

Methadone maintenance treatment in New South Wales and Victoria: Takeaways, diversion and other key issues

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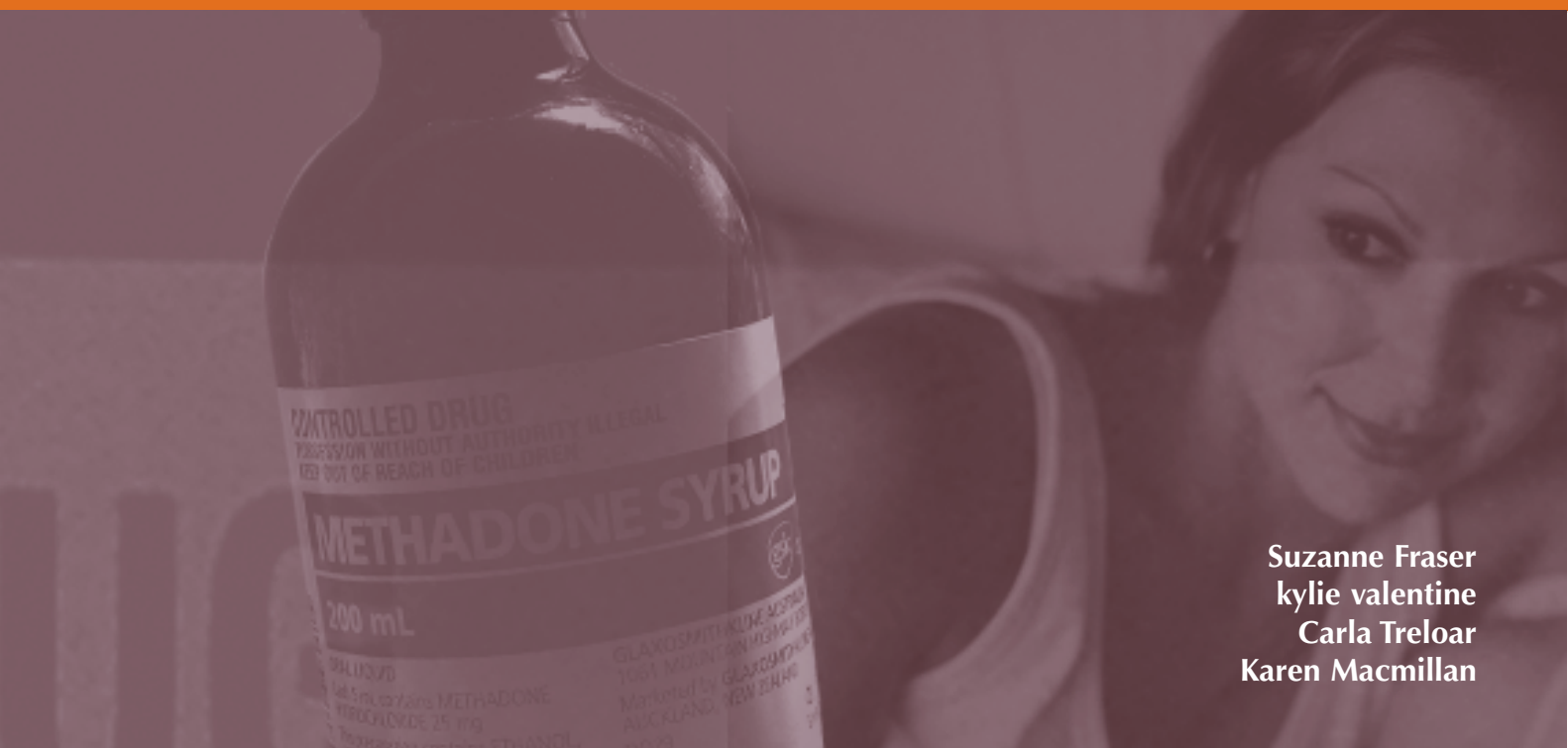
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Takeaways, diversion and other key issues



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Key findings and recommendations

The key findings and recommendations presented below summarise the study's most significant results and are aimed at strengthening and improving methadone maintenance treatment in Australia. More detail on all these matters and many others of importance can be found in the section on 'Findings'.

