (2008) preliminary data shows that codeine users do not perceive current ORT as being for them - reluctant to enter treatment.

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			shopping"; online prescription information for doctors and pharmacists to monitor misuse of pharma opioids; further computer software could be distributed for initial patient assessments, recall systems, complex care planning etc. NB: This is also currently available on an ad hoc basis.	
	22. Greater knowledge and awareness of pain management in our client group.	Improved clinical care for those with both chronic pain and opioid dependence	Evidence: Clients with chronic pain often perceive themselves as under-treated for their pain (Jamison et al., 2000). Health care professionals tend to under-medicate opioid analgesia because of fears of cognitive, respiratory and psychomotor side effects; iatrogenic drug addiction; and prescription drug diversion (Lander, 1990; Savage, 1999).	
	23. Develop clinical guidelines for meth/bup maintenance treatment for those dependent on pharmaceutical opioids	Improve ORT workforce for treatment of pharmaceutical opioid dependence	Evidence: Importance of clinical guidelines (Strang, Manning et al., 2007) in improving practice. Lack of knowledge regarding use of methadone and/or buprenorphine as maintenance treatment for those dependent on pharmaceutical opioids (need to check if any new literature). From Polygon: "There is currently no evidence to inform practitioners about the preferred medication regimes for those misusing pharmaceutical opioids, although both methadone and buprenorphine are being used without apparent ill-effect" (Ritter & Chalmers) Evidence: growing body of literature on this patient group suggests they are different from illicit opioid users and this may mean different guidelines are	Buprenorphine may be more "acceptable" than methadone for this group

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			required. On the other hand- Clinical experience suggests that this patient group is heterogeneous but that treatment options do not need to be different to what is available for the illicit opioid user. As prescription opioid abuse is becoming so common, should the manufacturers be levied to help set up treatment agencies?	
	24. Facilitate multi-disciplinary pain management clinics that include Addiction Medicine Specialists	Better care systems (expert advice re dependency, referral pathways, and shared care) for clients at pain clinics.	Evidence: See Wodak's report, and College report High levels of physical comorbidity/pain etc amongst this patient group compared to heroin users identified in a number of studies comparing different cohorts of opioid users	
Optimal dosing	25. Client and practitioner education campaign regarding "optimal doses"	Better client outcomes	Evidence: Higher doses, better outcomes (Lintzeris et al., 2007) See above re treatment attrition with suboptimal buprenorphine dosing during induction. Optimal dosing for buprenorphine limited by methadone thinking in induction. (Note: Reckitt-Benckiser has conducted induction training). New educational material is required for clients and for practitioners	Client resistance to higher doses. Check with RB re available material
Medication non-	26. Reduce take-	Decrease risk of	Evidence:	

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
adherence and diversion	away provisions	diversion and misuse	Comprehensive report on diversion now available: (Larance et al., 2009). Harms associated with diversion and misuse of medication in association with take-aways have been widely document, e.g.: (Jenkinson et al., 2005; Lintzeris et al., 1999; Reisenger, 2006; Southgate et al., 2001; Sunjic & Zador, 1999; Vidal-Trecan et al., 2003) BUT "We are happy with the more liberalized takeaway regulations in Victoria compared to other states e.g. NSW. The relatively widespread diversion of [buprenorphine] is noted". And see options 27 (take-safe technology); 28 (targeted supervision); 29 (bup-naloxone as monthly 'script'); 30 (unsupervised treatment).	
	27. Explore "take-safe" dispensing system	Reduces number of visits to pharmacy for stable clients Improve accessibility (esp for rural clients) Improve confidentiality Increase the capacity to have a 'normal' life whilst on a pharmacotherapy program	Evidence: NSW piloted the 'take-safe' (or similar) way of securing take-away doses in a safety container. It was disbanded in NSW after a critical incident.	Assessment of the technology is required. Review of risks and benefits required.

