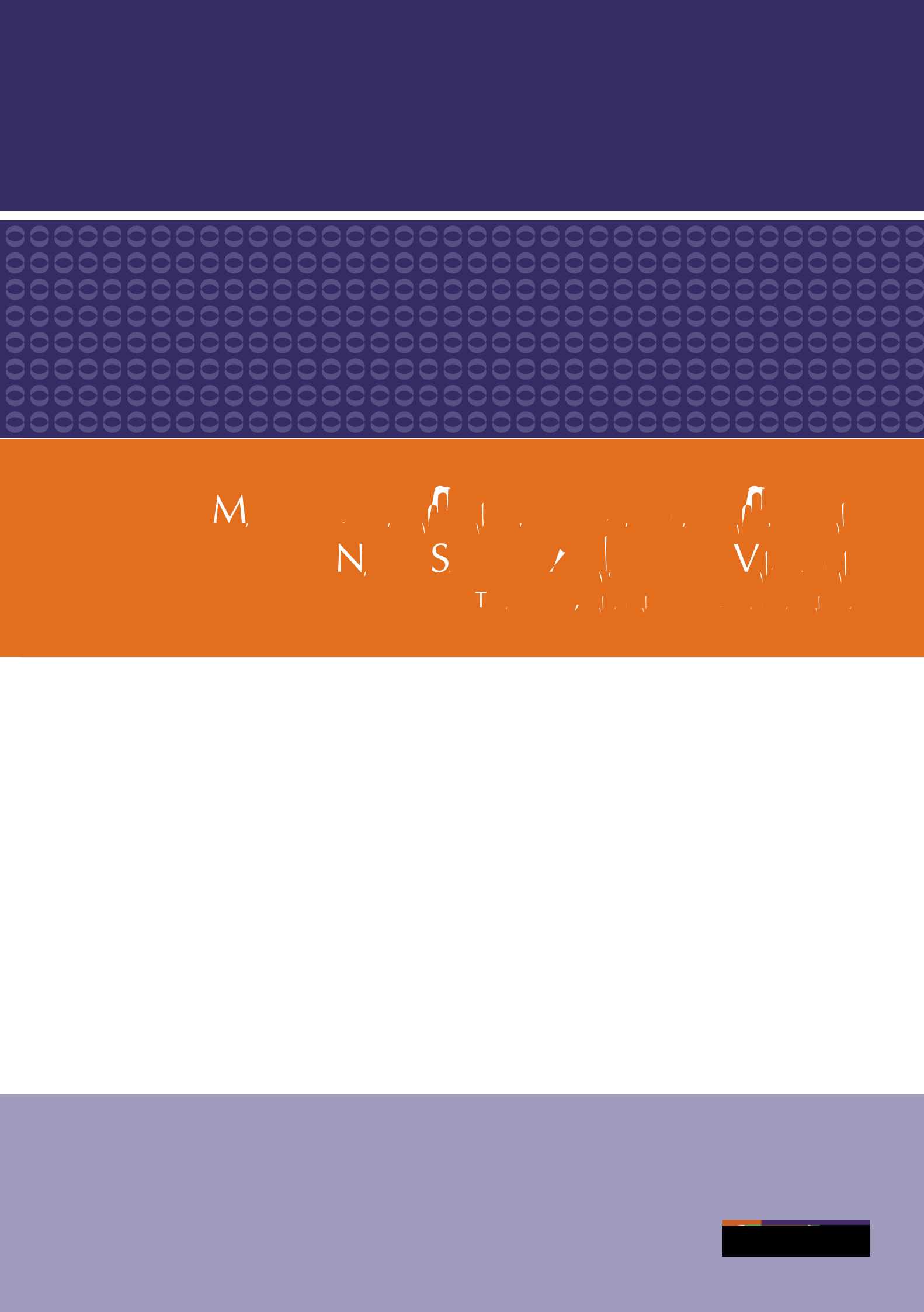

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the material needs of their children. In light of this set of issues, and of increasing concern around rare instances of child mortality related to methadone (which must be viewed in the context of the many benefits to families and children of parental access to MMT), there is a pressing

.

6 Our data demonstrate the heterogeneity of clients as well as the similarities between clients and service providers and policy makers. It is essential that an be actively integrated in policy development and service delivery. Clients frequently express frustration at 'one size fits all' approaches to treatment, which some feel involve greater restrictions than always necessary. Given that retention in treatment is recognised as central to the success of the program, it is important that clients feel their treatment is managed on an individual basis, and that policies possess enough flexibility to allow genuinely responsive care.

7 Clients and service providers identified a significant in both New South Wales and Victoria, and suggested that this affected quality of care. Where clients have difficulty accessing the program and have limited choice of service provider, they are especially poorly placed to negotiate treatment on an equal footing. Some expressed the view that this unmet demand and competition for treatment means service providers do not have adequate incentive to maintain high standards of care, and that clients do not feel free to pursue complaints. This serious issue points to an immediate in both states.

8 Indeed, much of the data collected demonstrates the central role that plays in the progress of clients. Where quality of treatment is poor, the difficulties clients already face and the disadvantage they often experience can actually be exacerbated by treatment. Factors indicating poor quality of treatment include:

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Policy changes have been introduced in both New South Wales and Victoria since the period of data collection. These include new recommendations for maximum numbers of takeaways to be prescribed at different time-points in treatment (see Appendix 1), to be implemented using checklists designed to aid prescribers in assessing clients. As access to takeaways was found to be critical to the experience of treatment for many clients, these changes are likely to affect clients directly or indirectly. However, as our study found, service providers in both New South Wales and Victoria interpret and make use of the guidelines in different ways (indeed, in Victoria, in that the new guidelines incorporate the abolition of the existing permit system, this discretion has increased in some respects). In relation to this, it is important to bear in mind that changes to the guidelines alone are unlikely to make access to takeaways more consistent. In that the particular circumstances of treatment delivery, including the provision of takeaways, remain largely at the discretion of service providers, the study's findings on takeaways also remain highly relevant.

