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Agency and dependency within treatment: drug treatment clients negotiating methadone and antidepressants

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Abstract

This paper explores how drug treatment clients exercise agency while finding their ability to act curtailed by the strictures of treatment itself. Drawing on interviews with drug treatment clients collected in an Australian study of drug treatment and mental health, the experience of methadone maintenance treatment (MMT) and that of commonly prescribed medications for depression (antidepressants) are examined. The ways that clients engage with MMT and antidepressants are detailed, illustrating how both types of treatment can make clients feel dependent, but can also motivate clients to modify their treatment regimens. These modifications are 'tactical' responses generated within the constraints of treatment regulations but can also be against clinical recommendations e.g. stopping treatment. Rather than seeing this as 'non-compliance', it is suggested that the negotiation of treatment is an inevitable response of clients who are trying to adapt to imperfect treatment conditions, and who may have understandable anxieties about taking medication. The ways in which treatment providers might better acknowledge the capacities of MMT clients to engage with or modify treatment are discussed, as is the need to

acknowledge drug treatment clients' anxieties about dependency and pharmaceutical drugs.

Introduction

In this paper accounts of drug treatment clients collected in an Australian study of drug treatment and mental health are drawn on to explore the experience of methadone maintenance treatment (MMT) and that of commonly prescribed medications for depression (antidepressants). The aim is to demonstrate the anxieties that MMT clients may have when taking prescription drugs, and the ways that clients negotiate or challenge their prescription regimens, particularly when they experience problems in treatment. The analysis presented here suggests that drug treatment providers could do better to acknowledge the anxieties of clients about taking medication, and recognise that it is unhelpful to characterise the modifications that clients make to their prescription regimens as 'non-compliance' (Ning, 2005; Wright, 1993).

Methadone maintenance treatment, like other forms of opioid replacement therapy or substitution treatment, is credited with reducing the problems associated with heroin addiction, such as frequency of injecting, drug-related crime, blood-borne virus transmission, and the fluctuations between intoxication and withdrawal experienced by heroin users (Bell, Dru, Fischer, Levit & Sarfraz, 2002; Farrell, Ward, Mattick, Hall, Stimson, des Jarlais et al, 1994; Ward, Mattick & Hall, 1998). In the United States, Europe and Australia, MMT is the most common form of substitution treatment for opioid dependence (Ward, Mattick & Hall, 1998).

Within MMT programs in Australia, clients typically receive daily doses of methadone, a long-acting synthetic opioid agonist, as a substitute for problem opioids such as heroin (Ward, Mattick & Hall, 1998). In essence, those receiving MMT are provided with a legal drug (methadone) as a replacement or substitute for an illicit or problematic one (i.e. heroin).The methadone prescribed for MMT is usually prepared as a liquid for oral ingestion. Methadone is typically prescribed at a level that prevents the symptoms of opioid withdrawal in the drug-dependent recipient (Bell et al, 2002). Australian guidelines suggest initial dosing levels should be up to 30mg per day (to allow monitoring for toxicity), with subsequent maintenance dosing of around 60-100mg per day (Henry-Edwards, Gowing, White, Ali, Bell, Brough et al. 2003). Dosing is administered and monitored by authorised prescribing doctors in public and private outpatient clinics. Doses are also distributed by some community pharmacies. After a period of stable dosing, and usually subject to doctor/patient negotiation and monitoring, MMT clients may qualify for take-home doses of methadone ('takeaways') and do not have to attend a clinic or pharmacy every day.

Despite its benefits, practitioners within the drug and alcohol field acknowledge that MMT has a fundamental problem for those seeking to 'treat' illicit drug addiction – this form of drug treatment cannot claim to cure the individual's dependence on opioid drugs (Bell et al, 2002; Dole, 1988; O'Brien, 1997). In substituting methadone for heroin, MMT involves the replacement of one form of opioid dependence for another, albeit a medically prescribed form. MMT is therefore quite different from other forms of drug treatment that encourage clients to withdraw from the use of drugs altogether (e.g. detoxification, 12-step

programs). Explaining the continuation of opioid dependence under MMT requires some finesse on the part of substitution treatment advocates in order that MMT is not seen as a form of legalised opiate distribution. As Phillipe Bourgois (2000) has noted:

> The contrast between methadone and heroin illustrates how the medical and criminal justice systems discipline the uses of pleasure, declaring some psychoactive drugs to be legal medicine and others to be illegal poisons (p.167)

