South Island Methadone Project Report

National Centre for Treatment Development (Alcohol, Drugs and Addiction)

December 2001

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CHAPTER 1
INTRODUCTION

Methadone maintenance treatment is well established as an effective treatment for opioid dependence [Ball & Ross 1991]. It has been estimated that there are between about 13,500 and 26,600 with opioid dependence in New Zealand, and likely to rise by 15% a year in the foreseeable future [Sellman et al 1996]. Presently in New Zealand there are 3,774 patients receiving methadone treatment for opioid dependence in New Zealand and these "methadone places" have in recent years been strictly controlled through service contracts.

The resulting tension between demand and supply has brought about significant methadone service waiting lists in many regions of New Zealand, particularly the South Island, where the rate of opioid dependence appears to be higher than in the North Island, indicated by opioid overdose deaths [Sellman & Robinson 1997]. To add to this problem, when an opioid dependent person wishes to move to another region, they are required to transfer to the new methadone service and generally this means going to the bottom of that service's waiting list. New Zealand research [Adamson & Sellman 1998] has shown that people on methadone waiting lists incur costs to the community in the region of $1000 per person per week. People on methadone waiting lists are therefore right to be considered "uniquely expensive citizens" as previously asserted by the late Dr John Dobson (personal communication).

This present work was commissioned in part because of complaints about the difficulty people have experienced, transferring from one region of New Zealand to another, when on methadone treatment. The present report focused on the issues of waiting lists and transfers in relation to methadone treatment in the South Island where some of these complaints had originated and where there have been known for some time to be long waiting lists for treatment. In addition, the opportunity was also taken to examine training in methadone treatment for programme staff and pharmacists.

1.1 LITERATURE

The research literature specifically related to methadone programme waiting lists and transfers is sparse. Only four studies have been undertaken which directly relate to this

problem, and all are from the United States. This literature largely investigates the differences in treatment outcomes from interim programmes versus a comprehensive methadone programme. Interim programmes can be described as the provision of methadone alone with no extra counselling or specific clinical case management, whereas comprehensive programmes provide an optimal methadone prescription, counselling and life skills training.

Before reviewing these studies, it should be noted that there are many issues with transporting the findings of research from other countries to the New Zealand situation. This is particularly the case in terms of drugs and treatment of drug problems when local patterns of drug use, local treatment practices influenced by local psychosocial culture and demographics have a significant impact on outcomes. New Zealand has a unique pattern of drug use, including opioid drug use as well as a set of unique cultural and demographic factors. A good example of difference is seen in the work discussed below of Yancovitz et al (1991) from New York, who noted with concern the high levels of cocaine use in their sample. Among New Zealand methadone populations cocaine is considerably less of a concern and cannabis use much more of a treatment issue. Recent Christchurch data shows that 76% of patients undertaking methadone maintenance treatment smoke cannabis and 56% smoke it more than weekly [Deering et al 2001]. Nevertheless, having pointed out potential difficulties extrapolating from the international literature, in the absence of informative New Zealand research, we must make full use of any information which could help in the unique problems faced by opioid treatment services in New Zealand.

Yancovitz et al (1991) studied 301 volunteer subjects recruited from a waiting list for methadone treatment who were randomly assigned to an interim clinic or remain on the waiting list. They found that those in the interim clinic significantly reduced their heroin use compared with waiting list controls but moreover, were more likely to subsequently engaged successfully in comprehensive methadone maintenance treatment. From the same research centre, Beth Israel Medical Center, New York, Friedman et al (1994) subsequently investigated the retention rates of those admitted initially to an interim clinic compared with those admitted directly to a comprehensive methadone programme and found no differences. Maddux et al (1995), Texas, conducted an open clinical trial of rapid (1-day) vs slow (14-day) admission to methadone maintenance treatment and found a significantly higher dropout rate in those randomly assigned to slow admission. They note that pre-treatment attrition can be markedly reduced by prompt (interim) medication and that those who receive interim medication are just as likely to remain in treatment longer term. Finally, Abbott et al (1998)

replicated previous findings in demonstrating that both addiction and mental health treatment outcomes were better in clients on an interim programme than on a waiting list.

This direct literature needs to also be examined in the light of the broader literature addressing low threshold programmes. These were designed in the mid-late 1980's as a public health measure to combat the spread of HIV through decreasing needle sharing. They had relaxed criteria for admission and few strict demands were made of patients in terms of mandatory attendance, counselling and urinary drug testing. Accessibility was the key goal, particularly of those who would not otherwise be interested in methadone treatment. As it turns out, low threshold programmes have not been demonstrated convincingly to decrease the spread of HIV and other blood borne viruses. One of the central studies quoted is that of Hartgers and colleagues, who studied 386 intravenous drug users over a period of four years. Those who were long-term regular attenders in a low-threshold programme were found to be no different in their HIV status compared with those who were short-term and/or irregular participants. The main concern for this paper however is low threshold programmes versus no treatment and there have been no studies comparing the risk of HIV and other blood borne viral infection in this situation. However, an even more fundamental issue is mortality and this has been studied in low threshold programmes versus no treatment. Van Ameijden and colleagues (1999) studied 498 intravenous drug users in Amsterdan and found that the relative risk of death by drug overdose was 0.35 in those treated with between 5 and 50mg methadone compared with those receiving no treatment, indicating a significant benefit from low threshold treatment. Even more benefit was found with higher doses of methadone.