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
		Potentially increases employment options Reduces demands on community dispensing points		
	28. Target supervised dosing only to those that need it.	Improved client outcomes; reduce risk of diversion	Evidence: See Option 40 re unsupervised treatment effectiveness. The RACGP Vic Drug & Alcohol Committee has a tentative proposal for a research trial involving a pilot study on a liberalized dosing regimen for Suboxone patients who continue to show low-risk behaviours. This is a variation of the "Buprenorphine-Naloxone Waiting List RCT" done at Hunter New England NSW Health by Adrian Dunlop & co. (see option 29).	GPs may have limited capacity to assess stability; may not be realistic that unsupervised dosing would be appropriately targeted
	29. All buprenorphine-naloxone delivered as unsupervised treatment (monthly 'script')	Reduce demand on pharmacies Improved client satisfaction (and hence retention)	Evidence: Australian study found no significant difference in treatment retention or client outcomes between daily supervised buprenorphine-naloxone and weekly unsupervised buprenorphine-naloxone (Bell et al., in press). Recent work by Adrian Dunlop in Newcastle also found no adverse effects of initiation into weekly scripting of buprenorphine/naloxone. The Australasian Chapter of Addiction Medicine has published a document outlining clinical guidelines for the assessment of stability (Winstock & Bell, 2006). They note a number of important overarching	Ongoing concern about diversion

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			principles for unsupervised dosing: • Careful client selection • Ongoing clinical monitoring • Importance of transparency in treatment decisions and involvement of the client in that process (Winstock & Bell, 2006) The USA and French models are largely unsupervised treatment, e.g.: (Auriacombe et al., 2004). But some evidence that supervision in the French system is linked to better retention/treatment outcomes (Auriacombe et al., 2004). For noting: Drugs and Alcohol Services specialists can already apply for a 'minimal supervision' permit which allows up to 28 days unsupervised supply of buprenorphine-naloxone. That is to say, current policy already allows for this in these circumstances. GPs may also apply for a 'minimal supervision' permit, if endorsed by a specialist. Follow-on effect would be that monthly scripts would remove need for supervised dosing and thus increase no. of possible dispensing points from which these monthly scripts could be dispensed.	
Unsupervised treatment model	30. Develop new guidelines for unsupervised treatment (that are independent from take-away dosing policy)	Improved client outcomes Improved retention	Evidence: See Option 29 (buprenorphine-naloxone as all monthly scripted) US office based model of treatment for Suboxone	Concern about diversion Unsupervised treatment guidelines already exist (?)
Transfers and	31. Implement a	Improved quality of	Evidence:	Beyond scope of

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client mobility	national permit system	care	In reviews of the difficulties associated with pharmacotherapy maintenance programs in Australia, temporary transfers and interstate and international transfers and travel have been raised as problematic (Ritter & Chalmers, 2009). Many considerations here around privacy legislation. Come 1 July, certain other jurisdictions will disallow doctors to prescribe to patients other than those in the State or Territory where the doctor practises.	current project. Many pharmacies still operate fairly old school exercise book systems. Requires some upgrade/ investment by pharmacists.
Counselling and psycho-social support services	32. Education for GPs re how to access the new MBBS numbers to fund case management	Better treatment outcomes	Evidence: Better remuneration is currently achievable for D&A work using Medicare complex care GP item numbers i.e. Management plans, Team care arrangements, Mental health treatment plans etc (plus reviews thereof). But the common perception is that D&A work is not worth the effort. NSW work: The Patient Journey Kit 1: Transfer of stable public clinic opioid dependent patients to GP prescribers; The Patient Journey Kit 2: Supporting GPs to manage comorbidity in the community (Adam Winstock & Jill Molan).	Some GPs report this is difficult to do (while others do well financially out of this)
	33. Better care for complex behavioural needs of clients	Better treatment outcomes Improved retention of GPs in the	Evidence: GPs want more back-up support for behavioural problems Better cross-referral between SPS and community	Limited capacity and geographical reach of the SPS

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		program	prescribing/dispensing (see option 11d (SPS secondary consultation) and option 14 (strengthen links). Some pharmacists (pharmacies) more experienced and better able to manage complex behavioural issues. Use a two-tiered system: stabilise dispensing then transfer to less experienced pharmacy. Enable pharmacists to initiate urine drug screening Provide better coordinated care for people with comorbid mental health problems through the use of GP Mental Health Care Plans ("better outcomes" program) – see option 32 (education for GPs re MBBS items).	system
	34. Register of psychologists (private) willing to see clients	Better treatment outcomes	Evidence: Evidence re improvements in outcomes associated with counselling (Amato et al., 2004; Gossop et al., 2006; Rowan-Szal et al., 2004) when made available but not compulsory. Good uptake and high demand for MBS Psychology – but no evidence that this is true for people with AOD problems.	Resource neutral Limit on number of session may not be good match to the needs of the client group Private psychologists charge a substantial co-payment
Privacy and confidentiality	35. Review ways in which privacy and	Improved quality of care	Evidence: Take-away dosing improves privacy	