Discriminating between the acceptability of legal and illegal substances (by defining some as 'medicines' and others as 'illicit drugs'), is part of the work that must be carried out in order to position methadone as a valid treatment for opioid dependence. More commonly, advocates of substitution treatment highlight the shift to institutional engagement and clinical regulation, and the subsequent 'stabilising' effects on clients' lifestyles, as one of the principal benefits of and justifications for MMT. Bringing drug users within the regulated system of treatment means that the use of street drugs of unknown origin can be replaced with known substances:

> Supplying a drug in a "treatment" context is a dramatically different activity from supplying the same drug in an illegal street market. An illegal and expensive street drug of unknown potency and purity is replaced with a medication. The role of the consumer changes, from being an autonomous agent to being a participant in treatment (p.1151, Bell et al, 2002).

Substitution treatment's acceptability and suitability is justified with reference to the 'knowability' of the treatment context (and the drugs used therein), but also to the apparent change in status of the drug treatment client from 'autonomous agent' to 'participant in treatment'. This change in the autonomy of MMT clients is significant, suggesting that part of substitution treatment's desirability is the perception that clients relinquish the freedom to pursue a drug-using lifestyle and instead willingly participate in treatment (where, by implication, they are subject to greater oversight and less free to act autonomously).

This change in the freedom or agency of clients is of course a quandary for advocates of substitution treatment, and (perhaps more pressingly) for the clients of treatment themselves. It is not clear whether clients can successfully engage in rehabilitation, avoid harmful drug use, and pursue stable or 'normalised' lifestyles, if their participation in treatment ties them to institutionalised or heavily regulated patterns of care, reduces their capacity for independent action, and maintains their dependency on drugs, albeit licit ones (Bell et al, 2002; Zajdow, 1999). If we wish to improve the experiences (and outcomes) of those in treatment, we must therefore consider how drug treatment clients exercise agency within the constraints of treatment, and negotiate feelings of dependency when receiving prescription drugs (such as methadone). These questions form the central focus of this paper.

While most studies of MMT focus on maximising treatment outcomes through issues such as dosing, administration and client retention (Lilly, Quirk, Rhodes & Stimson, 2000), few studies have considered the treatment experiences of MMT clients in general and the role of client autonomy or agency in particular. Those

that have suggest that clients actively test and negotiate the treatment systems of MMT, adapting to the constraints of treatment while retaining their own priorities for health and lifestyle.

Ana Ning's (2005) study of clients and staff at a methadone clinic in Toronto, Canada, suggests that MMT clients are actively involved in testing the limits of treatment regulations, trying to find favour with staff and attempting to maximise the benefits they receive from treatment (where benefits are not just 'treatment outcomes' as defined within regulations). Reporting on or gossiping about other clients, and dressing to impress those in authority, are examples of 'tactics' (de Certeau, 1984) clients use to adapt to the constraints of treatment. Ning deliberately characterises these client tactics as 'complicity', arguing that MMT clients recognise they must sufficiently adhere to treatment guidelines in order to not appear troublesome or difficult (and face penalties from staff), yet clients will inevitably seize opportunities within the regimented treatment system to gain modest personal benefits. Ning is clear to point out that clients' tactics are an inevitable response to the rigours of the MMT system, and not a sign of clients being 'non-compliant' (Wright, 1993), deficient or lacking skills (Treloar & Holt, 2006). MMT clients try to make treatment work for them within the broader context of their lives, adapting their treatment as 'one of many strategies towards health' (p. 372, Ning, 2005).

Ning's (2005) work is a corrective to bleaker analyses that see MMT as little more than a system of social control, implemented in ways that restrict and subjugate clients (e.g. Bourgois, 2000). Instead, it affirms that regulated subjects often find unexpected ways to act within the constraints of disciplinary power or

expert knowledge, although this rarely results in a challenge to the terms of the system itself (de Certeau, 1984; Foucault, 1980; Holt & Stephenson, 2006). Complying with a MMT regime, and aligning oneself with the contemporary 'duty to be well' (Greco, 1993), may be an ambivalent experience for MMT clients, intensifying their practices of (self-)regulation and burden of responsibility (cf. Rose, 1989) but also opening up opportunities for action, many of which will be modest, covert or unexpected.