Finally, somewhat closer to home is the work of James Bell in Sydney. He has conducted two studies pertinent to this discussion. In 1992 with colleagues he conducted a followup study of people who had been rejected for methadone maintenance treatment based on clinical judgements that they were not physically dependent on opioids (n=58) or who had dropped out of the initial assessment (n=26) [Bell et al 1992]. At followup four had died, four had achieved a degree of stable abstinence and the remainder were either continuing to use illicit drugs, were in treatment or were in prison. He concluded that it is important not to delay entry into treatment as the vast majority of those seeking help are genuine cases requiring assistance. Secondly, was a study reported several years later [Bell et al 1994] compared 89 patients rapidly admitted to methadone treatment when they presented compared with 74 patients who had been on a waiting list. Those rapidly inducted showed significantly better outcomes during the first six months of treatment.

1.2 CONCLUSION

The literature clearly demonstrates the short- and longer-term benefits of placing people with opioid dependence on methadone as soon as it is indicated. This induction should be rapid rather than a drawn out procedure, and that there are measurable benefits even when this treatment is not comprehensive at the outset and involves less than optimal doses.

1.3 THE PRESENT STUDY

The present study set out to investigate and describe the current situation of methadone treatment provision in the South Island in terms of waiting lists and transfers and subsequently propose ways of dealing more effectively with these problems.

CHAPTER 2
METHODOLOGY

In June of 2001 the Ministry of Health (MOH) commissioned the National Centre for Treatment Development (Alcohol, Drugs & Addiction) (NCTD) to examine clinical practice within the six methadone treatment programmes in the South Island. These programmes are in the following districts from north to south: Nelson, West Coast, Christchurch, Timaru, Dunedin, Invercargill.

The NCTD team consisted of Ms Meg Harvey – Junior Research Fellow, Associate Professor Doug Sellman – Director, and Ms Daryle Deering – Lecturer.

Phase One comprised the following:

- A comparison of referral and access criteria to treatment across the districts;
- Assessing current practice on managing waiting lists across the districts; and
- Assessing transferring clients between districts and/or regions.

Phase Two consisted of:
Making recommendations on establishing consistency for the three aspects of service functioning examined in Phase One. One possibility suggested by the funder at the outset was the development of a flexible funding pool being held at a regional level to create a 'transfer fund' and/or alleviate some of the other pressure points.

Phase One work began with consultation to develop a questionnaire in order to survey the six methadone treatment programmes in the South Island. The study team consulted with David Benton, Tauranga, Chairperson of the National Association of Opioid Treatment Providers (NAOTP) and Drs Murray Hunt, Waikato and Lee Nixon, Nelson, who had previously provided NAOTP with information and discussion documents related to the project terms of reference.

After this consultation and a review of the relevant literature (see Appendix I) two interview schedules were produced, one for programme clinicians and one for pharmacists (see Appendix II). These schedules were then presented as a check, to methadone managers and caseworkers attending the Cutting Edge 2001 conference in Napier in September.

Meg Harvey subsequently contacted all the relevant services and conducted interviews. The services were sent a copy of the interview questions prior to meeting to aid in collecting accurate data. The Nelson and West Coast interviews were conducted by telephone, while the Christchurch, Timaru, Dunedin and Invercargill interviews were completed as face to face interviews. Where possible, managers, co-ordinators and medical officers were all interviewed.

Doug Sellman conducted a series of telephone interviews with the lead pharmacies in all the South Island districts being surveyed, identified by the relevant clinical staff; three in Christchurch, two in Dunedin and one in each of the other districts.

CHAPTER 3
FINDINGS

3.1 REFERRAL AND ACCESS CRITERIA TO TREATMENT ACROSS THE DISTRICTS

3.1.1 Admission criteria

All six methadone treatment services in the South Island require evidence of a DSMIV diagnosis of opioid dependence before entry to methadone treatment. The Christchurch service also requires evidence of 12 months of continued daily use of opioids. Most services require the client to be over 18 years of age, although patients as young as 16 have been admitted in Invercargill. There is a small dedicated adolescent service in Christchurch which has admitted patients as young as 15 to methadone treatment.