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(esp in rural regions)	confidentiality can be improved in rural areas		Options regarding outreach "bus" (prescribing and dispensing) will assist on this issue (ie don't need to be seen by the local country GP). See option 19 (outreach dispensing bus). Unsupervised dosing for Suboxone one way to address this to a degree (less hanging about in pharmacies) Physical facilities at pharmacies could be improved to enhance patient privacy.	
Post-release prisoner maintenance – continuity of care on release	36. Ensure continuity of dispensing at point of release from prison	Improve post-release continuity of care	Evidence: The efficacy and cost-effectiveness of prison pharmacotherapy maintenance is beyond doubt (Dolan et al., 2005; Dolan et al., 1998; Haig, 2003; Shearer et al., 2004; Warren et al., 2006). Point of release is a high risk time for prisoners in relation to drug use and overdose (Bird & Hutchinson, 2003; Darke et al., 2000; Dolan et al., 1996). Hence continuity of dispensing is vitally important. On leaving prison, Corrections Victoria pays for dosing fees at pharmacies approved to provide the services for the first four weeks after the prisoner is released (at a cost of $140). Moreland Hall 'Blueprint' Submission' notes that the prisoner post release pharmacotherapy pilot had an 80% retention rate. Note: Burnet conducting an evaluation of the	May require resources Large amount of follow-up required (can take 3 months to get payments sorted)

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			methadone and buprenorphine dispensing subsidy program for Victorian prisoners ("hit and miss" study). One month may not be long enough. See also option 38b) (state paying dispensing fees for high risk groups); 38C). SPS to have no dispensing fees) and Option 38f (state to pay all dispensing fees).	
	37. Improve the peer support provided to clients	Better retention	Evidence: The PAMS (Pharmacotherapies Advocacy Service) provides support for clients currently on ORT in Victoria. This service could be strengthened (through increased funding) to - increase the capacity for the service to do more in all areas (policy advocacy, client support and consumer representation) - enable the service to provide peer education sessions for the pharmacotherapy consumer group which would cover a range of issues including the state guidelines, building effective relationships with service providers, pharmacotherapy drug pharmacology, problem solving etc, etc - allow greater consumer input and involvement in the Victorian pharmacotherapy treatment system - give clients greater access to an advocacy, support, information and complaints-resolution service - provide greater support to pharmacotherapy service providers on client related issues and concerns.	

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Goal 6: An affordable and equitable program for clients				
	38. Reduce financial burden of dispensing fees	Increase treatment uptake Reduce financial burden on clients Lower program drop-out Equity (with other medicines and with other drug treatment types)	Substantial evidence that the dispensing fees are a significant problem for clients. Additionally, it is inequitable. In 2008, the Salvation Army and RMIT launched a report entitled *A Raw Deal?*. The report was based on research involving clients of primary health services for injecting drug users: Access Health; Next Door (now InnerSpace) in Collingwood; Southern Hepatitis/HIV/AIDS Resource Prevention Service (SHARPS) in Frankston; and the Foster Street Clinic of South East Alcohol & Drug Services (SEADS) in Dandenong. It explored the issue of dispensing fees amongst this sample of ORT clients. (Rowe, 2007). Rowe reports that 'difficulty meeting the financial obligations of OST often contributes to the deterioration of the relationship between dispensing pharmacist and client. This is an obstacle to retention in treatment and involuntary treatment termination is invariably followed by problematic heroin use. The Pharmacotherapy Advocacy and Support (PAMS) Service Annual Report 2008/2009 reported that 'difficulty with the payment of dispensing fees' is the most common reason for consumer contact with PAMS. Many clients on income support are unable to pay (84% of those contacting the PAMS service in 2008/09). See Polygon report (Ritter and Chalmers, 2009) for	

