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The politics of place(ment): Problematising the provision of hepatitis C treatment within opiate substitution clinics

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ABSTRACT

The hepatitis C virus (HCV) epidemic is a significant public health challenge in Australia. Current initiatives to expand access to HCV treatment focus on opiate substitution therapy (OST) settings where the prevalence of hepatitis C among clients is high. In Australia, the provision of OST for many clients is via large clinics, with an estimated median of 150 clients per service. Conceptually informed by the work of Michel Foucault, our analysis of the proposed integrated treatment model focuses on the critical but overlooked question of organisational culture and power operating within OST. We argue that the specific context of OST not merely reflects but actively participates in the political economy of social exclusion via which the socio-spatial segregation and stigmatisation of the service user as 'drug user' is enacted. This paper analyses data collected from two samples during 2008/9: OST clients living in New South Wales, Australia and a range of OST health professionals working in Australian settings. In total, 27 interviews were conducted with current OST clients; 19 by phone and 8 face-to-face. One focus group and 16 telephone interviews were conducted with OST health professionals. Our analysis of key themes emerging from the interview data suggests that the successful introduction of HCV treatment within the OST clinic is not a given. We are concerned that particular areas of tension, if not explicit contradiction, have been overlooked in current research and debates informing the proposed combination treatment model. We question the appropriateness of co-locating a notoriously arduous, exacting treatment (HCV) within the highly surveillant and regulatory environment of OST. While applauding the intention to improve access to HCV care and treatment for people who inject drugs we caution against a treatment model that risks further entrenching (socio-spatial) stigmatisation amongst those already experiencing significant marginalisation.

Introduction

The hepatitis C (HCV) epidemic is a significant public health challenge in Australia and the burden of disease is increasing (Dore & Jauncey, 2009). With chronic HCV affecting an estimated 217,000 people, national health policy currently targets a doubling of treatment uptake to ameliorate the looming healthcare burden of end-stage liver disease and transplantation. In Australia, as elsewhere in the developed world, the primary risk factor for contracting HCV is injecting drug use. Estimates suggest 80% of all chronic HCV infections in Australia are due to injecting drug use and close to 90% of the 9700 incident infections recorded in 2005 were transmitted via this route (Hellard, Sacks-Davis, & Gold, 2009).

Australian initiatives to expand HCV treatment provision beyond the specialised clinics of tertiary hospitals have focussed on opiate substitution therapy settings where HCV prevalence among the client population is high (Hellard et al., 2009). Of the over 46,000 people (AIHW, 2010) currently receiving OST Australia-wide, it is estimated that over 27,000 have HCV antibodies and over 21,000 live with chronic HCV infection (Day & Haber, 2009), yet less than 5% have commenced treatment (Dore & Jauncey, 2009). In 2007 the E.T.H.O.S. (Enhancing Treatment of Hepatitis C in Opiate Substitution Settings) initiative was funded by the Australian Government and New South Wales Health Department to undertake HCV education and training of healthcare workers in OST settings, as well as qualitative and quantitative research around HCV treatment willingness and barriers. Additionally several pilot HCV treatment services were established within the NSW Opioid Treatment Program, which were still underway at the time of publication.

This paper argues that the successful introduction of HCV treatment within the OST sector is not a given. We are concerned that particular areas of tension, if not explicit contradiction, have been overlooked in the research and debates which inform the provision of HCV treatment in OST. Research seeking to document

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reasons for the low uptake of HCV treatment among OST clients has focussed primarily on questions of clinical appropriateness (Grebely et al., 2008; McNally, Temple-Smith, Sievert, & Pitts, 2006). Other research has examined levels of knowledge and willingness to engage with HCV treatment among OST clients in terms of both clinical and demographic variables (Doab, Treloar, & Dore, 2005; Grebely et al., 2007). Discussions of OST clients' suitability for HCV treatment have frequently been dominated by issues related to illicit drug dependence (of homelessness, poverty, court cases and so on). Clearly there needs to be recognition of the multiple disadvantages and complex life factors that regularly confront those on OST. Nonetheless, we are concerned that a focus on individual-level variables as the object of inquiry has rendered less visible other factors operating within OST settings that are of critical importance to the successful introduction of HCV treatment. Only recently has the consideration of barriers been expanded to highlight the importance of the treatment site (Novick & Kreek, 2008) and the structure of the clinic (Hellard et al., 2009).

This paper builds upon and extends earlier work that called for a more critical consideration of the culture and context of OST and the implications it held for the introduction of HCV treatment delivery (Treloar & Fraser, 2009). Our previous work cited perceptions of convenience among clients and clinicians inherent in a 'one-stop' treatment model (Treloar, Newland, Rance, & Hopwood, 2010). It also cautioned against the hasty and ad hoc amalgamation of one treatment system with another. This paper engages with the narratives of individual clients and clinicians within a framework that emphasises the importance of social structural factors operating outside, and organisational factors operating inside, OST clinics.

