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The Secretary
Family and Community Affairs Committee
Inquiry – **Substance abuse in Australian Communities**
House of Representatives
Parliament House
Canberra ACT 2600

Thank you, for the opportunity to address your committee. I will attempt to be succinct acknowledging that many others will also have also taken this opportunity.

I am a member of Family Drug Support (FDS) and work as a professional in the drug and alcohol field. The main focus of my work is methadone maintenance treatment and I also frequently receive calls on this topic in my capacity as a volunteer on the FDS phone line, which receives national calls.

I would like to draw the committee's attention to the financial inequities in methadone treatment for clients.

Methadone Maintenance treatment has the best outcomes for opiate dependency compared with any other treatment. However it also is the preferred treatment for the most chronic, recalcitrant and disadvantaged groups of clients.

Rehabilitation may be a long process for people with fractured lives as they adopt healthy social patterns for a better life style. This is not assisted by the unrestricted charges for methadone by community pharmacies.

The charges for any Commonwealth subsidised medications are for those on benefits less than $200 per anum and for people who are not means tested maximum $800 per anum or the equivalent of the cost of a weekly prescription times 52. Because methadone syrup is supplied by the Commonwealth Government free of charge to any agency prepared to dispense it, it is not on the subsidized pharmaceuticals list.

Clients of methadone services are being charged between $2 and $7 per daily dose resulting in an annual cost up to and in excess of $2,500. This is justified on the grounds that it is cheaper than heroin. Many clients who are in treatment have moved on from their heroin using life style and are frequently partnered by another ex user and have children. This places a huge financial burden on their resources. The most popular option is to try to stay at a public clinic but this is not conducive to

rehabilitation, independence or the opportunity of employment, as most public clinics have restricted hours.

Public clinics are the best place to stabilise clients and engage them in conjunctive therapies. For a long time places have been restricted due to the glut of long term clients who for financial reasons are very resistant to go to a community pharmacies. As the flow of younger dependent people are presenting for treatment at public clinics this is no longer an option for services and stable clients are being transferred to pharmacies. When this system was originally instigated in NSW, with the support of the Pharmacy Guild, a recommended fee was accepted by most pharmacists but the current trend is to charge what the market will allow and clients remaining opiate dependent on methadone have no choice.

This results in clients commencing a relationship with the pharmacist on a bad footing as they resent being forced to transfer and endure genuine financial hardship. This situation will inevitably lead to, if it hasn't already to a black market as clients sell their take away doses to pay for their pharmacy account. This has been the situation with the private methadone clinics and has resulted in a huge cost to the community as black market methadone is diverted for injection and accommodated the spread of hepatitis C.

There are other issues I would like to draw to the committee's attention on the inequity and financial exploitation in the delivery of treatments by the private sector but acknowledging the demand on the committee's time and will focus on the unrestricted fee for service from pharmacies.

Yours sincerely

Jennifer Rosewood RN RPN