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
			a review of the fees literature. There are a number of different options to reduce the financial burden on clients: 38a). SPS to provide respite treatment places (dispensing fee-free) 38b). State to pay dispensing fee for high-risk groups 38c). SPS to have no dispensing fees 38d). Introduce means testing for dispensing fees 38e). State to pay dispensing fee for first 3-4 weeks for every client 38f). State to pay all dispensing fees	
	38 a). SPS to provide respite places for those in financial difficulty (dispensing fee-free)	(see under point 38)	Evidence: Safety net required for that small proportion of clients requiring additional care, currently simply banned or stop dosing due to debts. SPS system to provide such a 'safety net' – immediate access to treatment, emergency dosing. PAMS 2008-2009 annual report recommended the establishment adequately resourced SMS in each region with a requirement to keep places for clients in crisis or with complex issues – who would otherwise face involuntary withdrawal sickness due to termination from community based providers. May clog the system rapidly (pharmacists would know that there was an alternative place for them to be treated).	Will require better accessibility of the SPS treatment places May require additional resources to the SPS Requires effective networked/ coordinated services to work well (see option 14a referral pathways)

Goal	Options	Main benefits of the change	Relevant evidence	Concerns
				SPS insufficiently funded for this to be currently viable (see option 11c funding for SPS)
	38 b).State to pay dispensing fees for certain high-risk groups	Reduce fee-burden for high risk client groups (see under point 38)	Evidence: This is already implemented in Victoria for clients recently released from prison, clients aged 18 and under and those subject to Juvenile Justice Orders. Other priority groups could include: - pregnant women - HIV positive - single women or men with one or more children in their care - women who are breast feeding In 2009, the Salvation Army submitted to the Department a proposal for subsidisation for pharmacotherapy services. The submission was prepared with the assistance of the Royal Women's Hospital Alcohol and Drug Service, the Burnet Institute and Professor James Rowe of RMIT. This subsidisation proposal draws on the *A Raw Deal?* report. In summary, the Salvation Army proposed that pharmacotherapy dispensing fees be funded by the state for the following specific populations: - women who are pregnant and mothers in the first 18 months post partum - PLWHA (people living with HIV /AIDS) - people who are homeless with complex co-morbidity.	Resources required

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			For those clients who experience financial hardship, access to brokerage funding (for the PAMS Service, on behalf of clients) that could be used on a state-wide basis to support clients for up to two weeks per year with the payments of pharmacotherapy dispensing fees.	
	38 c). SPS to have no dispensing fees	(see under point 38)	Evidence: If SPS are treating the most serious and complex presentations, then it is highly likely these clients are the least able to pay (see also point re horizontal and vertical equity). Model used in NSW (Langton Centre): specialist clinics in NSW have no dispensing fees. (Problem is that it is then very difficult to transfer stable clients back into primary care, as there is financial disincentive for the client)	May silt up SPS places (hard to move clients back to community-care) Need all SPS sites (at a minimum) to dose and have an agreement around accepting clients
	38 d). Introduce means testing for client fees	(see under point 38)	Evidence: ORT fees should represent both horizontal equity (clients with the comparable ability to pay should face the same costs) and vertical equity (those who can pay more should pay more). These two basic principles of equity mean the implementation of a safety-net, means-testing approach to ORT fees, as applies in other areas of health care. *A Raw Deal?* (Rowe, 2007) included the recommendation that the Victorian Government immediately move to extend the subsidisation of pharmacy dispensing fees to all financially	Resources required The Health Care Card is an obvious and relatively easy method of means-testing. Or use Centrelink benefit

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			vulnerable pharmacotherapy clients, suggesting all those with health care cards.	recipients (NSA, Centrelink Pensions, Single Parent Pension or Family Tax benefit, Carer's Allowance)
	38 e). State to pay dispensing fee for the first 3-4 weeks for every client	(see under point 38)	Evidence: International research shows that fees reduce likelihood of treatment entry (Booth et al., 2003). This option is also consistent with a Hepatitis C (HCV) prevention initiative; given that ORT reduces injecting and hence potentially reduces the risk of contracting (or recontracting) HCV, subsiding pharmacotherapy treatment will improve uptake of ORT.	Resources required Ethical issue with starting a client on a treatment they cannot afford after 3-4 weeks?
	38 f). State to pay all dispensing fees	(see under point 38)	Evidence: ORT should be compared to other long term drug treatments for opioid dependence (such as long term counselling, rehabilitation). These do not incur client fees (other than accommodation costs in residential care - check). Long-term counselling is not associated with client fees in the public system This is an equity issue. See also Option 41 (changes to the PBS).	Resources required Chalmers & Ritter (2009) estimated the likely cost associated with this option for whole Australia.
	39. Guidelines for pharmacists as to how to manage clients in debt	Better fee management practices for clients	Evidence in support: The PAMS service gets actively involved in mediating/sorting out strategies for debt management – but this is after the fact (relationship	Pharmacist being debt collectors may act as a disincentive to