1 Takeaways were of central importance to almost all clients interviewed in this study, be they male or female, located in urban or regional settings, new to treatment or veterans of treatment. **Takeaways were identified as contributing greatly to:**

- finding and retaining employment
- fulfilling family responsibilities
- the ability to travel for work and leisure
- self-esteem and a sense of progress in treatment
- control over contact with other clients
- confidentiality in treatment
- cessation of illicit drug use.

It is essential that present and future policy on takeaways allow adequate recognition of the differences in clients' circumstances, and adequate flexibility in prescribers' ability to prescribe takeaways.

2 **Diversification of methadone was described in a range of ways** in the interviews. These included sale to strangers, sale to friends or acquaintances, and sharing with friends or acquaintances. When seeking to understand the dynamics of diversion, it is essential to bear in mind the role of the following factors in instances of sale and sharing:

- unmet demand for treatment
- the economic disadvantage of most clients
- the operation of values of reciprocal care and responsibility.

Inasmuch as opportunities for treatment are inadequate, clients are economically disadvantaged and dosing interferes with clients' ability to obtain and retain paid employment, diversion needs to be understood as a product of social and

political factors as much as of individual factors. Policy makers, drug treatment service providers and other government agencies should all be seen as having a role in supporting drug users such that those both inside and outside the program can become less reliant upon diversion to meet their needs.

3 More broadly, there is a **need for greater coordination among agencies** so that a collaborative approach to the care of clients can be adopted. Drug dependence is not the only issue most clients face; indeed, drug dependence may be as much an outcome of other issues as it is a source of them. In this respect, there is a pressing need for agencies to work together to support clients, and for the recognition that alcohol and other drug services cannot alone provide all the necessary support if clients are to make genuine progress in treatment.

4 Comparisons between data from New South Wales and Victoria generally support the view that diluting methadone takeaways in Victoria helps minimise the diversion of methadone in that state. However, the data also suggest that this minimisation could simultaneously contribute to Victoria's higher levels of buprenorphine diversion and injection. There is no doubt that many factors contribute to these higher rates, but if the dilution of methadone is one of them, there is a **need to evaluate the benefits of dilution against the negative health effects of buprenorphine injection.** The hypothesis that methadone dilution relates to buprenorphine injection requires further research before any conclusions can be drawn.

5 Participants across all categories identified **parenting responsibilities** as an important issue in clients' ability to access and remain in treatment. For some clients, time commitments associated with child care represented a significant obstacle to dosing, especially daily dosing where takeaways were not provided. The financial burdens associated with child rearing were also identified as important in that clients sometimes experienced difficulty affording the cost of pharmacy dosing while meeting

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 **need for further qualitative social research into the interplay between treatment and families.**

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 **awareness of diversity among clients** 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 **unmet demand for treatment** 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 **need for increased funding for treatment** in both states.

8 Indeed, much of the data collected demonstrates the central role that **quality of treatment** 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:

- overcrowded or run-down treatment facilities
- overworked service providers
- inadequate training of service providers
- systems and procedures that do not sufficiently recognise the individuality and humanity of clients.

It is essential that policy makers and service providers reflect regularly on the ways in which funding limitations and residual negative attitudes towards clients among staff might adversely affect quality of care, and consider ways in which these adverse outcomes can be ameliorated or avoided by changes in policy and program delivery.

9 Related to this, there was widespread recognition among clients that the conventions of treatment in methadone maintenance treatment do not reflect those in other areas of medicine. Despite the identification of addiction as a health issue, aspects of treatment more closely resemble conditions in the criminal justice system. The impact of this disjunction, and of related **shortfalls in the areas of equity and natural justice**, on retention in treatment requires urgent attention. Again, more qualitative social research is needed in this area.

10 Our research into rural and regional service delivery highlighted both the **benefits and challenges of treatment provision in potentially isolated areas.** An important consideration in relation to this isolation is the fragility of services, their vulnerability to staff retirement and burn-out, and to difficulties in sourcing suitably qualified professionals. Programs in such areas require extra support in ensuring staff retention and continuity. Rural and regional isolation can also impact on clients, especially as a result of poor public transport. It is essential that clients living in these areas are able to access adequately flexible dosing arrangements, including sufficient takeaways, to ensure retention in treatment.