Methadone maintenance treatment (MMT) is widely recognised as the most effective treatment for heroin dependence (Bell & Zador, 2000; Gibson et al., 1999; Ward et al., 1998; World Health Organization & United Nations Office on Drugs and Crime, 2004) and is finding increasing support internationally, especially in the Asia–Pacific region (Humeniuk & Ali, 2005; Irawati et al., 2006; U.S. Department of State, 2006). This study was designed with this success and expansion in mind, and its aim was to improve understanding of some of the challenges this valuable program faces for the purposes of policy development and service delivery.

Methadone is a full agonist synthetic opioid developed mainly for the treatment of pain and MMT forms a central element in Australia's harm minimisation drug policy, instituted in 1985 (National Drug Strategy, 1998). MMT involves daily consumption of a prescribed dose of methadone, usually under the supervision of a pharmacist or nurse. To minimise the inconvenience associated with daily dosing, many clients are prescribed one or more 'takeaway' doses of methadone per week (these are doses consumed away from clinic or pharmacy premises). Some treatment clients are prescribed buprenorphine rather than methadone. This is a relatively new medication with slightly different properties from those of methadone (in particular, it is a partial agonist rather than a full agonist and is longer acting in the body). Even newer is the combination buprenorphine/naloxone medication which combines a partial agonist and an antagonist. It has been introduced to help minimise the injection of buprenorphine (discussed below). Together these three medications make up pharmacotherapy treatment in Australia.

The addition of buprenorphine and naloxone to the pharmacotherapy will no doubt have a significant effect on treatment as clients and prescribers become experienced in making best use of the choices available. Indeed, buprenorphine has already been taken up among a significant minority of clients (reliable data on rates of uptake are not presently available in Australia). This study focuses on methadone because it remains the main treatment in Australia. However, many of the issues the study canvasses, such as client treatment confidentiality,

recent studies concluded that methadone diversion is not synonymous with MMT, especially if clients are what is called 'stable' (for example, Schwartz et al., 1999; Robles et al., 2001). Indeed, some authors have suggested that diversion is exaggerated (see, for example, Lewis, 1999; King et al., 2002). Certainly, diversion appears to vary according to context and treatment structure. Better understanding of this relationship would significantly benefit MMT and related public health policy in Australia.

S [illegible] N
S [illegible] V [illegible]

Each state and territory in Australia has its own guidelines on takeaways. Recently, the guidelines for the provision of takeaways in New South Wales and Victoria underwent review. They now differ in some respects from those under which the interviews for this study were conducted. Up until late 2006, provision of takeaways in New South Wales was guided by recommendations made in the *NSW methadone maintenance treatment clinical practice guidelines* (NSW Health Department, 1999). These guidelines stated that no takeaways should be prescribed in the first three months of enrolment in a program. From Month Four to Month 12, a maximum of two takeaways per week were recommended, with the caveat that these should not fall on consecutive days. From Month 13 to the end of Year Two, a maximum of three takeaways per week were recommended, with no more than two on consecutive days. From the beginning of Year Three onwards, a maximum of four takeaways per week were recommended and, again, these were to be limited to two days in a row. In exceptional circumstances, other arrangements were allowable. For instance, in rural or remote areas greater flexibility was allowed as necessary, depending on access to services. Aside from length of time on treatment, there were other factors physicians were expected to take into account when considering prescribing takeaways. These included illicit drug use (based on self-report and urine testing), regularity in attending the clinic/practice and/or pharmacy, and presentation. According to the NSW Health audit conducted in 2001, the majority of MMT clients in New South Wales receive regular takeaways varying from two to four per week (Hailstone et al., 2004).

In Victoria, during the period of data collection, guidelines recommended no takeaways in the first two months on the program. After this period, a maximum of one takeaway per week was recommended. In exceptional circumstances, three takeaways could be given in one week, but this allowance was limited to one week per month. Any other arrangements had to be approved by the Drugs and Poisons Unit through the permit system.

Since June 2006 new Victorian guidelines have been introduced increasing access to takeaways. Likewise, new guidelines were implemented in New South Wales in the second half of 2006.[1] As noted above, the data presented in this report were collected before the new guidelines were introduced. They do, however, remain highly relevant to understanding service provision in that they cover areas still characteristic of treatment in both states, in particular the impact of stigma and discrimination, the high regulation of takeaways and the strategies advocated to minimise diversion and Fsays inTj6.3113 R s

through state health departments. To capture a range of experiences, participants were drawn from each of the main types of services (public clinics, private clinics and GP/pharmacy programs) in both metropolitan and rural areas (see Table 1).

After data collection, each interview was transcribed verbatim, checked for accuracy and interviewer consistency, de-identified, cleaned and coded. Each participant was assigned a pseudonym to protect anonymity. The data were then analysed to identify themes. These themes were organised using the qualitative data management program NVivo. This enabled cross-referencing and the analysis of patterns in treatment narratives, accounts of activities and practices, and metaphors. These patterns were analysed using 'grounded theory' (see Glaser & Strauss, 1967). This approach is inductive in orientation, which means that findings and resultant theories are grounded in, and generated from, the empirical data.

This project has been approved by the Human Research Ethics Committee of the University of New South Wales and by relevant state and area-health-service ethics committees.