3.1.2 Waiting list numbers

- Nelson 26
- West Coast 5
- Christchurch 110
- Timaru 0 (but running over contracted numbers)
- Dunedin 37
- Invercargill 3 (but running over contracted numbers)

3.1.3 Additional numbers of people waiting but not formally on the waiting list

All services found this very difficult to estimate. It was considered that many on the waiting list are ambivalent about methadone treatment and use the waiting list as an excuse to not contact the service. Dunedin and Nelson thought between 50 and 100 people may be informally waiting. Invercargill estimated very few, while Timaru and West Coast reported none (no current formal waiting list). Christchurch estimated between 40 and 400, while noting very few who make face to face contact with the service and hear what the length of the waiting list is, subsequently turn down the invitation to go on the list.

3.1.4 Estimated waiting time for the last three people admitted (months)

- Nelson 7-10
- West Coast 1
- Christchurch 9
- Timaru <1 (20 days) (but running over contracted numbers)
- Dunedin 4.5-8.5
- Invercargill 1-3

Services were also asked whether they thought the next three people admitted would have to wait for similar amounts of time to the last three. Dunedin and Nelson said the waiting time was not likely to be different. Invercargill said their last three places were special cases so the next wait will be longer, probably three months. West Coast and Timaru are both already over their contracted placement numbers and anticipate a longer wait. Invercargill has only had a waiting list for the last four or five months and have not had to deal with this issue before. Christchurch said that waiting times would be longer in the future, possibly ten or eleven months, because they were now adopting a more liberal approach to the programme so people are likely to be treated for longer periods of time.

3.2 CURRENT PRACTICE ON MANAGING WAITING LISTS ACROSS THE DISTRICTS

When asked in general terms how services manage their waiting list, most services reported they first provide people presenting to the service for help with their opioid problems, a full assessment, including relevant laboratory work up. This assessment varies both across districts as well as within services, between one and ten hours. A report is not always completed, although in Christchurch the referrer automatically gets a copy.

Clinicians then outline, if necessary, the length of the waiting list and talk with them about potential options to methadone treatment, such as residential treatment and/or detoxification. If methadone treatment is still opted for, they are then put on the waiting list and expected to maintain regular contact with the service, which varies between weekly and monthly. Communication is through regular visits and while not discouraging phone calls, they generally do not encourage them either. As Dunedin noted, it seems cruel to tell someone on

the waiting list, “ring me again next week for some more bad news”. In Christchurch those on the waiting list are case managed by counsellors while on the waiting list.

3.2.1 Movement on the waiting list

Unanimously across all services, pregnant or HIV positive clients or those with life threatening illness are moved up the waiting list. Timaru also gives consideration to family situations, such as solo mothers or if a partner is already on programme. Invercargill also gives some priority to people with a partner on the programme. West Coast reported that their waiting list is not chronological but that clients who are pregnant, HIV positive, Hep C positive, or single parents go first, which means the average uncomplicated male client is usually last on the list.

Unanimously across districts, people are not actively moved down or off the list, once placed, unless they lose contact with the service or go to prison.

3.2.2 Risk assessment

All services said that a risk assessment is always completed, generally as part of the overall assessment. Nelson, Christchurch, Timaru and Invercargill use standard assessment schedules. Dunedin are about to start using new forms Healthcare Otago are trialing = a worksheet with history + contingency plan + a sheet with concerns raised by significant others.

3.2.3 Authorisation of GPs to prescribe opioids to people on waiting list

No services reported they were engaged in this strategy. Further, there appeared to be limited numbers of GPs involved in any prescribing. Data collected from pharmacists showed the following percentages of their clients being prescribed methadone by a local GP.

Nelson	7%
West Coast	35%
ChCh (New Brighton)	14%
ChCh (Aranui)	13%
ChCh (Bacons)	14%
Timaru	24%
Dunedin (Knox)	15%
Dunedin (Green)	20%
Invercargill	0%

It is interesting to note that (except for Invercargill) the three regions with the longest waiting lists (Nelson, Christchurch and Dunedin) are also the three regions with the smallest percentage of GP prescriptions being dispensed in their lead methadone dispensing pharmacies.

3.2.4 Suggestions on how to reduce waiting lists

All services suggested that more money and more clinicians for the current service is needed. Only half the services volunteered greater use of local GPs as a strategy. One service suggested that FTE funding may be more accurately predictive of workload rather than placement funding.

3.3 CLIENTS TRANSFERRING BETWEEN DISTRICTS AND/OR REGIONS

3.3.1 Number on current waiting list who are transfers from elsewhere

- Nelson 17
- West Coast 1
- Christchurch 10
- Timaru 0
- Dunedin 3
- Invercargill 1

Several services maintain a transfer list, separate from the waiting list. The logic behind this is that people transferring are already on methadone and therefore are of lower priority. Unanimously, no services give transferred people priority on their waiting lists. This raises issues as to what happens when the out of region provision of a methadone prescription by the original service finishes for a client, and they are not yet admitted to the new service.