11 Our findings suggest that, with respect to the new clinical guidelines introduced in 2006 in both New South Wales and Victoria (see page 3), **additional resources are urgently needed** if service providers are to receive adequate support, and quality of service provision is to improve. These resources include:

- further education, training and mentoring of service providers (clinic staff, doctors and community pharmacists) in the assessment of clients and meeting client needs
- further training and support for service providers in reading and using the clinical guidelines. This includes 'refresher' courses through the life of existing policies
- a framework to monitor quality of treatment standards
- a robust and independent feedback and complaints-management process. Victoria's drug user representative organisation VIVAIDS currently runs a valuable complaints service, the Pharmacotherapy Advocacy, Mediation and Support Service (PAMS). Such mechanisms for handling complaints need significant expansion if clients are to receive adequate support in pursuing complaints to a satisfactory conclusion. This expansion should include increased resourcing for advocacy for clients navigating their state's health care complaints process (the Office of the Health Services Commissioner in Victoria and the NSW Health Care Complaints Commission) and, as noted above, consideration of the impact of competition for treatment places on clients' scope to pursue complaints.

Note on the 2006 changes to state policy

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.

Introduction

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

Methadone maintenance treatment (MMT) is widely recognised as the most effective treatment for heroin dependence

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, the impact of isolation on treatment, and the dynamics of diversion (see below), are relevant to buprenorphine and buprenorphine/naloxone provision as well.

The main focus of the study was twofold: the provision of takeaway doses of methadone, and diversion, that is, the selling, sharing or other off-label use of methadone by clients in New South Wales and Victoria. Takeaway doses of methadone are highly valued by methadone maintenance treatment clients because they offer flexibility and freedom from daily attendance at a clinic or pharmacy. In essence, they allow clients to develop or resume a lifestyle that does not revolve around accessing medication. However, the provision of takeaways has been linked to the diversion of methadone to street sale (Lintzeris et al., 1999; Neale, 1998), to the injection of methadone intended for oral consumption (Lintzeris et al., 1999; Darke, 2002; Vormfelde & Poser, 2001) and to instances of accidental fatal overdose among those who purchase street methadone (Lintzeris et al., 1999). For these reasons, takeaway dosing is highly controversial. Despite the complexities surrounding takeaways, little social research on them has been conducted in Australia. The project on which this report is based investigated the role takeaways play in MMT in New South Wales and Victoria, and looked closely at the conditions under which methadone is diverted to street sale and to other forms of sharing and circulation. In the process, it also identified a range of other issues of significance to MMT clients, service

providers and policy makers in Australia today. These too will be explored in the section on 'Findings'.

At present there are methadone programs in each state and territory except for the Northern Territory. The number of people in MMT has increased significantly since its introduction; for example, in New South Wales, the number of people entering MMT has more than doubled since 1987 (National Drug Strategy, 1998). In 2005, 38 937 people were registered in pharmacotherapy programs across the country (Australian Institute of Health and Welfare, 2006). The distribution of these between the two main pharmacotherapies, methadone and buprenorphine, is unknown and in any case very much in flux. However, given that methadone has had a much longer history in treatment in Australia and buprenorphine has known limitations (Barnett et al., 2001), there are good grounds for assuming that the majority of clients overall are taking methadone.

In New South Wales, MMT programs are conducted through both the private and public sectors. Public sector programs are commonly run as clinics, while private sector programs comprise both clinics and arrangements combining general practitioners and pharmacy-based dispensing. Some crossover between public and private sectors occurs, in which, for instance, private practitioners prescribe methadone from public clinics (National Drug Strategy, 1998). Public and private treatment differs in a range of ways. Of most relevance to this project are the differences in approach to takeaway doses. Fewer restrictions are placed on takeaways in the private sector than in the public sector. More clients in private clinics than in public programs obtain their doses through pharmacies, which are often less rigorously controlled than public facilities (Southgate et al., 2001; NSW Health, 1997). In general, private clinics have more autonomy than public programs.

In Victoria, MMT is largely administered by general practitioners and community pharmacies. However, specialist services are available for managing complex cases. Although the overwhelming majority of MMT is conducted privately in Victoria, this does not mean there are few restrictions around dosing. On the contrary, up until recently, restrictions were more stringent than in New South Wales. For instance, fewer takeaway doses were allowed by Victorian policy (Southgate et al., 2001).

