Drug and Alcohol REVIEW
APSAD
Drug and Alcohol Review (2022)
DOI: 10.1111/dar.13439

COMMENTARY

Commentary on 'Opioid agonist treatment and patient outcomes during the COVID-19 pandemic in south east Sydney, Australia'

Lintzeris *et al.* [1] provide the first analysis of changes to opioid agonist treatment (OAT) programs and patient outcomes in response to COVID-19 in New South Wales (NSW). We commend the authors for undertaking the analysis, especially considering the additional challenges involved in offering complex care to people with opioid use disorder during the COVID-19 pandemic.

The findings were generally positive [1]. The number of people receiving six or more takeaway doses (TAD) a week increased from 6% in March 2020 to 31% following COVID-19-related service delivery changes, with no major adverse outcomes for recipients. In fact, increased rates of alcohol or other drug use over the study period may have been related to more frequent supervised dispensing. The lack of adverse outcomes associated with increased TADs will likely resonate with the experience of many people enrolled in OAT. However, we feel that there is one major implication that is not sufficiently addressed in this paper, that is, the cost to consumers associated with community pharmacy dosing may be prohibitive and limit a person's ability to access treatment and these costs remain despite the changes to service delivery.

The OAT service delivery model in NSW consists of a mixture of limited, no-cost programs available through public clinics, and fees-based programs via either private clinics or general practitioners and community pharmacy dispensing [2]. The current model requires consumers at public clinics to attend for daily dispensing of methadone or buprenorphine, while consumers at pharmacies and private services generally receive at least one TAD each week after a period of stabilisation. Current NSW guidelines recommend to limit consumers to four methadone TADs per week or 28 buprenorphine TADs per month [2]. Weekly and monthly depot injections of buprenorphine have recently become available in Australia, although most patients remain on oral OAT.

Lintzeris *et al.* [1] found that the number of patients transferred from (free public) clinic dispensary to private community pharmacy for dispensing during the COVID-19 pandemic increased from 25% to 49%, almost doubling the number of people attending pharmacies. This shift to the private system could have profound impacts on the finances of clients. The study period ran until September 2020, a period in which unemployment benefits were exceptionally and temporarily raised (approximately doubled) in response to the pandemic. This temporary change lifted many out of poverty as the pre-COVID unemployment benefit rate in Australia was below the poverty line, at about $560 per fortnight [3]. Other income support such as the Disability Support Pension, which some OAT clients receive, is not significantly higher with 41% of Disability Support Pension recipients in 2017–2018 reported as experiencing poverty [3]. Although ultimately unemployment benefits have been raised by $40 per week from pre-COVID levels, it is generally agreed that this amount is insufficient, particularly for those who are required to pay fees for pharmacy-based OAT dispensing. We agree with Lintzeris *et al.* that ongoing evaluation of the COVID-related impacts on clients is needed in this shifting financial environment [4,5].

Retention rates in OAT depend on a number of factors but affordability is a central reason for low-income people leaving OAT [6,7]. The cost has always proved a major barrier to OAT treatment for consumers in Australia [8]. As indicated, the program in NSW includes a limited number of free places provided through public clinics but average fees associated with private dispensing range from $134.82 to $354.70 per month in NSW (or up to $4256.40 per year) [9]. These fees are a significant financial burden for clients, particularly as the best outcomes for OAT consumers appear after long-term treatment, over months to years [10]. One Australian study indicated high levels of personal debt among people attending OAT programs [9]. The resulting poverty makes it hard for consumers to make the changes they would like to make in their lives, as well as meet the requirements of the OAT program [11–13]. A range of adverse events may ensue if a

Received 19 January 2022; accepted for publication 19 January 2022.

consumer misses a dose and experiences withdrawal, such as using other opioids such as heroin or contracting a blood-borne virus if the person cannot access clean injecting equipment [14,15]. Notably, the risk of overdose is highest when ceasing OAT, signifying the importance of retention in treatment [16].