Services were asked, how many additional places would be required to meet current transfer needs. This varied according to the numbers currently on the waiting list in this position. One service said however that the only way to deal with this problem is to first deal with their considerable local waiting list.

3.3.2 Number of clients currently on programme wanting to transfer elsewhere

Very few were identified overall, even in the larger services (range 2-6 per service, South Island total = 21).

3.3.3 Number of clients who were transferred elsewhere in the past 12 months

This was surveyed in terms of both formal transfers ie pre-arranged transfers organised between the two services involved, and informal self-transfer. Very few formal transfers occurred (range = 1-5 per service, South Island total = 22). The number of informal self-transfers were estimated to be even lower (range = 0-10 per service, South Island total = 16)

3.3.4 Procedure of formal transfer

Most services gather notes, contact the other service, send notes and ask the client to contact the other service as well. Most will provide a methadone prescription for up to 3 months out of region, with monthly visits to the prescribing service. Some will provide out of region prescribing for up to 6 months and one service said it would do this indefinitely if necessary.

An optimal situation is where there is a possibility of a direct swap with another service. Nelson has a particular difficulty with this because many people appear to want to move there and no one wants to leave. Timaru requires other services to undertake random urine collections on their clients who are being provided a methadone prescription out of region.

In terms of transfer problems, these were largely voiced in terms of communication and co-operation difficulties between services (usually with those in the North Island). The length of other services' waiting lists was mentioned as a significant problem. Conflict between the two services can leave both the client and the service at risk, the former in terms of ongoing medication supply and stability, the latter in terms of responsibility and accountability.

3.3.5 Number of clients in the region who are being prescribed for from elsewhere

Two sets of data were collected to gain an impression of the extent of this current practice. Firstly services were asked to simply estimate the number, which are outlined below.

Nelson	20-30
West Coast	2
Timaru	unable to estimate, although "always surprising how many there are"

Christchurch	20- 30
Dunedin	3-4
Invercargill	3-4

Secondly, the lead pharmacies in each district were asked for their total dispensing numbers and then the numbers who were being prescribed out of region. From these numbers a percentage was calculated, outlined below.

Nelson	7%
West Coast	17%
ChCh (New Brighton)	4%
ChCh (Aranui)	0%
ChCh (Bacons)	4%
Timaru	0%
Dunedin (Knox)	10%
Dunedin (Green)	10%
Invercargill	0%

3.3.6 Experiences with out of region prescribing

Both methadone clinics' and pharmacists' experiences are documented below.

1. Clinics

Few problems were perceived overall. Problems when they did occur, were usually to do with change of dose or the takeaway arrangements, particularly if the elsewhere prescribing service has a different regime to the local one. Concern was expressed by one service about the lack of control and supervision of clients who are being provided a methadone prescription from elsewhere. There were safety concerns in terms of unsupervised out of region prescriptions particularly in terms of clients using alcohol and benzodiazepines, putting themselves at risk of overdosing. Several services outlined the difficulty of developing a therapeutic relationship with a client who is continuing to be provided a methadone prescription from elsewhere. Tales of takeaways being sold were also mentioned. However, the majority of clients being prescribed for from elsewhere were reported to be stable and posing no problems for the local service. One service pointed out that in some ways the difficulty for clients transferring to other regions or districts, which is largely to do with other services' waiting lists, is a lot like Home Detention as they are "imprisoned" in the area.

2. Pharmacists

When pharmacists were first asked what problems they encounter providing a methadone dispensing service, none identified out of region clients as a problem. When asked specifically about these clients, few real problems were those mentioned were similar across regions. A specific problem identified by several pharmacists was clients demanding to be taken on in the new region immediately, not wanting to wait to join the new service and being intolerant of having to. Communication with counsellors from the prescribing out of region clinic can be difficult at times. One pharmacist noted that problems seemed to depend on which out of region service the client was with.

Out or region arrangements ranged from 3-4 days for those just visiting another region temporarily up to about 3 months for those waiting to go onto the new service. One pharmacy in Christchurch thought clients being prescribed for out of region may be slightly less stable, but pointed out they are probably a more transient population anyway. Everyone else said out of region clients were no less stable than local service clients.

Generally no significant differences were noticed in methadone dose for out of region clients, except for one where the local service seemed to provide higher doses. The most common point of difference was in there being more liberal takeaway regimes in out of region prescriptions, particularly from North Island services.

3.3.7 Suggestions on how to better manage transfers

In fact, this was not considered a particularly important issue compared with the issue of long waiting lists, particularly in Nelson, Christchurch and Dunedin. Various suggestions were as follows:

- a national computerized database of opioid substitution clients including photographs would promote better communication between services;
- better service reciprocation in terms of transfers could be achieved if there was a South Island regional agreement for the provision of methadone treatment;
- establishing a part-time national co-ordinator of transfers (with every service contributing to costs). This co-ordinator would hold a budget, which would assist with funding each transfer to the new region for 12 months, by which time it was thought they should be well and truly settled with the new service.
- a person's funding to go with them from service to service, although there was recognition of the problems this would create in terms of staffing.