O

The research that forms the basis for this report aimed to provide data that could inform and improve MMT policy and services, and to generate much-needed information on the experiences and perspectives of service users. In particular, the research aimed to investigate the *meanings* given to takeaways and the conditions under which diversion of methadone occurs. The findings are divided into five sections. The 'Key findings and recommendations' (found at the outset of the report) offer conclusions based on the data.

S **1** of the findings details the practical and symbolic role takeaways play in MMT from the point of view of clients. What do takeaways mean to them? How do takeaways impact on the experience of treatment? This section examines interviews conducted with clients in both New South Wales and Victoria.

S **2** investigates the circumstances under which diversion of methadone to street sale and other forms of off-label circulation takes place. Data gathered from clients and service providers in both New South Wales and Victoria are analysed to elucidate the reasons for, and circumstances in which, diversion takes place. In addition, the role of dilution in dosing in Victoria is also considered. What is the relationship, if any, between diversion, dilution and practices of pharmacotherapy injection in that state?

S **3** explores the hitherto rather neglected issue of confidentiality in treatment and control over disclosure. As we will demonstrate, takeaways are identified regularly in the interviews as an important tool for maintaining confidentiality. This section considers the implications of limiting takeaway dosing in light of this.

S **4** considers the specific issues related to the provision of MMT in rural settings. It argues that treatment in these areas can offer both challenges and advantages for treatment, and emphasises the importance of avoiding generalisations when thinking through the impact of regionality and the needs of different regional programs.

S **5** considers the rules and guidelines of MMT in practice: how are these rules understood and used by health care workers and clients? It argues that while state-specific regulations are very important to the delivery of MMT, the practices and decisions of individual agencies and health care professionals also matter.

Table 1: Research participants

		n	Female	Male	Age range
Clients (Total = 50)	NSW metro	20	8	12	27–52
	NSW regional	5	2	3	24–49
	Vic metro	20	12	8	24–47
	Vic regional	5	1	4	31–39
Health care workers (Total = 29)					

> I just, I couldn't afford it, I really couldn't afford it. Having to pay for it and train fares—no way.
>
> *(Alison, client, metropolitan NSW)*

Access to regular takeaways was also considered a necessary precondition for gaining and sustaining paid employment. As Jeff explains:

> By the time I start work most days, you know, the chemist is just opening, so, um, and I need to be at work at the same time. And my lunch break, well, that's the only time I get to have it. He [chemist] closes at the same time I do, so it's a real catch-22. So I need and rely on takeaways. Um, occasionally I've gone away for work, or, ah, representing work at conferences and whatnot, and it, it's a real hassle; I can't do it unless I can get my takeaways.
>
> *(Jeff, client, metropolitan Vic)*

Furthermore, some participants valued takeaways as they helped to remove the necessity of socialising with other methadone clients. This was particularly important to New South Wales clients, many of whom attended large clinics for dosing where queuing was a regular part of treatment (Fraser, 2006). The congregation of clients around methadone clinics was likened by one participant to 'organised crime' *(Dave, client, metropolitan NSW)*, and associated with the diversion of methadone:

> You know, sometimes you don't necessarily want to be hanging around all those other people [because] you're more likely to have, there are people there who want to do things like sell methadone, buy methadone or, um, sell drugs, buy drugs, whatever.
>
> *(Lisa, client, metropolitan NSW)*

The link between access to takeaway doses and compliance with treatment was described in very strong terms by participants. When asked to consider what they would do without takeaway doses, some participants emphasised the serious negative impact on morale:

> If there was no takeaways, you'd be stuck in Melbourne […] stuck to the chemist. You know, you may as well just bloody set up a tent in there or something. And you can't get away […] I reckon that would just bring you down, you know, it really would.
>
> *(Joel, client, metropolitan Vic)*

Some participants went further, indicating that removing takeaways would lead to a return to regular heroin use:

> If they ban takeaways, I think it's going to cause a lot more problems than it's worth because I certainly won't be going to the chemist again. I'll be back on heroin to get off methadone because I cannot go to the chemist every day, you know. I don't like going there when I do.
>
> *(Ivan, client, metropolitan NSW*)

> I, I don't know what I'd do [without takeaways]. I'd probably end up getting off it and back into everything, you know, if I couldn't get them.
>
> *(Jim, client, regional NSW*)

Takeaways also signified in more personal, intimate ways

all about, the whole thing about fighting it is, getting that self-confidence back, you know building yourself up. You've got to keep telling yourself that you're not a hopeless, useless individual, that you can be some use to society, you know, otherwise you just go back to using again.

(Darren, client, metropolitan NSW)

If being provided with takeaway doses was seen as a 'reward' for 'good' behaviour or evidence of progress in treatment, the reverse was also true when takeaway doses were not granted. That is, those who did not receive takeaways tended to see this as a punishment or individual failing:

But when you're going there every day of the week [and] you know other people are getting takeaways, [you ask yourself] 'why can't I get some, what's wrong with me?'

(Faith, client, metropolitan NSW)

While access to takeaways is often considered a treatment milestone in itself, it simultaneously enables certain kinds of freedoms that participants also experience as progress. For example, it facilitates and eases increased social participation. Clients reported that takeaways allowed them to develop a sense of 'normality' in their lives, and to 'fit in better' with society. Aside from enabling clients to undertake employment, the flexibility in daily routines

'GPs can't really underestimate takeaways in someone's life in terms of just also giving you back a bit of independence.'

accorded them by access to takeaway doses permitted such simple activities as sleeping in when feeling sick or tired, staying overnight with a friend, being able to take holidays and participating in family functions. While these may seem to be trivial issues to those who do not experience such restrictions, this normality and flexibility was highly valued by participants, and was described as integral to their sense of self and their perceptions of their own role in wider society:

Like I said, I mentioned the community before, but it, it gives you a sense of belonging, being able to, to get out there—a bit of normality, sort of. You're not going to the chemist every day at the same time and standing out the front, you know? It just sort—you just get out and are able to mix with people. It just, it means a lot to me.

