



**From Rhetoric to Reality  
A comparison between UK and  
Australian Drugs policy and practice**

**APSAD 2004 - Fremantle**

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Illicit Drug Users League (AIVL)**

## **Slide 1**

**My name is Nicky Bath and I am currently employed by the Australian Injecting and Illicit Drug Users League (AIVL) as Policy Manager. AIVL is the national peak organisation representing the state and territory drug user organisations and issues of national significance for people who use and inject illicit drugs. AIVL is a peer-based organisation which means that it is run by and for people who inject and use illicit drugs.**

**Today, however I am going to share with you my past working experiences in the UK. I have been here in Australia, working with AIVL for four years. It was a dream of mine to pack up and move to Australia to work within what I had been led to believe was a progressive policy and practice environment. A dream that I was luckily able to achieve and I thank AIVL for taking the risk and bringing me over. I have attended the international harm reduction conferences since 1997 and it was at these conferences that I listened to amazing presentations evidencing harm reduction policy and practice here in Australia. I also read a great deal of research and reports that compounded what a great and amazing nation Australia is in relation to working with the issues of the use of illicit drugs. Australia is held by those in the sector as a country leaps and bounds ahead of us in the UK. For example; you have funded drug user organisations, fit bins in places we could only dream of having them and national strategies that the UK slowly follow.**

**However, when I moved here, it seemed to me that the picture that I and so many of us from the UK paint of Australia is misinformed. Sure there are the amazing initiatives, policy and practices however, for me it's not all great. What I found to be the real status quo for people who inject and use illicit drugs was a far cry away from the conference platforms.**

**I have for a while wanted to talk about this in the public domain and I thank the organisers of APSAD for giving me the time today. For the record, I have never received drug treatment I have been a provider, and my intentions here today are not to stand here and winge – but to demonstrate that overall things could be so much better for people**

receiving drug treatment. So what I hope to cover today very briefly indeed is :

- ❖ An overview of where I worked in the UK
- ❖ Community based drug treatment options
- ❖ Financial Costs
- ❖ Community Dispensing
- ❖ Holistic Care

## Slide 2

So then let's turn back the clock. From 1994 – 2000 I worked for an amazing and unique service call the Healthy Options Team which was warmly referred to as HOT. HOT is a user led harm reduction service based in an area of East London called Tower Hamlets. Tower Hamlets is the poorest area within England with the highest rates of unemployment and social deprivation. Part of the National Health Service, HOT provides a comprehensive low threshold, community based harm reduction service with specialist services for people who use drugs and are living with HIV and those that are homeless. HOT seeks strongly to work with people that are seen as “hard to reach” or the most disenfranchised section of east London's drug using community. Workers at HOT included current and ex users, clinical nurse specialists for primary health care and mental health and we also acted as a placement for social work students studying for degrees and master degrees.

At HOT, drug treatment was provided in partnership with local GPs and drug dependency units. Access to this service was via self referral, followed by an assessment which may or may not have been undertaken by a peer depending on who was on duty and the allocation of a prescriber and pharmacist. From point of referral to the actual receiving of the prescription could take from between a couple of hours to one week.

HOT case managed and worked with GPs to ensure that a person's drug treatment program was satisfactory for them. HOT considered the consumer to be the most important person in the development of a treatment program from what pharmacotherapy they wanted, amount needed and frequency of pick up from the pharmacy. It was not always plain sailing

and at times we could not always achieve what the consumer wanted however, we worked hard to make sure that the treatment a person was seeking was the most beneficial.

### **Slide Three**

While there are many differences as to how drug treatment is provided here and in the UK, what surprised me the most when I arrived was the absolute lack of pharmacotherapy options available, particularly for people dependent on opiates. The list on the screen shows you just what I and other workers at HOT were able to offer. This list is important for many reasons. We all know that one glove does not fit all and that is true in the treatment of drug dependence. The prescribing flexibility that we had was on reflection fantastic.

Not all of the pharmacotherapies were readily available or in high demand but, never the less they were on offer. You may be surprised to learn that a minority of people sought alternatives to methadone mixture. And that those that did had genuine and specific reason to do so. The label of indiscriminate drug seekers did not fit the majority of people seeking drug treatment at HOT. I must note that the limited heroin prescribing was indeed that and people at HOT receiving such prescriptions were usually much older and had been receiving these prescriptions for many years. However for people who were living with HIV and other complex health issues, there were specialist clinics in London that did provide this invaluable service.

Given the array of options then, I do not understand why this is not the case here in Australia. I cannot believe that until most recently, that all people were able to access was methadone mixture. I feel frustrated just standing here and saying it – for someone whose life depends on such treatment the frustration must be soul destroying.

At HOT we had such flexibility that to the best of our ability we were able to tailor treatment to individual need. For example we had people who wanted to reduce their injecting behaviour so accessed part oral and part injectable prescriptions, we had young people with short term small habits who wanted to detox. We were able to send them home

with a one to two week supply of Dihydrocodeine (along with family and HOT support and a carefully planned detox regimen).

Making changes to a prescription was easier too with requests to increase or decrease a persons dose being undertaken meaningfully and with ease. We did not have the situation that a person I know is being forced to go through here – increase in prescription is only 1 ml a week. I do not know of anyone who will benefit from an increase of only 1 ml per week. Such regimes mean that many people in this situation are left to manage their drug treatment programs through the illicit market. Drug treatment has clear goals – to reduce harms and to enable individuals to improve the quality of their lives. Lack of pharmacotherapy options and barriers to receiving effective treatment regimens makes reaching the broad goals of treatment near on impossible.