- there would be no problem with transfers if there was no waiting list
- establishing various streams within services; for example, a dosing stream with minimal case management versus one with a more intensive case management component
- more places to be funded, not just more money to the service

3.4 GENERAL COMMENTS RELATED TO IMPROVING METHADONE TREATMENT SERVICES IN THE SOUTH ISLAND

Both methadone clinics and pharmacists comments are documented below.

1. Clinics

- Concern was expressed that money could just end up being thrown at the problem – is it a bottomless pit? A very clear plan needs to be formulated before any new money is used new staff taken on.
- There may be some benefits of running a waiting list to prevent some clients abusing the service.
- Smaller services have less capacity to absorb increased numbers of clients, including transferring clients.
- There is a lack of community pharmacies willing to cooperate in some districts, which means that even if they wanted to take on more people than contracted, they can't.
- There seem to be different models of practice based on different interpretations of and adherence to the Protocols.
- There is recognition that some services are not "popular" because they "stick strictly to the Protocols". Cases of clients wanting to transfer "to get onto a slacker programme" were mentioned.
- Rural people pose special problems in terms of them often being car-less and there is a general lack of pharmacists to dispense to them. There is at times considerable goodwill being given by health professional not formally associated with the programme eg practice nurses who go out of their way to dispense methadone to isolated people. These professionals are not being paid at present due to limitations in service budgets.
- One service wanted to see addiction more accepted and less stigmatised, which they thought would aid clients in coming off methadone. They wanted to see a change in policy to make coming off the programme with service support more acceptable and therefore lessen the emphasis on methadone as maintenance.

- Scepticism about the value of research was expressed rather strongly by one service. They said they wouldn't waste the money on research, as that would just reach the conclusion they all knew anyway and waste money getting there.
- Research was considered to be important by another in identifying specific programmes with different combinations of treatments for opioid dependent people rather than having one homogenous programme for everyone.
- Some services seem better than others at marketing themselves as a "good service". Auckland was mentioned in this regard.
- One service (Timaru), which has taken on more clients than contracted, said that if they didn't their waiting list could be as high as 18 months. They go over their placements because they are not willing to take responsibility for the health or criminal activity of someone on a waiting list for a year. They pointed out that it is a matter of numbers vs. burden (stable = ¼ hour, unstable = ½ day). If there are stressed staff with a huge waiting list they point out this will contribute to the high mobility in A&D staff and reduce recruitment and retention of staff.
- Workload could be eased by changing the prescribing requirements of methadone from a Class A controlled drug to B or C, in that this would ease up the time taken in making changes to regimes which currently require so much paper work.
- Although some services are strongly in favour of transferring stabilized clients to GPs their ability to do this is limited by resistant and uncooperative GPs.
- A limiting factor in GPs' involvement seems to be money – these are not viewed as attractive general practice patients. Also there are currently financial disincentives for patients to transfer to GP care.
- GPs are generally considered not good on counselling.
- A residential programme should be set up to assists clients in skills training as well as helping them understand better the concept of addiction. This facility should be available for both going on, as well as off, methadone.
- Half of the people on the waiting list have been on the programme before and it can take up to 2-3 times for a client to work out how the programme best works for them.

2. Pharmacists

- Methadone treatment is a complex area, which is nevertheless working well - good working relationship with the local service.
- Methadone treatment is "liquid handcuffs" but this should be seen as a plus as it gives people an incentive to get off methadone.

- Is there a safe long acting methadone or an implant of some description?
- More urinary drug screening should be done.
- Most clients seem to be gradually reducing their dose and so that's good.
- If they are firm, but polite and treat the clients as normal human beings then everything goes smoothly. Wonders if counsellors are sometimes too flexible, especially in terms of takeaway doses.
- A positive attitude and relationships with methadone clients is essentially (recently received flowers from a client). Good to see clients resuming work and so was happy to get to the pharmacy early so they could get their methadone before work.
- While cost of medication ingredients has gone up, funding has not.
- Remuneration to pharmacists should go up. Not always recognized the amount of background work in preparation and documentation as well as the daily dispensing and monitoring that goes on.
- Should clients be allowed to just go off to the Coast or Golden Bay if they feel like it, when there are better job opportunities in the city.
- Methadone should have higher priority in the health scheme, as it is currently under-funded and under-staffed.
- Pharmacists' daily monitoring role and their academic qualifications are not always recognised.
- How qualified and experienced are drug counsellors to have that much power over people's lives?
- Would be good to have regional meetings of all the professionals involved in methadone (2-3 times a year) and also an annual national conference, which includes pharmacists (on a weekend).