(Jim, client, regional NSW)

It's not normal to go into a pharmacy and to have to drink medication there, like, every day, under supervision. If [MMT] is really supposed to be about, you know, reintegrating us drug-dependent junkies into a normal life, then takeaways enhance our capacity to do that.

(Moira, client, metropolitan Vic)

I suppose I'll just say, um, I think that, um, GPs can't really underestimate takeaways in someone's life in terms of just also giving you back a bit of independence. And the feelings of, you know, belittlement, being in that junior/infant kind of position are lessened, I guess, just by, through distance, not having to deal with it so much, um, and give you so much more sort of flexibility in your life.

(Lisa, client, metropolitan NSW)

For Mary, who had a young child, takeaway doses also meant that she could attend 'normal' activities such as her son's soccer match without the added complication of missing her clinic hours and then being unable to care for her child or enjoy his company due to the presence of withdrawal symptoms.

This enhanced sense of being 'normal' was also associated with having greater control over life, including being able to focus on parts of life other than those related to the acquisition of drugs (in this case methadone, but previously heroin):

[W]ell, they make me feel more of a normal person, like more of, into society. They make me feel like I fit in more, because, I don't know, it's this really horrible feeling, like, it's like, um, they're in control of my life and I haven't got a say. And, and I don't think it's, it doesn't feel fair.

(Betty, client, regional NSW)

But I mean, it was just a good feeling to know that you're just, your brain's not ticking over all the time, thinking about either heroin or methadone all the time, because that's all I've done for the last six years, you know. You've got to get that out of the brain and get other things in there.

(Darren, client, metropolitan NSW)

As will be discussed in more detail in Section 3, access to takeaways also made treatment more private. Reducing the number of visits to dosing points reduced participants' risk of being publicly identified as methadone clients. Thus, takeaway doses were seen as playing a major role in preserving confidentiality and reducing daily incidents of discrimination.

> [W]hen, when I get up in the morning and I haven't got the takeaway, I feel trapped automatically. Immediately I feel, 'Oh no, I've got to go down there', and I get apprehensive. And I, and I think, 'Oh no, if only I could just go, detour away where no one could see me walking down there'. And um, I, I do feel better when I come out of there, but I still feel that stigma, that's always there … And it makes you feel second, like a second-rate citizen. But if you're, if you didn't have to come in so much, you, I don't know, you could get your life around, people wouldn't know so much.
>
> *(Betty, client, regional NSW)*

Finally, participants raised concerns about the takeaway system being 'abused' and methadone being diverted for illegal sale. Participants emphasised that diversion was carried out by only a small percentage of clients, and many argued that the inaccurate perception among service providers that diversion was widespread led to arbitrary decisions around eligibility for takeaway doses and a lack of consultation when eligibility was decided.

In short, participants listed the following advantages of takeaways:

- increased convenience
- reduced cost and time spent
- improved employment opportunities
- reduced need for interaction with other methadone clients
- greater ease of compliance with methadone treatment
- positive gains in self-concept related to feeling 'trusted' by health workers
- increased sense of 'normality' and social participation
- protection of privacy and confidentiality.

D

These data concur with British findings (Neale, 1999a) and also provide additional information on the role and function of takeaways from the point of view of clients. Attending a methadone dosing point is not the only daily obligation clients face, and must therefore be recognised as the significant, sometimes prohibitive, requirement it is. Moreover, the demands of daily attendance need to be considered in light of the relative poverty, disadvantage, powerlessness and lack of professional and social standing experienced by people in methadone treatment. Most clients are reliant on public transport timetabling, and have few child-care options or choices about where they live. Jobs typically available to people on methadone treatment are those in the manual and service industries, and work conditions in these fields frequently include sudden roster changes, compulsory overtime and shift work. For all these reasons, takeaways should be understood not only as an aspect of effective treatment, but as an equity issue.

Participants also emphasised the benefits of increased social functioning as a direct result of access to takeaways. Mary, for example, noted that takeaway dosing had a number of major positive effects on her ability to participate in, and enjoy caring activities with, her son. These types of benefits, while difficult to quantify, can impact on the service user's need for other health and social services, as well as on the need for other welfare interventions.

Another important benefit of access to takeaways cited by participants was the feeling of being trusted and deserving of respectful treatment. The marginalisation of injecting drug users is well documented (Boeri, 2004; Wodak et al., 2004). The data reported on here show that, for clients, takeaway doses allow treatment regimes to more closely resemble the medical treatment available to the general population, mitigating the humiliation often experienced in relation to MMT. The improved self-confidence arising from this different relationship to treatment is a benefit in itself, but can also produce other gains in health outcomes (Wilkinson, 1999), as well as increasing the chances of positive treatment outcomes. Conversely, a lack of trust and respect are common complaints among clients who receive few or no takeaways. Thus, limiting or prohibiting takeaways does more than withhold the 'rewards' of flexibility and convenience. It also reduces or withholds the conditions of trust and respect, simultaneously increasing humiliation and damage to self-esteem. These effects have serious implications for compliance and success in treatment.

In summary, while some of the issues identified in this section, such as those related to the convenience and confidentiality associated with takeaways, have been noted in previous studies (Neale, 1999a), other issues have not. These include: the facilitation of normal social functions; an improved sense of fit with—and fitness for—society; and the achievement of trust. Thus, an important finding of this study is the centrality of the less tangible benefits of takeaways to clients and the importance of acknowledging these when formulating policy on takeaway dosing and evaluating services.