There is an expectation from some quarters that consumers at a public program ought to move on to private clinic or pharmacy once they have stabilised, in order to make place for people entering the program [17]. This expectation ignores the fact that consumers may want to move to pharmacy-based dispensing and have access to TADs, but it is not always possible for those of limited incomes who may be living in poverty. Access to TADs leads to a range of benefits, including reduced travel time, potentially better protection of confidentiality, as well as less tangible gains related to feelings of 'normality' and having flexibility in daily life patterns [13]. In the UK, services that offer flexibility and allow people to self-regulate their doses, have significantly helped their consumers move towards achieving their goals [18]. The restricted provision of TADs has the potential to reduce personal autonomy as a result of a person's socioeconomic status. The decision to provide clients with TADs should be based on clinical indication and client goals. However, the utilisation of TADs in NSW often appears to be based on a consumer's ability to pay. One simple way to address this issue would be to shift our models of care to allow public clinics to provide TADs. This is not to say that there is anything inherently wrong with private institutions like community pharmacies charging for services, but the anomaly of direct payment of OAT dispensing fees (unlike other medications) for clients who often experience poverty means that more needs to be done to ensure that these more vulnerable clients have equitable access to services without the pressure to move to a user-pays service.

Lintzeris *et al.* [1] propose a departure from a model of care based on supervised dispensing, something that Australian OAT consumers have been suggesting for some time [19]. Unlike other countries, the OAT program in Australia is heavily reliant upon supervised daily dispensing. But the NSW OAT Clinical Guidelines also state that supervised daily dispensing is 'intrusive and not compatible with community reintegration through activities such as work or study' [20]. Daily dispensing provides little flexibility, as one OAT consumer said, 'It is not normal to have come to a clinic every day' [12].

Lintzeris *et al.*'s [1] analysis supports the safe provision of six or more TADs a week as no adverse events were recorded, and we agree with their conclusion that the existing risk assessment process is working well, although the review does not specify whether TADs were being supplied through community pharmacy or public clinics. But the framework to assess the appropriateness of providing TADs should also include a financial assessment to ascertain whether consumers can afford the fees associated with pharmacy-based dispensing, particularly, in the context of the reduction in unemployment benefits at the start of 2021.

Provided that ongoing reviews are carried out with consumers, and that consumers are aware of the reasons why their TADs might be reduced, there appears to be sufficient reason to allow multiple TADs each week via public clnics. There also needs to be more training and guidance around the provision of TADs as many clinicians are risk averse, for example, some believe that the NSW Clinical Guidelines are legislated [20]. Currently, OAT services in NSW are expected to bear the cost of increased patient numbers while receiving no functional increase to their funding by government. A number of calls have been made to increase funding of drug treatment services [19,21].

Australia's public health system is based on ensuring that health care is available free of charge to those in need. The OAT program caters for one of the most vulnerable groups of people in our society, yet they are expected to pay for their medication. While it is unfair to expect OAT programs to address structural inequality such as poverty, health service providers cannot ignore it either. Services should be modified to meet the needs of clients, including those without the financial freedom to pursue fee-based care.

Ultimately, TADs should be decided based on clinical assessment, and dispensing point should not be a factor. We acknowledge the important role that private clinics and community pharmacies play in the provision of OAT in NSW; however, most consumers cannot afford the associated fees, nor should people of limited means be expected to pay such large proportions of their income for medical treatment. This expectation reduces the ability of the most vulnerable clients to choose the best care for themselves, otherwise, we risk leaving them behind. Future research to assess the feasibility of expanded TAD programs must ensure questions around client ability to pay for TADs are included, and methods allow for those living under the poverty line to be represented.

We hope that the upcoming post-market review of OAT medications will result in them being protected by co-payments and the safety net, to provide parity with other medications provided under the Pharmaceutical Benefits Scheme [22]. However, we would argue that an entirely independent review of how the program is administered across Australia is required. In the meantime, we believe that public clinics in NSW should offer takeaways in accordance with the guidelines until such a

time that OAT products, and the people receiving them, are no longer stigmatised and treated differently.

Acknowledgement

We would like to thank Mary Harrod and Nadine Ezard for their assistance in preparing this commentary.