3.5 COMMENTS RELATED TO TRAINING

These two sets of comments are distilled from the clinic and pharmacist interviews respectively.

1. Clinics

Nelson, Timaru, Christchurch and Dunedin do, or are about to, conduct GP methadone training co-ordinated from the Goodfellow Unit in Auckland. Invercargill used to but only pharmacists turned up and it was not well attended. Dunedin tries to get practice nurses along

to the Goodfellow Unit course as well. Timaru have found a lot of resistance to methadone training amongst their GPs. In Nelson they do a half-day training course with district nurses.

Thus training is largely through Goodfellow and informal meetings. Christchurch also holds training evenings for GPs and practice nurses and pharmacists. They have developed a close working liaison with the Pegasus medical group.

In terms of the main gaps in training, the most common comment was the lack of knowledge of methadone treatment by other health professionals including mental health professionals. Nelson thought a practice manual for new clinicians is needed. Timaru felt there was a need for recognised trainers and that medical and nursing students needed an increased overall A&D input. Christchurch felt specialised methadone training was lacking everywhere. Some Christchurch staff were aware of postgraduate papers available to staff but considered them relatively inaccessible because of the undergraduate requirements and cost.

2. Pharmacists

Very little formal training about methadone treatment has been provided for pharmacists. In fact virtually all of these lead pharmacists surveyed had had no formal methadone treatment training. However the majority were tutors for the Goodfellow Unit training programme. Further, there did not appear to be a huge desire for any further specific training and certainly did not think postgraduate qualifications should be compulsory. The possibility of face to face networking and being involved in some form of distance learning appealed to many. The majority would want this to be with other health professionals (GPs/practice nurses/clinic staff), although there was also interest in training with other pharmacists only.

CHAPTER 4
CONCLUSIONS

4.1 LITERATURE

- The literature clearly demonstrates the short- and longer-term benefits of placing people with opioid dependence on methadone as soon as it is indicated. This induction should be rapid rather than a drawn out procedure, and that there are measurable benefits even when this treatment is not comprehensive at the outset and involves less than optimal doses.

4.2 REFERRAL AND ACCESS CRITERIA TO TREATMENT ACROSS THE DISTRICTS

- Waiting list times vary considerably across the six methadone treatment programmes in the South Island from no more than several months in Timaru, West Coast and Invercargill to around nine months in Nelson, Christchurch and Dunedin.

4.3 CURRENT PRACTICE ON MANAGING WAITING LISTS ACROSS THE DISTRICTS

- Comprehensive assessment including a specific risk assessment of all patients who come onto methadone waiting lists, seems the rule for all six programmes in the South Island.

- Patients who are pregnant, HIV+ve, or have life threatening illness are unanimously given higher priority on waiting lists, and once placed there is no active moving down of people on the list except when contact with the service is lost or the patient is sent to prison.

- No services currently authorise GPs to prescribe interim methadone to people on the waiting list.

4.4 CLIENTS TRANSFERRING BETWEEN DISTRICTS AND/OR REGIONS

- The issue of transfers appears to be of far less importance than the issue of waiting lists. In fact, the issue of transfers appears to be driven primarily by the issues of long waiting lists.

- The reason why there have been more complaints received about transfers rather than waiting lists is that people wanting to transfer are already undertaking methadone treatment and therefore more stable and in a better position to lay complaints. This is in contrast with people on waiting lists who are generally more preoccupied by the exigencies of their opioid dependence.

- As long as adequate communication with the prescribing clinic is had at the outset and then continued during treatment, pharmacists experience no special difficulties dispensing methadone to patients who receive their methadone prescription out of region. They do not report any significant differences in stability of out of region patients.

4.5 TRAINING ISSUES

- There is generally good liaison, both day to day as well as intermittent formal face to face liaison meetings, between pharmacists and clinics in all regions and these activities appear to be viewed as the mainstay of training for both sets of professionals.

- There is generally a lack of motivation amongst staff to undertake postgraduate training both within the specialist methadone clinics as well as amongst pharmacists in the South Island.

- The Goodfellow Unit national training course is generally valued, particularly for its facilitation of networking between the various professionals involved in methadone treatment provision.

CHAPTER 5
RECOMMENDATIONS

5.1 PRIMARY RECOMMENDATION

The primary recommendation of this report is for funders, managers and providers of alcohol and drug services to recognise and respond to, the serious crisis that exists in at least half of the South Island's methadone programmes. These are the largest programmes, in Nelson, Christchurch and Dunedin. The serious crisis is the existence of current waiting lists requiring acutely ill opioid dependent patients, to wait for methadone treatment for around nine months.