2 T

The sharing, selling and injecting of opioid pharmacotherapy treatment medication are serious concerns for policy makers, service providers and clients themselves. As noted in the 'Introduction', takeaway doses are thought to be the main source of diverted medication. At the same time, takeaways are also known to have a wide range of benefits. These include improved retention rates in treatment programs and compliance with treatment regulations (Pani et al., 1996; Rhoades et al., 1998) as well as a variety of other benefits to clients (see Section 1). This section explores the diversion of methadone takeaways from the perspective of clients. In particular, it focuses on differences between Sydney and Melbourne in attitudes towards, and experiences of, diversion, and a consideration of whether these differences can be linked to the variations in state policies on takeaways.

This section draws on the interview data gathered from methadone clients in Sydney and Melbourne (n = 40). Eleven Sydney participants were male, 9 were female, and ages ranged from 27 to 52 years. Nine Melbourne participants were male, 11 were female, and ages ranged from 24 to 47 years. Three clients in the Melbourne sample were receiving buprenorphine rather than methadone at the time of interview. Participants were asked a number of questions about diversion, including how often they encountered others wishing to buy or sell their medication, whether they had ever bought, shared or sold medication, and what the reasons for diversion might be. Clients in both Sydney and Melbourne reported having encountered interest from others in buying or selling medication, and some had participated in diversion themselves. The type of medication involved and the degree of interest in diverting it, however, were strikingly different in the two cities.

In New South Wales some clients described the diversion of methadone as common. Chris, for example, stated that diversion of methadone was ubiquitous in New South Wales clinics:

> Oh, at the clinic they all do. Nearly 95% of them use it, shoot it up and sell it. […] Everyone does it. Every clinic you go to, if you want methadone you just go to any clinic and there's people out the front waiting and selling it.
>
> *(Chris, client, metropolitan NSW)*

Others, such as Ray, went so far as to argue that diversion occurred more frequently in clinics than pharmacies:

> You walk out of there [the clinic] and there's people just pouncing on you, like, 'Do you want to buy some pills, you got any takeaways?' you know—where, in the chemist, there's nothing like that.
>
> *(Ray, client, metropolitan NSW)*

While most participants expressed an awareness of diversion, there was no agreement on how common it was. Danny, for example, argued that the selling of

was also understood in the context of those unwilling to enter treatment. According to some participants, illicitly purchased methadone offered a relatively inexpensive alternative to heroin and the risks drug users had to undertake to access it:

> Some people […] still want to use, but control themselves a bit better. So if they can't, haven't got money to use, at least they're not going to be sick, at least they're not going to do desperate measures to go and get money.
>
> *(Hank, client, metropolitan NSW)*

Clients repeatedly noted that illicit access to methadone worked to reduce the need to undertake criminal, dangerous or otherwise undesirable activities in

> From what I've seen, [it's] people that, um, have had trouble with the system, being on the system, and I think a big part of it's to do with the system's not flexible enough to, like you know, the system says, 'You be here at such and such time and we'll give you 'X' amount and then …', you know [… you have to leave]. I remember reading something once […] one of the forms they gave you says […] you're not allowed to hang around outside. Now, they [herd] you all together, shove you all in there and dose you all together, and yet you're not allowed to walk twenty feet outside and stand there and talk to someone familiar, you know. It's crazy things like that.
>
> *(Danny, client, metropolitan NSW)*

Other participants talked about the long waiting lists associated with some programs, contending that the illicit purchase of methadone went on among some who were otherwise unable to access treatment. One participant described a period during which he felt forced to buy illicit methadone in order to stay out of trouble:

> Because of the waiting list to get back on the program, you know, I didn't want to have to start committing crime to [get enough money to buy heroin…]. It wouldn't have made sense for me to buy it if I could have gotten straight on to a program. [People] buy methadone because they can't get on a program and they want to stay well enough all day to be able to work.
>
> *(Hank, client, metropolitan NSW)*

'[People] buy methadone because they can't get on a program and they want to stay well enough all day to be able to work.'

Many of the issues raised by Sydney clients were also relevant to Melbourne clients. Participants in both cities mentioned having tried methadone before enrolling in a program, and some of these described this experience as having encouraged them to consider undertaking treatment. Others talked about buying illicit methadone as a stopgap when heroin was too expensive, or when the limitations of the program meant that they could not get enough takeaways to cover travel. Some talked about selling takeaways, sometimes for cost price, and sharing them with partners and other friends and family, while others were prompted, either by financial hardship or the desire to purchase heroin, to sell them.

There were, however, a number of striking differences between descriptions of diversion in Sydney and Melbourne, and these arise from a central difference in program delivery between the two states. In Victoria, methadone doses are diluted (most often with cordial) up to 200 millilitres. In New South Wales this is rare. This dilution appears to affect the saleability of takeaways. Clients in both states explained that one of the reasons illicit methadone is bought is for injection. Where the volume of fluid to be injected is large, as it is in Victoria, and contains particulate matter such as cordial, the viability of injecting is reduced. Some Melbourne participants contended that, for this reason, there was little or no market in illicit methadone in Melbourne:

> I think, maybe, because it's diluted so much. So people would just be buying it to maintain. I mean, I've heard of some people that whack it up with the cordial [but] I mean, I've worked on the street, you know, doing outreach, and I have not heard of people selling their methadone.
>
> *(Alina, client, metropolitan Vic)*

Alina was not alone in saying that she was unaware of an illicit market for methadone in Melbourne. However, there is evidence that some diversion occurs in that other participants stated they had witnessed it. While the extent of diversion in Melbourne, as compared with Sydney, cannot be reliably ascertained from this study method, the Melbourne data would suggest that methadone is relatively less frequently bought and sold there (and recent figures support this view [see Ritter & di Natale, 2005, for details]).