Background: treating hepatitis C and opiate dependence in Australia

The available treatment for HCV infection has been described as 'long and arduous' (Hopwood & Treloar, 2007, p. 253). The toxicity of the anti-viral drugs (interferon and ribavirin) and the duration of treatment — either twenty four or forty eight weeks depending on factors such as viral genotype — present substantial challenges for patients. Studies indicate significant impairment in physical and mental functioning during interferon-based treatments (Fried, 2002) due to physical and psychiatric side-effects (Cornberg, Wedemyer, & Manns, 2002). Dose reduction and discontinuation of treatment are reported to occur in between 10 and 50 percent of clinical trial patients because side-effects become dangerous or intolerable (for example, Potgieter, Hickey, Matthews, & Dore, 2005). Patients in trials who discontinue treatment usually do so because of psychiatric impacts, which include depression, anxiety, amotivation, suicidal ideation, anorexia and paranoia (Majer et al., 2008). Over 30 percent of people receiving treatment experience depression, anorexia, weight loss, irritability, hair loss, joint pain, nausea and insomnia and more than 50 percent of people experience chronic fatigue, headache and muscle aches (Fried, 2002). Even among well-resourced patients with strong family and social support systems in place, adherence to hepatitis C treatments is often adversely affected by these side-effects (Hopwood & Treloar, 2008).

HCV treatment has typically been provided by a hospital-based specialist within a dedicated multi-disciplinary team (including nurses, social workers or psychologists) who assist the person with HCV to prepare for and cope with treatment. However, current low rates of HCV treatment uptake (Grebely et al., 2007; Mehta et al., 2008) have led to a growing interest worldwide in the provision of care and treatment for HCV infection within opiate substitution treatment programs (Astone, Strauss, Hagan, & Des Jarlais, 2004; Litwin et al., 2007; Winstock, Anderson, & Sheridan, 2006). In Australia, only 4% of people who inject drugs have entered treatment despite reported high rates of willingness to undertake treatment among this population – many of whom would also be receiving OST (Doab et al., 2005; Grebely et al., 2008). Estimates suggest that among Australian OST clients, HCV prevalence ranges from 67 to 87%, with available evidence suggesting prevalence has remained at this level since the mid-70s (Day & Haber, 2009).

In Australia, barriers to HCV treatment have been relaxed considerably over the past decade, with active injecting drug use as an exclusion criteria removed in 2001 and the requirement for a liver biopsy prior to treatment removed in 2006. While some research suggests that the biggest barrier for physicians in prescribing HCV treatment to current users remains a perception that this population will not adhere to treatment (Hopwood & Treloar, 2007), this perception is contradicted by a growing body of clinical data and opinion (Hellard et al., 2009; Novick & Kreek, 2008; Sylvestre & Zweben, 2007). Early clinical trials using interferon/ribavirin combination therapy among methadone maintenance treatment clients concluded that this population 'should be considered good candidates for referral and HCV treatment' (Sylvestre, 2002, p. 117). Further, there is mounting clinical evidence that OST clients achieve acceptable rates of adherence to anti-viral treatment and sustained virological responses (Novick & Kreek, 2008).

In Australia, methadone maintenance treatment (MMT) has been available since the early 1970s, with buprenorphine registered for use in opiate substitution therapy since 2000 and now accounting for approximately 15% of all OST (Day & Haber, 2009). Given MMT and buprenorphine are delivered in the same clinics and subject to essentially the same socio-spatial regimes we will treat both under the general rubric of OST. Arrangements for the provision of OST vary across state jurisdictions within Australia: for many clients it is via large clinics – both public and private – with an estimated median of 150 clients per service (Fraser & Valentine, 2008), but also via community pharmacies. Our focus is the clinic as the intended site for the introduction of HCV treatment.

It is important to note that while this paper may take a critical stance towards the organisational culture within the Australian OST program, it is not our intention to undermine the value of this program. The benefits of the Australian OST program are well documented (Ward, Mattick, & Hall, 1998). OST remains a critical, pragmatic and often compassionate response to the manifest problems associated with opiate dependence under existing socio-political and legal conditions. While we do not want to flatten out the differences that exist across OST operational cultures and between the philosophical approaches of individual workers – and the enormous impact both have on clients' experience (Fraser & Valentine, 2008) – we do want to focus here on some of the shared, troubling aspects of OST culture and practice. In addition, while individual client–clinician relationships within the OST sector may be characterised by a complexity evident across all areas of organised medical treatment, we do not believe that OST is just another medical treatment. Instead, we contend that as an organised, institutionalised 'treatment', OST contributes to the structural and discursive frameworks within which the stigmatisation of illicit drug use is produced and this should be recognised within the debates around introducing HCV treatment into these settings.

Approach: Foucault, social space and the 'stigmatised' subject

Our approach draws on the work of French post-structuralist, Michel Foucault. Foucault has been credited with 'opening our eyes to processes and relationships of central importance to health and social care' (Twigg, 2006, p. 12) and with providing 'an analysis of power [that] has proved particularly useful in understanding the functions of the medical profession and the clinic' (Turner, 2004, p.