In making this recommendation, it is suggested that the current intolerable situation is one that funders, managers and providers, appear to have grown somewhat accustomed to, perhaps numbed by. It is suggested, however, that continuing this intolerable situation is analogous to maintaining a nine-month waiting list for acute tuberculosis, a similarly life-threatening, personally and socially damaging and infectious disorder. Apart from apathy, the situation is perhaps being perpetuated by a moral position being taken from which opioid dependent patients are considered an essentially undeserving category of people because of perceptions that they brought their suffering on themselves and don't deserve more adequate service. Further, because in New Zealand, opioid dependent patients have very little choice in terms of dealing with their problems and there are very high retention rates in methadone treatment as a result, provider complacency is a likely to be a further contributing factor to perpetuating the status quo of long waiting lists.

5.2 IMMEDIATE GOAL

It is proposed that an immediate goal be set, to reduce waiting lists to less than one month as currently exists in only one programme (Timaru).

5.3 SUGGESTIONS INVOLVING NO INCREASE IN FUNDING

Suggestions as to how this goal, of reducing waiting lists to less than one month, could be achieved, albeit with some considerable effort and a degree of altruism on the part of the existing workforce, with no increase in funding are as follows:

1. That specialist methadone programmes be freed up to treat more patients if they determine they are able to with the resources available, rather than be tied to a specific contracted number of placements.

2. That specialist methadone programmes be encouraged to further develop treatment streams within their overall service, one of which would be a low intensity stream. In this stream, patients could choose to receive methadone only, without either additional counselling or intensive clinical case management. All patients choosing this low intensity option would be encouraged to receive this through their GP on authorisation from the clinic, thereby freeing up places at the clinic.

3. That all patients on regional waiting lists be offered the choice of receiving interim, low dose, low intensity, methadone treatment (up to 40mg), through their GP on authorisation from the clinic, thereby reducing the waiting lists to more acceptable lengths ie less than one month.

4. That protocols for these low intensity options be developed by the National Association of Opioid Treatment Providers (NAOTP) with GP, pharmacist and consumer input.

5. That one or several pilot projects of interim low intensity treatment be undertaken as a first step, in consultation with NAOTP as a reference group.

NB If these recommendations were acted upon, there could likely develop a waiting list for comprehensive or high intensity treatment. The differentiating features between low intensity and high intensity treatment would be:

- low standardised dose (<40mg) vs an individualised (normally >60mg) dose;
- no takeaway doses vs an individualised takeaway regime;
- no formal psychosocial treatment apart from periodic contact with pharmacist (daily) and GP (monthly) vs the presence of additional counselling and individualised clinical case management.

5.4 SUGGESTIONS INVOLVING AN INCREASE IN FUNDING

Suggestions as to how this goal, of reducing waiting lists to less than one month, could be achieved without relying solely on altruism and increased effort by an already stressed and in some instances severely demoralised workforce, are as follows:

1. Ensure that staff working in specialist methadone programmes are fairly remunerated for their clinical work in relation to other mental health professionals who are engaged in the active clinical case management of similarly complex and difficult cases.

2. Ensure that pharmacists who provide a community dispensing service remain properly remunerated for their work.

3. Provide appropriate remuneration to GPs who are willing to be authorised to treat people from either the programme or the waiting list who choose low intensity options.

4. Provide appropriate remuneration to GPs who are willing to be authorised to also treat people from either the programme or the waiting list who choose more than an interim methadone prescription option, where the GP and the specialist clinic agree on the parameters for this work.

5. Provide funding for the majority of staff (clinic and pharmacist) to attend at least one national treatment conference per year, which includes opioid substitution treatment content.

6. Provide incentive funding for staff (clinic and pharmacist) to undertake postgraduate training in addiction including opioid dependence and its treatment including pharmacotherapy.

7. Provide funding for additional innovative research and development projects aimed at reducing methadone treatment waiting lists.

5.5 OTHER SUGGESTIONS NOT DIRECTLY RELATED TO THE SUGGESTED IMMEDIATE GOAL

1. Consider establishing a South Island register and minimum data set of people being admitted to methadone treatment, in order to: gain an accurate profile of the patients; establish and monitor waiting times for treatment; track changes in waiting times for treatment; and, establish a baseline for an outcome measurement system. This work would need to be undertaken in close consultation with relevant stakeholders and experts.

2. Consider establishing an interim South Island co-ordinator through the South Island Shared Services Agency Ltd (SISSAL) who could manage transfers between the various regions as a temporary measure while waiting lists are being reduced. This co-ordinator would need a budget, perhaps contributed to proportionally by each service, which could fund people transferring to a new locality for up to 12 months. This person could also be given responsibilities for establishing the South Island register and minimum data set.

3. Consider establishing a central clinical advisory service, which all clinicians could get advice on the assessment and management of difficult patients and difficult clinical situations.