This relative rarity of the sale of takeaways, and of their injection, is in some ways a positive characteristic of the Victorian program. However, other data collected in our study indicate that the effects of methadone dilution might not be all positive. A frequent assertion made throughout the Melbourne interviews was that, while methadone was infrequently diverted and injected, buprenorphine diversion and injection was extremely widespread:

> I found that down here [in Victoria], since I've been down here, in the last few months, everyone is like bupe, bupe, bupe.
>
> *(Kara, client, metropolitan Vic)*

> I know that people are selling bupe, and I've heard [that in] Frankston, that it was huge down there, that there was a street market for bupe. Which has got so many huge problems because of the mouth stuff. I mean, we've been alerted to the fact that there've been cases of fungal eye infections from bupe injecting, and we've seen some hideous, um, injecting injuries at work.
>
> *(Debbie, client, metropolitan Vic)*

Because takeaway doses are relatively rarely supplied for buprenorphine, diversion appears almost always to occur via doses that have been held in the service user's mouth

3 T

The many benefits of methadone takeaways for clients were outlined in Section 1 of these findings. That section also alluded briefly to a relatively under-researched benefit of takeaways, that is, their role in allowing clients more control over disclosure and greater opportunity for maintaining confidentiality around treatment. This section explores more deeply the issues of confidentiality and disclosure as they emerged through interviews with clients (*n* = 50). This group comprised 20 clients from metropolitan Sydney , five clients from regional New South Wales, 20 clients from metropolitan Melbourne and five clients from regional Victoria. Among the participants, access to takeaways varied considerably. To begin, we will present one case in some detail. This case illustrates the difficulties methadone treatment poses for maintaining what clients consider normal social relationships, as well as the many obstacles they face when attempting to manage confidentiality around MMT.

'There are quite a few close friends who know absolutely nothing about that part of our lives […] It's very awkward.'

It is widely accepted that injecting drug use is stigmatised in Australian society. Undergoing pharmacotherapy treatment is often equally stigmatised. From this point of view, the preservation of confidentiality, and clients' control over when and to whom disclosure is made, needs to be a central consideration in the provision of treatment. This is well understood by many professionals working in the area, yet it is not always reflected in the pragmatic arrangements made around treatment, in particular, in relation to dosing. The interviews we conducted with clients suggested that being on MMT was a carefully kept secret for many—at least in relation to some individuals and institutions—and that dosing represented a point of significant vulnerability in the maintenance of this secrecy.

Renée is a 37-year-old woman of Anglo-Australian background who lives in an outer west suburb of Sydney with her partner and three children. Her second child is severely disabled, and her youngest is five years old. Renée's interview was filled with references to past and present difficulties in juggling family commitments with the need to be dosed. Some, though by no means all, of these difficulties were alleviated by her access, at some points in her treatment, to five takeaways per week. As a longstanding local resident and parent with ties to her children's schools, treatment confidentiality was a central concern for Renée. As demonstrated below, she described many situations in which the confidentiality of that treatment had been threatened or breached, both directly by health care professionals and indirectly through inadequate procedural or spatial arrangements at dosing sites.

Renée identified a range of people with whom she spoke openly about her treatment, including her partner. Yet she also made clear that she kept her treatment secret from many others, even some close friends. Renée believed that disclosure would damage these social relationships. However, as her case shows, maintaining confidentiality is not simply a matter of 'not telling'. It requires vigilance and sustained effort on the part of the service user, and this process can take a toll on the service user as well as on the relationships it was designed to protect. This first extract gives an example of the kinds of careful negotiating, planning and juggling that everyday social interactions entailed for Renée:

> There are quite a few close friends who know absolutely nothing about that part of our lives […] It's very awkward. One time I had a girlfriend in the car who didn't know and I had to go to the chemist. And you're sort of trying to get rid of them so you can sneak off. And you do have to lie, you know, and it is really awful when you've got close friends that you're basically lying to.
>
> *(Renée, client, metropolitan NSW)*

Work trips, holidays and other social events involving travel were also discussed by participants as situations in which unplanned exposure could occur. As Renée explained, fielding invitations to travel or holiday with friends and relatives was a challenge, as was declining invitations without disclosing her reasons:

> There've been circumstances where our neighbours have asked us to go camping with them. And we just can't do it because, you know what I mean, they're not aware of our being on methadone.
>
> *(Renée, client, metropolitan NSW)*

These instances tax Renée's ingenuity and are a source of constant concern that exposure will occur, bringing with it a range of undesired consequences.

Another instance of Renée's concern about disclosure related to the circumstances around picking up her dose. In this situation, managing the risk of exposure is largely out of Renée's hands:

> You are a methadone client so you're treated differently […] you're only allowed to have two methadone clients in the shop at one time and you're not allowed to wait outside the store either so you've got to go to somewhere else, which I think, like, where do you go when you've got kids and things? […] I've got to stand out the front, like most people actually stand out the front and down two stores, and there's a group of them. And nobody will leave because their place will be lost […] and it's obvious who they are, and I was standing there one day and three of the mothers from the school walked past, looked and then did a double take […] now I stand up the other end.
>
> *(Renée, client, metropolitan NSW)*

Here Renée describes regulations around pharmacy visits that clearly differ from those applied to other members of the public, and which make maintaining control over disclosure of treatment extremely difficult. Ultimately, Renée is forced to choose between maintaining her place in the queue (so as to minimise the amount of time taken to get her dose) and ensuring that her status as a methadone-maintained mother of school-aged children remains confidential. The routines of her day allow for little spare time in that they revolve around getting her children to school, being home when they finish school and taking care of the needs of her severely disabled daughter. For Renée, the choice between confidentiality and timeliness represents a serious test of priorities.