Emilie Gomart (2002, 2004) also makes issues of client agency central to her analysis of a French methadone clinic. In this clinic Gomart suggests that staff deliberately set out to find forms of 'generous constraint' (rules, suggestions and 'mini-contracts') that provoked activity and resistance among clients, with the aim of furthering client progress within treatment. Gomart's analysis suggests that staff recognised the tactics and agency of MMT clients and tried to harness this potential for action to improve treatment outcomes. The staff Gomart spoke to described how they tried to find the levers for change (such as the desire for takeaway doses, using urine tests to establish success in treatment, or how to agree a stabilised dose) that would both enmesh drug users within treatment and propel them towards rehabilitation. Gomart's description suggests the clinic is unusual in accommodating the difficulties clients have in adapting to treatment, while also using these difficulties as prompts for change. What is not clear from Gomart's analysis is whether clients experienced this form of MMT organisation as any more fair, just or beneficial than rigorously regulated forms of MMT, such as that described by Bourgois (2000). It is likely that even within the 'generous constraints' of the clinical setting Gomart describes, clients maintained their

own diversionary 'tactics' to preserve a sense of independence and a life outside the clinic.

The analysis presented in this paper echoes the work of Ning (2005) and Gomart (2002) in that it considers how Australian MMT clients exercise agency and experience dependency while participating in treatment, and how experiencing regulation and constraint may be productive of agency among clients in some circumstances. However, my analysis also shows that prescription drugs other than methadone, in this case, antidepressants, generate similar issues around dependency and agency for MMT clients. I therefore suggest that drug treatment clients may have very similar anxieties about medication to those of the general population, challenging the idea that drug treatment clients, having demonstrated a problematic relationship to illicit drugs, have an inherently 'excessive appetite' for drugs in general (Keane, 2002; Orford, 1985; Sedgwick, 1993). To situate these concerns, below I outline the common experience of mental health problems and related medications (particularly antidepressants) for drug treatment clients, and research that suggests people are often ambivalent about consuming medication over the long-term.

Compared with the general population, drug treatment clients are diagnosed with very high rates of comorbid mental health problems (around two-thirds meet diagnostic criteria), most commonly mood and affective disorders such as depression and anxiety (Callaly, Trauer, Munro & Whelan, 2001; Ross, Teesson, Darke, Lynskey, Ali, Ritter et al, 2005; Teesson, Hall, Lynskey & Degenhardt, 2000; Teesson, Havard, Fairbairn, Ross, Lynskey & Darke, 2005). Although

some participate in psychological counselling or psychotherapy, within Australia drug treatment clients diagnosed with mood and affective disorders typically receive psychiatric medication as a frontline mental health treatment, as medication is a less resource-intensive mode of intervention. This means that drug treatment clients receiving substitution treatment are often additionally medicated with psychiatric drugs.

Psychoactive medications like antidepressants are designed to alleviate troubling, debilitating symptoms and, like MMT, help patients return to the realm of 'normal', productive life. Contemporary antidepressants, like Prozac, Zoloft and other selective serotonin reuptake inhibitors (SSRIs), are offered to clinicians and the public as targeted neurochemical interventions that allow us to cope with the 'exigencies of the life to which we aspire' (p.58, Rose, 2003). As in other countries, there has been a rapid increase in the prescribing of SSRI antidepressants in Australia since the 1990s (McManus, Mant, Mitchell, Montgomery, Marley & Auland, 2000).

However, like MMT, antidepressants rarely 'cure' or remove the causes of the problems they are designed to treat (Healy, 1997; Rose, 2003). In consenting to antidepressant treatment, patients may be committing themselves to a long-term reliance on these drugs; Australian guidelines suggest that antidepressant treatment should last for at least one year in the first instance (Ellis & Smith, 2002). This can be an uneasy experience, given that people are often uncomfortable taking medicines for long periods of time (Carder, Vuckovic & Green, 2003; Grime & Pollock, 2003; Pound, Britten, Morgan, Yardley, Pope, Daker-White et al, 2005). Discomfort in relying on medication is one of the

many reasons patients give for not 'adhering' to their prescribed treatment regimen (Conrad, 1985; Grime & Pollock, 2003; Steiner & Earnest, 2000). Using antidepressants may stigmatise patients by identifying them as mentally ill or chemically dependent and necessitate strategies to manage the disclosure (or concealment) of pharmaceutical use and depression (Garfield, Smith & Francis, 2003; Grime & Pollock, 2003, 2004). Patients may also need to renegotiate their sense of self to incorporate long-term medication use (Carder, Vuckovic & Green, 2003). For drug treatment clients receiving MMT, a prescription of antidepressants or similar drugs can mean an intensification of concerns around their reliance on medicine, the risk of drug or institutional dependence, and the prospect of dealing with drug and mental health problems without resorting to pharmaceutical products.