Despite this broad range of treatment policy and practice, very little research is available on the role of takeaways in MMT in Australia (Southgate et al., 2001). The problems associated with takeaways suggest that there is a pressing need for public health research in this area. As Victoria's rates of methadone injection appear to be far lower than those in New South Wales (suggesting a

low level of diversion [Lintzeris et al., 1999]), adoption of a policy of reduced access to takeaways in New South Wales would appear to be logical. However, without a fuller understanding of the role takeaways play in MMT, such a decision runs the risk of creating other problems. For example, research indicates that a reduction in the availability of takeaways leads to a higher drop-out rate among MMT clients (Pani et al., 1996; Rhoades et al., 1998) and, conversely, that greater availability of takeaways benefits retention rates, even where dosing levels have been reduced (Rhoades et al., 1998). These findings suggest that takeaways are very highly valued by clients. Other research supports this observation (Calsyn & Saxon, 1999; Chutuape et al., 2001). Studies that manipulated takeaway frequency rates as a means of controlling aspects of the behaviour of service users report high rates of success. Focusing on the UK context, Neale (1998) argues that the views of service users on the conditions placed on substitute prescribing have been under-researched. A similar lack of data is evident in Australia.

Research on diversion is equally incomplete. Public health concerns about the widespread availability of diverted methadone have centred on methadone addiction, overdose, abuse and childhood poisoning, with each of these problems evident throughout the US (Greene et al., 1975). Early research identified methadone clients who sold part of their takeaway dose as the primary source of diverted methadone (Inciardi, 1977; Vista Hill Psychiatric Foundation, 1974; Weppner & Stephens, 1973). Over the past decade, international and Australian research has focused on methadone-related deaths and found that most mortality occurs among people who are not on MMT programs at the time of overdose (Caplehorn & Drummer, 1999; Ernst et al., 2002; Perret et al., 1999; Sunjic & Zador, 1996; Vormfelde & Poser, 2001). The authors of these studies speculate that those who died had accessed diverted methadone, perhaps to enhance the effects of other drugs or perhaps because of a high unmet demand for places in MMT programs (Ernst et al., 2002; Sunjic & Zador, 1996). Suggested strategies to minimise diversion and limit mortality from illicit overdose include the complete removal of takeaways, limiting the number of takeaway doses, diluting takeaway methadone syrup to volumes difficult to inject, and replacing takeaway methadone with slow-onset substances such as buprenorphine (Ernst et al., 2002; Lintzeris et al., 1999; Caplehorn & Drummer, 1999; Vormfelde & Poser, 2001).

Other studies, however, have indicated that diversion is on the whole uncommon (Spunt et al., 1986). Therefore, it has been suggested that removing takeaways from MMT programs in order to curb diversion would harm the majority of those on programs while failing to reduce diversion (Bell et al., 2002; Spunt et al., 1986). Several

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.

State policy and provision in New South Wales and Victoria

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 illicit drug use among clients.

Method

A total of 87 interviews were conducted between July 2004 and May 2006. Participants comprised clients ($n = 50$), prescribing doctors, dosing nurses and dispensing pharmacists (combined, $n = 29$) and policy makers ($n = 8$).² Each participant received an information sheet and signed a consent form. An in-depth, semi-structured interview method was used and questions covered a range of issues, such as experiences of and attitudes towards MMT, the meaning of takeaways in treatment, illicit sale and consumption of methadone, the impact of location on how easy it is to obtain treatment, and prospects for employment and social participation for clients. The interviews were approximately one hour in duration. The semi-structured interview format permitted a balance between consistency of topics and coverage and flexibility, enabling the issues most pertinent to interview subjects to emerge in context and via the modes of expression characteristic to them.

Participants were recruited from public and private programs, rural and urban needle and syringe programs and methadone clinics, state health departments and professional bodies in New South Wales and Victoria. Flyers and posters were distributed to surgeries, clinics, needle and syringe programs and user organisations to recruit clients, and a snowballing technique was also employed. Remuneration was offered to all clients to cover travel expenses and interview time. Doctors, nurses and pharmacists were recruited through professional organisations. MMT policy makers were contacted

¹ See Appendix 1 for details on the changes in policy and the new guidelines in New South Wales and Victoria.

² Among the clients interviewed for the Victoria arm of this study were three individuals who were on buprenorphine treatment at the time of interview. All had been in MMT in the past and were interviewed because, as will become clear in Section 2, some aspects of MMT are closely linked to aspects of buprenorphine treatment.