The availability of many of these pharmacotherapies has been greatly hindered over the past four years. It was recognised that by in large drug treatment across the UK was being delivered poorly. The Department of Health's response to this was to develop what is referred to as the Orange Guidelines - Drug Misuse and Dependence: Guidelines on Clinical Management. These guidelines advised against the prescribing of for example physeptone tablets and ampoules as mainstream treatments by GPs within the community. Sadly, this I feel is a step backwards for UK drug policy.

#### Slide 4

As you can see, there are great differences between Australia and the UK in relation to the financial cost for accessing drug treatment. We know that the required payment for being in drug treatment whether employed or unemployed can place a great burden on individuals. AIVL is aware of many people who have incurred great debt with pharmacies as they are unable to pay the required dispensing fees.

Across the UK, the NHS ensures that seeing a GP is free for all. In addition, there are no dispensing fees at pharmacies or prescription costs for people receiving treatment for drug dependencies. People who are unemployed receive free

prescriptions and for employed people who are on long term medication exemption from payment certificates are available.

VIVAIDS our member organisation in Victoria has a Pharmacotherapy Advocacy and Complaints Service. The service reports that half of all the complaints that they receive relate to dispensing fees. Further evidence of the issues that dispensing fees raise has also been documented by Linteris' in his work back in 1996, within the Community Methadone Evaluation in Victoria. He showed that the issue of debt was a disincentive for pharmacists to provide a service and about 45% of treatment drop outs was related to dispensing fee debt. No doubt this will have increased with the increase in dispensing fees. In 2001 AIVL undertook a snap shot of dispensing fees and we discovered that dispensing fees ranged from free within public clinics to between \$10.00 and \$53.00 per week.

What is important here is that we must work to remove the barriers and increase the incentives for people accessing drug treatment. Finance is an area that must be addressed urgently.

#### Slide 5

So while I was working in the UK then– supervised consumption was not an option. It was however, being introduced when I left. I again refer to the orange guidelines. They recommend that for those entering treatment, supervised consumption should take place and then be replaced with up to one weeks dispensing at a time. This can then be extended for holidays and special requests.

I understand that supervised consumption can be extremely helpful for some people but not all. At HOT we were able to facilitate for people to pick up and take away their doses on a daily, every few days, weekly, fortnightly and monthly basis. What we could offer was choice. This flexibility allowed people to take control of their treatment and their lives.

Few people at HOT would take their dose in one go. Many would split the dose throughout the day. There were no time

restrictions as to when they could go to the pharmacy to pick up their medication other than the Pharmacy opening times.

I know professional people here in Australia who have been on the methadone program for over ten years and still have limited takeaways. This hinders them professionally and personally. I would agree that some people need the increased security that supervised consumption provides until such a time that they no longer need it. The people I know no longer need it and have not for a very long time. What are we saying to drug dependent people here in Australia? That oh yes we want you to have a fulfilling life and drug treatment can help you to achieve this but, we do not want you to be fully functioning – we will keep you dependent – not on substances but on us. Employment is also effected and for some in public programs the traveling to the clinic can take hours each day.

The flexibility that you and I take for granted – going away for weekends etc... is just not there. Traveling interstate is a major hassle as is going overseas. Many people also have to prioritise work over personal life when it comes to takeaways.

## Slide 6

I would now like to finally talk about what I have termed as holistic care.

Here in Australia, drug treatment is pharmacotherapy focused. Few services are offered that take a more holistic approach. I know of clinicians here that do not see issues such as hepatitis C as being their responsibility. For some people the only person that they see is their drug treatment prescriber and as a result they do not access support for any other issues that they may be experiencing. Within the UK drug treatment is offered in a variety of settings.

Drug dependency units – hospital based services that are run by Psychiatrists and nurses. People have to be referred by another agency and are more clinical

Community Drug Teams – these are a lower threshold service staffed by generic workers. Most workers will have a social or

youth work background or will be ex users. These services work with GPs in the community and provide additional services such as:

- ❖ NSP
- ❖ Referral to detox and rehab
- ❖ Housing support – This includes access to emergency short and long term housing solutions
- ❖ Legal support – providing letters of support to the court, appearing in court and advising legal representatives
- ❖ Primary Health Care – Easy to access health care, blood borne virus testing and diagnosis and referral, support and monitoring of ongoing care, access to dentists and other health care providers and safer injecting advice and information
- ❖ Mental health support – on site and referral to mental health specialists with on going support
- ❖ Social support – this covers an array of issues such as access to funding grants for purchasing furniture and other household appliances, arranging days out, access to sports activities, food and clothing, prison visits.
- ❖ Access to training and employment
- ❖ Support with children – such as child care, respite if needed, parenting skills training

Shared care is common in the UK – there is multi agency working and care plans and interagency agreements. This model which is less utilized here enables people who are most at need to be cared for in a meaningful way.

I had planned today to address other issues such as harm reduction, prisons, human rights and the drug users' movement. Sadly time is against me however, I am happy to discuss these with you outside of this session.

## Slide 6

So let me begin to wrap up this presentation. I hope that I have been able to give you a very brief snap shot of the issues that are real for people who are dependent on drugs here in Australia and some different options. Australia has a great history of success and international acclaim however, it is vital that as a nation it continues to move forward in a

**meaningful way. By building on its strength of innovation and bravery in trialing harm reduction initiatives such as the Medically Supervised Injecting Centre in Sydney, Australia can continue to hold its place at the forefront of drug policy and practice. Such innovation must be extended into all of the components of drug treatment and we must do this now. Not only to save lives but to ensure that people who are drug dependent are able to lead fulfilling lives and realise their health and human rights.**

**Thank you**