In the accounts that follow, the ways that clients engage with methadone and antidepressants will be explored, illustrating how engagements with different medications can assist or hamper clients' attempts to act with agency. As will become apparent, it is not suggested that psychoactive medications in and of themselves produce agency or passivity, but that it is in negotiating the consumption of these substances within the constraints of treatment that MMT clients may discover unexpected capacities for action or unacknowledged anxieties about dependency.

The study

The interview material presented here was collected as part of a qualitative study of barriers and incentives to drug treatment for people with both illicit

drug and mental health problems. The study was conducted by the National Centre in HIV Social Research, the Australian Injecting and Illicit Drug Users League (AIVL) and LMS Consulting. Approval for the conduct of the study was granted by the University of New South Wales Human Research Ethics Committee and local ethics committees in all of the jurisdictions where recruitment took place.

To reflect a range of metropolitan and regional areas in Australia, participants were recruited from Brisbane (Queensland), Perth (Western Australia) and Sydney and Bathurst in New South Wales. Recruitment was achieved using peer recruitment (employing local drug treatment clients to find eligible people through social networks), word-of-mouth, and advertising in local drug treatment centres and user organisations. In each location, AIVL brokered access to drug user organisations (where available) and oversaw the peer recruitment process, ensuring that recruiters were adequately trained and supported in their work. Potential participants had the project explained to them and were screened for eligibility by a peer recruiter. To be deemed eligible, participants had to be able to give or withhold consent, be aged 18 or over, report a history of illicit opiate or stimulant use, have current or recent experience of drug treatment at a public or private institution (within the previous two years), and report a clinical diagnosis of (or treatment for) a common mood or affective disorder, such as depression or anxiety, during the previous two years.

Peer recruiters arranged interview times with eligible participants. Interviews were conducted face-to-face by a member of the research team (the author or a colleague) after participants were provided with a project information sheet and

had given written consent. The majority of interviews were held at local drug user organisations, with a minority being conducted at drug treatment or research centres or participants' homes. Interviews were semi-structured and tape-recorded, focusing on drug use history, experience of drug treatment, mental health background and mental health treatment. Interviews lasted up to one hour. Participants received AU$20 expenses for taking part in the study.

77 consumers of drug treatment services were recruited across the four sites. The mean age of participants was 37 years with an equal representation of men (n=39) and women (n=38). The majority of participants were Australian born (n=63) and 12 reported Aboriginal or Torres Strait Islander heritage. All participants had sought drug treatment after problems with illicit opiate or stimulant drugs, particularly heroin and amphetamines. Nearly all the participants (n=70) had received or were receiving substitution treatment (most commonly MMT), and a similar number (n=73) had received a diagnosis of depression during their treatment history. Less than a third of participants (n=22) had received a diagnosis of anxiety.

After being transcribed verbatim, checked for accuracy and de-identified, interviews were coded by the research team according to main areas of interest (e.g. experiences of substitution treatment, relationships with doctors, mental health background) and entered into NVivo qualitative analysis software. Analysis proceeded by taking each main area of coding in turn and looking for patterns of consistency and points of difference, drawing on the core procedures of post-structuralist discourse analysis (Potter & Wetherell, 1987; Willig, 2001). Points of connection (or contradiction) between coded areas were also

identified. The experience of different types of medication, particularly MMT, antidepressants and other prescription drugs, was identified as an area warranting further attention and provided the starting point for the analysis presented here. All quoted participant names are pseudonyms and other identifying details have been removed or changed.