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APPENDIX I

INTERVIEW QUESTIONNAIRES

SOUTH ISLAND METHADONE TREATMENT SERVICE PROJECT INTERVIEW

National Centre for Treatment Development (Alcohol, Drugs and Addiction)

Questions for Manager and Senior Medical Officer in the region

For some of the questions the precise answer may be very difficult to access. A "best guess" would be greatly appreciated. (Mark as "best guess")

1. What are your criteria for admitting a person to your methadone programme?

2. How many people do you currently have on your waiting list?

3. How many further people in your region do you estimate are waiting for methadone, but because of the waiting list are reluctant to make contact with your service?

4. What was the average time the last three people admitted to your methadone programme had to wait to be admitted?

5. Is the waiting time likely to be any different for the next three people? If so, what is the average time you expect they will have to wait?

6. How many of those on the waiting list are people transferring from another region?

7. How do you manage your waiting list?

8. How do you communicate with people on the waiting list? e.g. to keep them informed of any changes.

9. Do you move people up the list for any reason? Explain

10. Do you have high priority people/groups to whom you give immediate access/admission? Explain.

11. Do you move people down the list for any reason? Explain

12. When do you take people off your waiting list?

13. Do you assess people before they go onto the waiting list? If so, how long does this assessment typically take to complete?

14. Is a written report of this assessment routinely sent to the person's GP and/or other health professionals?

15. Do you assess people's risk of harm to themselves or others as part of this assessment? Explain your procedure.

16. Once a person is placed on your waiting list, do you consider them as patients of your overall service? (in the sense of taking responsibility for their ongoing care despite their lack of access to a methadone prescription)

17. How often are people on your waiting list scheduled for a face to face follow-up review by your service?

18. Do you see people face to face for other than pre-scheduled follow-up reviews?

19. Do you encourage or discourage telephone calls from people on your waiting list? Explain

20. Do you ever authorise local GP's to prescribe opioids for people on your waiting list? If so, what opioids? If so, how many have your service authorised in the past 12 months?

21. How many people on your programme are currently wanting to transfer to another region?

22. How many people did you formally transfer to another region in the past 12 months? (formal in the sense of pre-arranged organised transfer in which consultation between services occurred BEFORE the transfer occurred)

23. How many people transferred themselves to another region in the past 12 months?

24. What is your procedure for transferring people?

25. Do you have a policy of exchange/swapping people with other regions? Explain.

26. What problems do you experience with transferring people?

27. Do you give transferring people priority on your waiting list? Explain.

28. What is your procedure for accepting transfers from other regions?

29. How many people in your region do you estimate are being prescribed for by a service/doctor in another region?

30. How many people are you currently monitoring or supervising in your service and yet they are currently being prescribed for by a service/doctor in another region?

31. What problems do you experience with these people?

32. How many additional placements for MMT do you think would need to be funded immediately to meet current transfers in your region?

33. What are your protocols for prescribing for people who have transferred out of your region? (any restriction on dose/takeaway arrangements/monitoring by local service/how long for)

34. Do you have any ideas about how your waiting list could be reduced?

35. Do you have any ideas about how transfers to and from your region could be better managed?

36. If there was money available to help with better access for people to methadone treatment in your region, how would you use it?

37. Which is the main pharmacy(s) that dispenses methadone in your region? (Name and contact details)

38. How do you liase with GPs/practice nurses/pharmacists in your region?

39. Do you provide any training for GPs/practice nurses/pharmacists in your region?

40. What are the main gaps you see in methadone treatment training for your region?

41. Do you have any final comments?

SOUTH ISLAND METHADONE TREATMENT SERVICE PROJECT INTERVIEW

National Centre for Treatment Development (Alcohol, Drugs and Addiction)

Questionnaire for the Main Pharmacist in the Region

For some of the questions the precise answer may be very difficult to access. A "best guess" would be greatly appreciated. (Mark as "best guess")

1. How many patients are you currently dispensing methadone to as treatment for opioid dependence?

2. Do you experience any particular problems with methadone maintenance? Explain.

3. How many are being prescribed by a doctor working in the local Methadone Treatment Programme?

4. How many are being prescribed by a local GP?

5. How many are being prescribed by a Methadone Treatment Service or other doctor in another region?

6. Do you experience any particular problems dispensing to these out of region patients?

7. Of those prescribed out of region, in your experience how long do these arrangements normally last?

8. Of those prescribed out of region, do you notice any differences in the general stability of these patients compared with those prescribed by the local Service or a local GP?

9. Of those prescribed out of region, do you notice any significant differences in dose, takeaway arrangements or anything else about the prescriptions?

10. Do you have formal liaison with your local Methadone Treatment Service? Explain.

11. What training/professional development have you been provided with or undertaken on methadone treatment and service delivery?

12. Do you feel you would benefit from any specific training? e.g. workshops/seminars, post graduate papers, distance learning modules

13. If you did undertake further training would you prefer it to be with other pharmacists or in conjunction with others e.g. GPs/pharmacists/ practice nurses?

14. Do you have any final comments?