These instances are only a few among many in which maintaining confidentiality was problematic for Renée. Other situations included her experiences during labour in a public hospital, in which a nurse disclosed to other members of her family that she was on treatment. Renée's case was especially significant in that the problems she faced managing confidentiality and disclosure occurred in spite of her relatively free access to takeaways. For those clients on fewer takeaways per week, and who are also concerned about privacy, these issues are likely to be magnified.

Indeed, many other clients also nominated disclosure and privacy as important to their experience of being on treatment. Chris, for example, described the regular apprehension he experienced when visiting his pharmacy to collect his dose:

> I'm just waiting for the day my auntie's going to walk in [to the pharmacy]—the methadone's going to be poured and she's going to walk in, because she only lives in Brighton … Yeah it's just, a little paranoid, like who's going to come in while I'm having a quick drink?
>
> *(Chris, client, metropolitan NSW)*

In this extract, Chris characterises the burden of anxiety attached to attending dosing sites as paranoia. But he knows that the possibility of exposure is real and likely to have significant negative effects. This concern about the exposure to public view that dosing entails, and the consequent risk of unwanted disclosure, is cited by numerous participants. Jeff, for instance, expresses concern that the privacy afforded in his pharmacy is minimal:

> Um, up at my chemist, right, you can sit out on the street, and just sit there looking straight into his shop and see who's having a dose, who's getting takeaways, or, or who is getting what prescription.
>
> *(Jeff, client, metropolitan Vic)*

Pick-up poses a particular set of problems for clients who are employed, even when their standard working hours are able to accommodate trips to the pharmacy or clinic. This is not only because employers, colleagues or clients might

'You know, you can only cover it up so much in front of the boss.'

recognise them while they are queuing, but also because the limited nature of dosing times can leave them unable to fulfil overtime or work-related travel expectations. One participant described having to disclose to his employer when asked to spend time away from Sydney for work:

> You know, you can only cover it up so much in front of the boss. My boss wanted me to go away to Eden a fortnight ago and I had to tell him why I couldn't go and I was lucky he was understanding about it. You know, if it was easy, if […] I could have just called my doctor that day, but it's not that easy to do. I could have gotten

> down to Eden and [found] no transfer script there, and I could have gotten sick and I would have finished back up here and it would have turned out pretty messy.
>
> *(Hank, client, metropolitan NSW)*

Many others expressed an unwillingness to inform employers because of the likelihood of a stigmatising response. Thus, when asked whether he planned to tell his new employer about his methadone treatment, Cameron responded:

> You can't get ahead if people know, so it's better not to. Not to hide it, but in general terms […] I won't hide it, um, but I won't tell the new employer or anything like that.
>
> *(Cameron, client, metropolitan Vic)*

Also important in the extract preceding Cameron's is their unfeasibility to go commonly reported problems with transferring to different pharmacies while travelling. While transfers may go some way towards freeing clients to travel in the absence of adequate takeaways, their occasional unreliability means that, for some, travel is not worth the risk. Hank was fortunate in that his employer greeted his disclosure with tolerance. This is not always the case. Indeed, one participant reported that clients had been admonished by Centrelink staff not to disclose their treatment to potential employers. The implications of this expectation on the part of Centrelink staff are far reaching. Should clients be expected to deliberately hide

4 M

Delivering methadone maintenance treatment in rural and regional settings presents unique challenges. Distance, resourcing and availability of trained staff are common concerns. This section draws on the interviews conducted with regional service providers in New South Wales and Victoria to outline some of the issues related to service delivery in rural areas. The participants comprised GPs, pharmacists, a nurse and a counselling and support services manager (*n* = 10).

These interviews offered differing and sometimes competing accounts of the impact of geography on service delivery. The circumstances common to rural and regional settings, such as distance from major centres and limited resources and staffing, do not always play out in the same ways, nor do they always have the same effects. For some participants, small town and rural service provision was characterised by isolation and paucity of opportunity. For others, it provided conditions for intimacy and high-quality care. Isolation was largely talked about in terms of the issues related to the long distances that some clients needed to travel to their dosing points, but also included the geographical and sometimes professional isolation of service providers.

While some participants talked about isolation as limiting the size of programs and thus generating unmet demand for treatment, others talked about their programs having vacancies because of their isolation. As one service provider in a Victorian town of approximately 5000 residents with two dispensing pharmacies said:

> We can take many more, you know, we can take up to, I think 20 our licence is, or something like that. Um, but we have never had the demand for it. So, yeah, anyone who wants to come along, they're straight in if they want to be.
>
> *(Nathan, pharmacist, regional Vic)*

In other areas, long waiting lists are a problem:

> It's, they say twelve months, up to twelve months. But it sort of depends. Yeah, because when they, when they put their name on the waiting list they've got to ring up every week to make st7Se

town], their access to chemists is probably better than it might be in Melbourne. I mean, if you live in Melbourne and you have to travel a significant distance to dose, then you'll have to do that on public transport, whereas most of our clients would, if they wanted to, most of them would be able to walk to their dosing point.

(Derek, GP, regional Vic)

Other issues broached by the participants related to the ability to attract service providers in regional and rural areas. Small populations and limited facilities and resources meant that finding and keeping professionals willing to provide methadone treatment could be difficult:

That's probably the major [issue]: finding suitable dispensing agents somewhere close enough to the patient, and/or GP. For instance there's a bigger town than ours adjacent [...] which used to have its dispensing done through the hospital pharmacy, and no community pharmacy would take it on. And for a long time the hospital pharmacy was in strife for staff and wasn't putting any new patients on.