Methadone maintenance treatment

> 'It [methadone] makes me feel like a normal person. There's no highs, there's no lows, there's no wanting to use, there's no… you're just a normal person. The only thing I do different to everyone else is that I need to go to a chemist every day' (Craig, 30 yrs old)

For participants like Craig, the experience of MMT was strongly aligned with the broad aims of most substitution programs – returning clients to a semblance of normal life. Craig felt that methadone had helped him overcome his desire to use heroin, and that his moods no longer fluctuated as much as when he was using heroin. Despite having to go to a pharmacy every day to get his methadone dose, Craig felt that he had become a 'normal person' through MMT. For others, the experience of methadone was not so benign:

> '…if it was effective treatment I'd tolerate that but it's just not an effective treatment and the idea of eventually having to withdraw from methadone is just too daunting. I never want to do it again, at all. It's really awful. If um…it's ridiculous the methadone program it's so… rigid, which is never going to change because it's sort of, it's just never going to, the whole culture is against what would be necessary.' (Richard, 35 yrs old)

> '…it was good because it stabilises you and y'know, you're not hanging out everyday and you can, y'know start getting your life back together, go to work. Um the problem with methadone is that you're chained to it, y'know? You can't go away without a lot of drama organising takeaways or getting doses somewhere else so, y'know that's, that's the worst part about being on methadone is having to go there every day' (Kate, 44 yrs old)

Many participants described their anxiety at becoming dependent on methadone, not only in terms of physical dependence on the drug but also in terms of being 'chained' to the restrictions of the MMT program (the phrase 'liquid handcuffs' was often used to describe the experience of MMT). While some were fearful about methadone withdrawal (which most, like Richard, agreed was 'really awful') and their prospects of eventually getting off methadone, it was equally common for MMT clients to resent the restrictions placed on them by participating in the program. Attending for dosing every day, restrictions on takeaway doses, and not being able to travel for work or pleasure were just some of the frustrations commonly reported by clients like Kate. The idea of a 'treatment' that maintained dependence (on the drug and on the institution delivering treatment) was difficult for clients to rationalise and could be seen as a threat to recovery:

> '…that's the only problem with methadone, it drags you back to the same mindset you had when you started it, you have healed in other ways but, the raw addiction is still there and that can overpower your other thoughts at the time and it can ruin your treatment as you go back into

> that mindset. You've got to keep reminding yourself that you're not an addict so much any more but you're just getting through this healing period' (Bruce, 44 yrs old)

> 'For me to cope and not feel so scummy, I'd tell myself 'Oh, it's just the medicine I have to take' and that's how I dealt with it [methadone]. But um in the beginning I could come off it easily and not go on it for eight months or even a year one time but then, each time I got back on it, it became harder to get off it.' (Stuart, 40 yrs old)

Clients like Bruce and Stuart (who had both experienced many years of MMT) had to work to maintain the idea that methadone was a treatment or form of therapeutic medicine, and not just another form of addiction requiring intervention. Bruce, in particular, suggests that clients must actively work against the restrictions of treatment in order to make progress. However, the similarity of the treatment to the drug problem it was designed to alleviate was often too apparent to clients, making it difficult to feel that they were making progress in 'recovery' or 'healing'. The sense of dependence on methadone was matched by a common desire to be free of the program, to become independent. For many their level of dosing (how many milligrams of methadone they were receiving each day) became an important marker of their success in managing their reliance on methadone:

> 'I'm only on 30mg, so, like I'm not on 100 or nothing like that. I've never been over 60, y'know like I don't really use it and I didn't really need to

> go up that high. Um, yeah, just on a maintenance dose.' (Mark, 26 yrs old)

Achieving a low and stable dose held some importance for participants like Mark, as it appeared to suggest that they 'didn't really need' methadone and could explore the prospect of leaving treatment at some point in the future. However, many of the longer-term clients had experienced alternating periods of low and high doses and did not view a low daily dose as inevitably leading to further reductions. Although the idea of being 'free' of methadone was valued, participants often recognised that remaining in the program continued to be necessary to avoid problems with heroin use. John was one of the participants who had reconciled remaining on the program by emphasising that methadone gave him a choice about using heroin or not:

> '…at the moment I am quite happy to find a maintenance dose which strikes a reasonable balance um, I don't want to go too low coz I know if I start lowering my dose too much, too quickly I'll go back to using which I don't want to do, on the other hand I don't want to be on a dose so high that I can't use ever. And it's funny it's one of those, just knowing that I can is nice even though I choose not to. And I suppose it's more empowering as well, I think 'I've got the money in my pocket, I could use heroin if I want to but I choose not to'' (John, 34 yrs old)

For John, striking 'a reasonable balance' between methadone and heroin was important in giving him a sense of control over his drug use. John felt he had arrived at a methadone dose which prevented him returning to regular heroin

use (a 'habit'), but which did not preclude the occasional 'taste' of heroin for pleasure. In many respects, John gives the impression of managing both his methadone and heroin use, playing one off against the other to achieve the most strategic benefit and balancing the cultural demands for both control and release in the management of his health (Crawford, 1984). This appears to be an example of controlled and strategic drug use (Parker, Williams & Aldridge, 2002; Zinberg, 1984), a modest exercising of agency within the broader confines of treatment like the client 'tactics' described by Ning (2005).