Maureen Steele[1] & Liam S. Acheson[1,2,3]
[1]Alcohol and Drug Service, St Vincent's Hospital Sydney, Sydney, Australia, [2]National Drug and Alcohol Research Centre, UNSW Sydney, Sydney, Australia, and [3]National Centre for Clinical Research on Emerging Drugs, UNSW Sydney, Sydney, Australia
Correspondence to: Ms Maureen Steele, Consumer Participation Worker, Alcohol and Drug Service, St Vincent's Hospital Sydney, 390 Victoria St, Darlinghurst, NSW 2010, Australia. E-mail: maureen.steele@svha.org.au

References

[1] Lintzeris N, Deacon RM, Hayes V *et al.* Opioid agonist treatment and patient outcomes during the COVID-19 pandemic in south East Sydney, Australia. Drug Alcohol Rev 2021. [Epub ahead of print].
[2] Fraser S, Valentine K. Substance and substitution: methadone subjects in liberal societies. London: Palgrave Macmillan, 2008.
[3] Davidson P, Saunders PG, Bradbury B, Wong M. Poverty in Australia 2018. ACOSS/UNSW poverty and inequality partnership report no.2. Sydney: ACOSS, 2018.
[4] Lines P. Australia, march quarter 2021. Melbourne, Australia: Melbourne Institute, The University of Melbourne, 2021.
[5] Grundoff M. Poverty and a reduced coronavirus supplement. Canberra, Australia: The Ausitalia Institute, 2020.
[6] Shepherd A, Perrella B, Hattingh HL. The impact of dispensing fees on compliance with opioid substitution therapy: a mixed methods study. Subst Abuse Treat Prev Policy 2014;9:32.
[7] Mattick RP, Ali R, Lintzeris N. Pharmacotherapies for the treatment of opioid dependence: efficacy, cost-effectiveness and implementation guidelines. London, UK: CRC Press, 2009.
[8] Lord S, Kelsall J, Kirwan A, King T. Opioid pharmacotherapy fees: a long-standing barrier to treatment entry and retention. Policy Brief 2014; 8:1–4. Centre for Research Excellence into Injecting Drug Use Available at: https://creidu.edu.au/policy_briefs_and_submissions/10-opioid-pharmacotherapy-fees-a-long-standing-barrier-to-treatment-entry-and-retention
[9] Tran AD, Chen R, Nielsen S *et al.* Economic analysis of out-of-pocket costs among people in opioid agonist treatment: a cross-sectional survey in three Australian jurisdictions. Int J Drug Policy 2022;99: 103472.
[10] Kleber HD. Pharmacologic treatments for opioid dependence: detoxification and maintenance options. Dialogues Clin Neurosci 2007;9: 455–70.
[11] Rowe J. A raw deal? Impact on the health of consumers relative to the cost of pharmacotherapy. Melbourne, Australia: The Salvation Army, 2008.
[12] Madden A, Lea T, Bath N, Winstock AR. Satisfaction guaranteed? What clients on methadone and buprenorphine think about their treatment. Drug Alcohol Rev 2008;27:671–8.
[13] Ryan J, Thomson N, Muhleisen P, Griffiths P. Chronic unfairness: equal treatment for addiction medicines? Melbourne. Australia: The Pennington Institute, 2015.
[14] Greenwald MK. Heroin craving and drug use in opioid-maintained volunteers: effects of methadone dose variations. Exp Clin Psychopharmacol 2002;10:39–46.
[15] Chalmers J, Ritter A, Heffernan M, McDonnell G. ANCD Research Paper 19. 2009; p. 64–66.
[16] Sordo L, Barrio G, Bravo MJ *et al.* Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ 2017;357:j1550.
[17] Letter to the Editor: Moving On and Paying Up. NSW Users & AIDS Association Users News no 97, 2021.
[18] Harris M, Rhodes T. Methadone diversion as a protective strategy: the harm reduction potential of 'generous constraints'. Int J Drug Policy 2013;24:e43–50.
[19] National Medication Assisted Treatment for Opioid Dependence (MATOD) Summit Report. In: Harm Reduction Australia and ScriptWise, 2018.
[20] Centre for Alcohol and Other Drugs. NSW clinical guidelines: treatment of opioid dependence. Sydney, Australia: NSW Department of Health, 2018.
[21] Hendrie D. Renewed calls to fully subsidise methadone treatment: Royal Australian College of General Practitioners (2019). Available at: https://www1.racgp.org.au/newsgp/clinical/renewed-calls-to-fully-subsidise-methadone-treatme (accessed December 2021)
[22] The Pharmaceutical Benefits Scheme: Australian Government Department of Health. Available at: https://www.pbs.gov.au/pbs/home (accessed January 2022).