(Howard, GP, regional Vic)

While not all pharmacists and health care professionals are interested in providing services to people on methadone treatment programs, isolation and lack of support can also be an issue for those who do:

'[T]he doctor can ring up our opposition and find out whether people are double-dosing ...'

[If I ask] questions like, 'Why do we do these sort of things?', [I'm] basically told, 'I've been doing this for fifteen years and this is the way it's done, so I've got more experience than you, and just shut up'. Not in those words but that was the message […]. I did find that even GP support or outreach meetings weren't very warm. Plus we didn't have a director of clinical services at that stage, and so we were, really, leaderless.

(Stuart, GP, regional NSW)

In several ways, rural and regional service provision was characterised by isolation and had negative implications. At the same time, participants also described corollaries of isolation that they considered valuable to the methadone programs they were involved in. While distance from large centres meant lower population numbers and a narrower range of options for sociality, it was also conducive to closer relationships based on proximity, and on the absence of anonymity. Participants described the advantages of close-knit, small-town environments in which information tended to be readily shared. The 'small-town grapevine' was one notable example:

When we hear a few stories, we just have a chat to the doctors and, and people we suspect who are, you know, or when, it's fairly obvious the people who are having issues. Um, we're a small town, you know. Without breaking the privacy laws, the doctor can ring up our opposition and find out whether people are double-dosing, essentially … And, you know, if it appears to be the case then they can direct a limited supply; this is for benzos and things like that. And that seems to work pretty well.

(Nathan, pharmacist, regional Vic)

[The drug and alcohol worker] knows all the pharmacists. Like, on the way down to the interview, I dropped there to get some of my own pills and here she is, ah, down the back of the chemist shop, yarning, just yarning away. And I'm able to join in the conversation almost like we're at the dinner table, with two or three pharmacists, in terms of how this person's going, what's happening there, this is looking good, you know, they're okay about having to have their takeaways chopped, they've calmed down, you know. It was silly of them to be selling straight in front of the chemist shop and some honest citizen's spotted them.

(Terence, GP, regional NSW)

Close relationships between health professionals and a small number of pharmacies in the region work to enhance access to information that is considered useful by the service providers. This might include information about the clients' general situation and well-being as well as about incidences of medication diversion or doctor-shopping among clients:

You actually get quite a lot of, you know, the spy network is much better in [a certain town] … And they'll tell, like, you know, if someone's doing bad things, or trying, ripping me off in some way … they do tend to dob on each other.

(Stuart, GP, regional NSW)

The small-town grapevine was also considered to be a tool used by clients, enabling them to keep track of issues such as availability of new treatments:

They hear that on the street. So, you know, we have little spates of it where people will come and ask, and then, you know, if they're told, 'Look, it's really not a very viable option, not at this point,' they'll drop off. And the word will just be out in the street. I mean […] there's a culture and the news is very quickly spread.

(Teresa, counselling and support services manager, regional Vic)

Ultimately, the kinds of grapevines created and the nature of the information shared are specific to each program, as they are a result of unique arrangements of local factors. Thus it is not possible to predict the ways grapevines work, the effects they have in specific communities, and who they will benefit. In some cases they can create and strengthen trust among clients and workers, in others they can undermine it, especially given that information gathered via 'the grapevine' is not always reliable.

Service provision in rural and regional areas is in some respects more fragile than in large centres, mainly because of the small number of health care workers involved. A single retirement can close down a program. Burn-out as a result of being overburdened or under-resourced and unsupported can also threaten a program. However,

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No takeaways during first **3** months. **2** takeaways from Month **4** to Month **12** (not consecutive days). **3** takeaways from Month **13** to end of Year **2** (max. of **2** consecutive days). **4** takeaways from beginning of Year **3** (max. of two consecutive days).	No takeaways for first **2** months. **1** takeaway per week thereafter. In exceptional circumstances, **3** take-aways (consecutive days), but only for **1** week per month.
Policy quite open for rural and remote areas where there's no regular clinic.	Other arrangements need approval from Drugs and Poisons Unit.
(NSW Health, 1999)	(Drugs and Poison Unit, 2000)

2006

N S	V
No takeaways during first **3** months. **2** takeaways from Month **4** to Month **5** (not consecutive days). **3** takeaways from Month **6** to Month **8** (max. of **2** consecutive days). **4** takeaways from Month **8** to Month **12** (max. of two consecutive days). **4** takeaways from Month **12** to Month **24**. Must attend every four days. No information on what happens after **24** months.	No takeaways for first **2** months. Three levels of supervision thereafter. High intensity: no takeaways (default that should be adopted at commencement of treatment). Medium intensity: **1** to **2** takeaways per week. Low intensity (after **6** months of treatment plus other requirements): max. of **5** takeaways per week, max. of **3** consecutive days. Must attend at least twice per week.
(NSW Health, 2006)	(Drugs and Poisons Regulations Group, 2006)

Aspects of this study were reported on in presentations made to Australian and overseas conferences. Some findings were also written up in refereed journal articles. Details of these presentations and articles are provided below.

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T :

Suzanne Fraser
International Journal of Drug Policy, 2006: *17*, 192–202

This paper analyses methadone maintenance treatment as a temporal and spatial phenomenon, a set of practices and arrangements that operate 'intra-actively' in response

Fraser, S., & valentine, k. (2005, March). *Framing addiction in methadone maintenance treatment in New South Wales*. Poster presented at the 16th International Conference for the Reduction of Drug Related Harm, Belfast, Ireland.

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Treloar, C., Fraser, S., & valentine, k. (2006, November). *Valuing methadone take-away doses: The contribution of service user perspectives to policy and practice.* Paper presented at the Australasian Professional Society on Alcohol and Other Drugs Conference 2006, Cairns.

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