Antidepressants

Nearly all the participants recruited into the study had received a diagnosis of depression at some point during their experience of drug treatment. Many of these people had been prescribed antidepressants (most commonly SSRIs) to cope with depression and many had been prescribed a number of different antidepressants over time. Participants often had extensive 'medication careers' (p. 414, Carder, Vickovic & Green, 2003), recounting experiences of many different pharmaceutical drugs. The main positive effect of taking antidepressants reported by participants was a reduction in severity of symptoms of depression, giving participants a greater sense of control over their lives:

> 'Yeah they've made a difference, I was able to cope for the first time without being overwhelmed with my feelings. Just get stuff done, get more structure in my life.' (Helen, 24 yrs old)

However, often the same participants could report side effects or problems in taking antidepressants. Common side effects that participants attributed to

antidepressants included tiredness, dizziness, nausea and disturbed sleep. For some the effect of antidepressants was to 'dull' their experience of everyday life, erasing both the highs and lows associated with 'normality':

> '…it was like blurry vision in the morning and you had a hangover and a furry tongue and do you know what I mean? That feeling, that just a horrible, ahh, so I just stopped taking them altogether' (Jack, 41 yrs old)

> 'I missed the high highs. Y'know, I miss my highs and the lows are part of life I'd come to accept. But the highs I missed, y'know, and that sort of plateau that antidepressants put me on I didn't enjoy really.' (Francis, 38 yrs old)

For participants like Francis, although antidepressants alleviated the 'lows' associated with depression, the unexpected flattening of the 'highs' he had previously experienced was of some concern. Not being able to experience the extremes or 'rawness' of life was seen as a reason to stop taking antidepressants. Side effects (or unexpected or unwanted effects) were often cited as a justification when participants decided to stop taking antidepressant medication. For others, the apparent ineffectiveness of the medication they were prescribed was a source of frustration and another reason to reconsider taking it. For these participants, any noticeable beneficial effect would have been welcome:

> 'Antidepressants, Zoloft um all those other ones, y'know what I mean and it's supposed to, they kick in after a while, they kick in after a while, y'know what I mean like, fuck I've been taking them for six months, when are they gonna kick in?' (Geoff, 37 yrs old)

> ‘Okay so I was on antidepressants for a while and, and they reckon with antidepressants y’know, you can’t tell whether they’re helping or not, people around you can, y’know which was sort of this kind of spurious way of saying ‘you might think they’re not working, but they are really, believe me,’ y’know and so I stopped taking them, and I mean I didn’t really feel that different.’ (Peter, 38 yrs old)

In cases like Geoff and Peter’s, participants believed that antidepressants might help them and persevered in taking them even when they did not notice any changes in their mood or behaviour. However, the ongoing absence of noticeable or recognisable therapeutic effects (particularly, we should note, for clients who had experience of drugs having fairly immediate or dramatic effects) was associated with participants quitting their medications. Not feeling ‘that different’ after stopping taking antidepressants (as Peter described) was then often cited as additional proof that the drugs had been ineffectual. Other participants were ambivalent about taking additional medication and could refuse to take antidepressants, despite or perhaps because of their problems with drug dependence:

> ‘…some people can judge you and say ‘he’s on antidepressants’ or ‘he’s on methadone, he’s not clean’ or y’know, it’s about within myself whether I think I am clean or not or whether I am happy with being on medication or whether I am not happy being on medication... and I have never really been happy being on medication, it’s been just like a last option...’ (Matt, 42 yrs old)

> 'I really don't want to enter into a chemical regime to try um to do anything about it [depression]. Um… I think a job would cure it.' (Tom, 48 yrs old)

Matt and Tom express common reservations about taking medicines. For Matt, taking any form of medication clashed with his belief that he should be 'clean' or free from all drugs (Matt had been a keen participant in the abstinence-based, Narcotics Anonymous program). For Tom, he did not believe that his depression would be 'cured' by drugs and thought that re-engaging in the workforce would be a better solution. Ambivalence about taking medication (or medication in addition to methadone) was linked to participants moderating their use of antidepressants, despite the advice of doctors:

> 'I use Cipramil more like a bandaid now. I'm prepared to go on it for a two to three months period and then stop. I've had doctors tell me in the past that they would like me to stay on it but I just don't like that idea. Yeah, so I use it as a bandaid.' (Stuart, 40 yrs old)

The anxieties MMT clients have about antidepressant medication and the reasons they give for modifying or stopping antidepressant use are remarkably similar to those found in studies of patients receiving antidepressants but not in drug treatment (Bultman & Svarstad, 2000; Grime & Pollock, 2003, 2004). It is interesting to note that the absence of intended, noticeable or therapeutic drug effects, the presence of undesirable effects, or ambivalence about taking additional medication often seemed to motivate agency (decisions about treatment) in drug treatment clients. Agency was thus often incited by problems

with antidepressant treatment, rather than the success of drugs in ameliorating symptoms. While refusing antidepressants, deciding to stop taking medication or moderating one's dose (generally without discussion with doctors) could be characterised as 'non-compliance' within a biomedical framework, we could equally regard these instances as patients taking control of their treatment to alleviate common anxieties about chronic medication (Carder, Vuckovic & Green, 2003; Conrad, 1985; Steiner & Earnest, 2000; Pound et al, 2005; Wright, 1993).

Discussion

The material presented here challenges a number of common assumptions about drug treatment clients, particularly the idea that former or current drug users have an inherently excessive appetite for psychoactive drugs or that they lack the willpower to make decisions about treatment (Keane, 2002; Orford, 1985; Sedgwick, 1993). It is also raises interesting questions about how treatment can encourage agency without intensifying anxieties about dependence, and whether, as Gomart (2002) suggests, a degree of 'generous constraint' within treatment can encourage rehabilitation among clients.

Those receiving MMT or antidepressants can appreciate the beneficial effects of these treatments, aligning themselves with treatment goals and trying to use therapeutic drugs to return to the path of productive, self-regulating citizenship. Participants rarely refused their cultural 'duty to be well' (Greco, 1993). However, in their attempts to become productive, rational, healthy subjects, anxieties about dependence (on drugs, treatment or institutions) often became

intensified (see McKeganey, Morris, Neale & Robertson, 2004). This appears to be one of the consequences of encouraging neoliberal, self-regulating forms of citizenship within drug treatment (Moore & Fraser, 2006), but whether anxieties about dependence can act as levers for change and generate beneficial progress for clients receiving MMT, as Gomart (2002) suggests, is open to question.

When they found that participating in the program emphasised their dependence on medication and tied them to clinical supervision, MMT clients struggled to see methadone as a 'treatment'. This is perhaps no surprise, given the pejorative connotations of 'dependence' and the cultural value assigned to attaining 'independence' (Fraser & Gordon, 1994; Keane, 2002; Reindal, 1999; Room, 1985). The intensification of a sense of dependence within the treatment program could strengthen participants' desire to be free of drugs (both licit and illicit), but participants rarely described successful experiences in quitting methadone under these circumstances (see Lenné, Lintzeris, Breen, Harris, Hawken, Mattick et al, 2001).

Although it is true as Zajdow (1999) notes that 'Indefinite MMT does not allow for a drug free existence' (p.76), I do not want to suggest that MMT is an inherently problematic therapy or without benefit, or that we should automatically assume that a 'drug-free existence' is better than one that incorporates medication. However, what is clear from the current study is that, like other consumers, MMT clients may be ambivalent about dependence on any drug, including methadone and antidepressants. This anxiety about dependence may be an integral part of trying to become a rational, decision-

making, productive subject (Rose, 1989), and may motivate client decisions about treatment.

While the risk of institutionalisation and passivity is recognised by substitution treatment providers (e.g. Bell et al, 2002), what is rarely acknowledged is that MMT clients have the capacity to assess their treatment (and to decide whether to continue using illicit drugs or not), and that exercising this agency can produce anxieties for clients. This may reflect the fact that those marked with the sign of 'addiction' are often seen as lacking rationality or as being psychologically deficient (Keane, 2002; Sedgwick, 1993; Treloar & Holt, 2006). Acknowledging that clients in some circumstances can institute their own controlled and strategic use of methadone and other drugs to maximise both treatment stability and the maintenance of pleasure may be a way to foster greater independence among clients (Gomart, 2002; Parker, Williams & Aldridge, 2002; Zinberg, 1984). Unfortunately, this may be a difficult and risky strategy for clinicians in a political climate in which harm reduction is contested, abstinence and prohibition continue to be highly valued, and discussions of pleasurable drug use are fraught (Brook & Stringer, 2005; Keane, 2003; O'Malley & Valverde, 2004).