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			breakdown has already occurred) and is very resource intensive.	participate in the program. Pharmacists may be resistance to adhering to guidelines
	40. Divorce the fee payment from the service delivery in community dispensing.	Resolves a number of aspects of the dispensing fee problem	Evidence: In a review of client fees, pharmacists noted that fee subsidisation led to improved staff-client relationships (Health Care Management Advisors, 2007). Transfer to another pharmacist is often difficult due to lack of availability. The need to provide a letter of reference from the original pharmacist and sometimes the requirement to pay dispensing fees a week in advance are problematic for clients. Data shows that pharmacists struggle with the fees and that it's a disincentive to their participation in the program. Basic model would be: pharmacists paid by the state; state collects the fees directly from clients	Implementation requires careful thought. Greater state involvement in collection of fees may impact on client perception of how confidential their treatment is (as a result of a 3rd party collecting the money). Introducing complex system of payment may be inefficient.
	41. Lobby Commonwealth to have methadone and buprenorphine dispensing costs as part of the PBS	Equity	Evidence: The ORT dispensing fees are inconsistent with Australia's approach to funding essential medicines. Current funding arrangements contravene the fundamentals of the PBS… "access to life saving drugs for all the Australian population at an	

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	funded component		affordable price". Discrimination occurs under the PBS whereby people with drug dependence as their particular diseases state receive nothing like the support that other disease state sufferers receive. Importantly, for this to happen, the medications do not necessarily have to be moved from Section 100 to Section 85 of the National Health Act 1953. Recent review of S100 meds, specifically investigated this issue: Health Care Management Advisors (2007) Funding Model Options for Dispensing of Pharmacotherapies for Opioid Dependence in Community Pharmacy. This small study showed that positive client outcomes in terms of reduced financial stress, reduced conflict with partners or spouses and other benefits do occur as a consequence of subsidising dispensing fees. Benefits were greatest in the fully subsidized funding model. At a minimum seek to have listed on PBS in Zyban form, that is once a year for three months Rowe (2007) also recommended that the Commonwealth amend the PBS to include pharmacotherapies	
	42. Prohibit pharmacies from charging the same fee for daily dosing and weekly dispensing	Remove inequity in fee structure	Evidence: A number of pharmacies charge the same weekly fee, regardless of the number of takeaway doses. This has been raised as a concern by many (ANEX, Polygon report). Same payment levels for daily vs weekly, vs less frequent dispensing represents an	Regulation of pharmacists regarding fees Some concerns from pharmacist

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			inherent inequity in the fees. Inequity of health care options... thrice weekly dosing makes it possible to offer buprenorphine treatment for $15 a week, reducing cost as a barrier but many pharmacies charge $30 even if people don't collect all three doses. However, the dispensing fee may not represent a "fair" fee (according to pharmacy funding study, fair fee is $9.00 per day; $65 per week). Notion of a "program fee", rather than a "per dose" fee would alleviate some of the complexities around this issue. Need to distinguish between the amount (fair fee issue) versus the link between doses and payment.	perspective: arguably not inequitable because hidden levels of service provisions; pharmacists are already underfunded; clients miss doses to save money resulting in erratic attendance.
	43. Introduce guidelines for 'fair' dispensing fees		Evidence: Pharmacists argue that the fees are currently too low. The same fee ($30 per week) has applied since the 1980's. True value of the service > $9 per day (Pharm Funding Model PGA / Dept health study 2010). Same study showed 93% compliance for 700 clients over 6 mths for collecting doses. (demonstrating just how successful the program actually is). See also option 39 (debt management for pharmacists)	Need to be careful to avoid anti-competition issues.