As in Ning's (2005) study, MMT clients in the present study engaged with treatment but also modified it in limited 'tactical' ways to fit in better with their needs. However, the difficulties they faced in participating in MMT did not seem to be used as motivators for change as Gomart (2002, 2003) describes. Perhaps the kind of progressive treatment philosophy that Gomart outlines needs to be in place first before clients and service providers can use treatment

problems as drivers for progress or change. However, it remains to be seen whether adopting this kind of treatment philosophy on a broader scale would be well received by MMT clients or not. It might be possible to reposition difficulties or challenges in treatment as opportunities for change, with staff and clients working together to achieve progress after problems have been identified. It is equally possible that the philosophy of 'generous constraint' could be seen as a way to justify restrictive regulations on clients participating in treatment. Clients may be prompted to act because or in spite of constraints within treatment, but whether this is an ethical mode of treatment delivery is debatable.

It is also interesting to consider whether treatment could encourage client decision-making without contributing to a greater sense of personal responsibility and fear of dependence among MMT clients. In fostering self-reflexivity and independent action, success in treatment (however arrived at) may inadvertently induce the fear of losing that independence and capacity for action. This may, in fact, be an inevitable consequence of striving to become an autonomous subject (Moore & Fraser, 2006; Rose, 1989), and treatment programs would do well to better acknowledge this source of concern among clients.

Participants' experiences of antidepressants also emphasise that, despite debilitating or troubling symptoms, drug treatment clients may be highly ambivalent about taking chronic medication, like other health consumers (Carder, Vuckovic & Green, 2003; Conrad, 1985; Pound et al, 2005). While attempts have been made to sell contemporary SSRI antidepressants as highly

refined, targeted interventions for the treatment of depression, the accounts of drug treatment clients support the idea that the effects of these 'wonder drugs' are often highly variable (Grime & Pollock, 2003, 2004; Healy 1997; Rose, 2003; Wilson, 2004). Unexpected or unpleasant effects or an apparent lack of noticeable impact can motivate clients to modify, reduce or stop a course of antidepressants, 'tactically' negotiating or ignoring clinical recommendations (de Certeau, 1984). Some do not want to resort to medication to deal with symptoms of depression and are motivated to seek out other options, such as employment or talking therapy, but these options are often difficult for drug treatment clients to access (Treloar, Abelson, Cao, Brener, Kippax, Schultz et al., 2004).

Clinical research suggests that it is far from clear whether SSRI antidepressants are of any significant benefit to drug treatment clients, either in reducing depressive symptomatology or in assisting clients in continuing with drug treatment (Dean, Bell, Mascord, Parker & Christie, 2002; Nunes, Sullivan & Levin, 2004; Torrens, Fonseca, Mateu & Farré, 2005). Other treatment options may be preferable, such as counselling, psychotherapy or assistance in achieving productive life goals (Ellis & Smith, 2002). Even when antidepressant medication seems warranted, the material presented here suggests that consumer anxieties about chronic medication need to be addressed. Research suggests that patients are more likely to accept their medicines if they understand why (and agree that) medication is necessary, understand what drugs are supposed to achieve, and are offered options for moderating or

stopping use, particularly if the treatment goes awry (Bultman & Svarstad, 2000; Carder, Vuckovic & Green, 2003; Conrad, 1985; Pound et al, 2005).

If clients cannot be convinced of the need for medication or its efficacy, they will continue to modify or refuse treatment regimens. This is not recalcitrance on the part of drug treatment clients but a failure within service provision to explain the need for treatment, its consequences, and how clients might manage unexpected or unwanted treatment effects. It is also a failure to recognise that clients will be actively involved in negotiating their treatment, and that trying to encourage clients to become engaged decision-makers will likely intensify anxieties about dependence. Rather than positioning clients as 'non-compliant', treatment providers would do better to recognise clients' investments in their own wellbeing, and to consider treatment options that could be better aligned with clients' capacities for decision-making and tactical modifications of pharmaceutical interventions. Otherwise, drug treatment will continue to produce experiences of dependency amongst its clients, clients will continue to perceive medication as clinical and pharmaceutical excess, and client agency will continue to be motivated by treatment limitations rather than treatment success.

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