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.

Organisation of the report

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.

Section 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.

Section 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?

Section 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.

Section 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.

Section 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

		<i>n</i>	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)	NSW metro	10	4	6	32–55
	NSW regional	5	1	4	45–59
	Vic metro	9	3	6	36–62
	Vic regional	5	2	3	37–54
Policy makers (Total = 8)	NSW	5	2	3	44–61
	Vic	3	0	3	42–'50-ish'
Total		87*			

*Two interview participants classified as 'health care workers' were also classified as 'policy makers' in the analysis, due to their experience in both service delivery and policy development.

Findings

1 Takeaways: client perspectives

In evaluating MMT it is essential to gather clients' views (Neale, 1998). Consideration of these views can increase the efficacy of services (National Treatment Agency for Substance Misuse, 2005) and provide an understanding of the impact of MMT in terms of increases and reductions in demand for other health and social services (Neale, 1998). Despite this, there is a dearth of research on the perspectives of service users. Some overseas studies examine clients' perspectives on MMT in general (Fischer et al., 2002; Neale, 1998, 1999a, 1999b), but none focus on takeaway doses or on the conditions placed on substitute prescribing (Neale, 1998).

This section explores clients' descriptions of the role and meanings of takeaways, and outlines the ways in which takeaways are valued by them.³ In this, it offers

'I need and rely on takeaways.'

important information for the development and refinement of policy around drug treatment services.

The results discussed here are based on interviews with 25 methadone treatment clients in New South Wales and 25 in Victoria. For further demographic information on the clients, see Table 1, page 8. Forty participants used services provided by general practitioners (and received takeaway doses at a pharmacy), six used public methadone clinic services (one of whom received takeaway doses at a pharmacy) and four used private methadone clinic services.

A wide range of factors associated with takeaway doses was valued by participants. Numerous practical issues related to dosing were cited, including time, cost, travel and personal security. All these concerns were said by participants to be alleviated by access to takeaways, in that takeaways rendered dosing more convenient and compliance with treatment less arduous.

³ This section is based on an article published in 2007 in *Drugs: Education, Prevention and Policy*. See Appendix 3.

Participants also identified a number of less tangible issues related to the provision of takeaways, such as trust, respect, and protection of confidentiality (see Section 3). These had a strong impact on clients' sense of self-worth and the quality of their relationships with others, including service providers. The issues raised by participants are explicated below and illustrated with extracts from interviews.

The convenience of takeaway dosing was highly valued by participants, who noted its impact on a number of areas of daily life. Not being required to attend methadone clinics daily meant clients did not spend so much time travelling and waiting in queues:

INTERVIEWER: Were you getting many takeaways then, or?

SEAN: Yeah, I was able to pick up three at a time.

INTERVIEWER: Okay. And did that make things easier for you, or –

SEAN: Oh, hell of a lot easier. It gave me more time to do other things.

(Sean, client, metropolitan Victoria)

The time and effort involved in travel was identified as posing particular difficulties for those with child-care responsibilities (predominantly women), as well as for those with poor access to public transport:

Yeah right, well it makes a huge difference for me. Um, obviously I've got a child so, um that, that affects my mobility. I mean, I can get to the chemist with him, obviously, but um, public transport is always a bit of a hassle you know—getting on and off buses and stuff like that. Getting him organised, getting there on, you know, on time. It takes me, um, a good couple of hours to get there to the chemist and back [...] You know, it's a 20-, 25-minute walk to the bus stop from here.

(Lisa, client, metropolitan NSW)

The cost of travelling to clinics every day was also prohibitive for some participants:

[I]t's like, um, a bus and a train or at least a train, anyway, you know, and

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)

'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 ...'

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 for participants, standing as a marker of trust for many. As Debbie states:

I think there's a lot of judgment. So having [takeaways] in some really silly respects means that I can be trusted with them, yeah.

(Debbie, client, metropolitan Vic)

Further to this, some participants spoke of access to takeaway doses as a 'reward' for being a 'good' methadone service user, and as something to work towards through producing clean urine samples (demonstrating that illicit drugs have not been used). Participants also spoke of takeaways as marking the attainment of trust from service providers. This trust was, in turn, linked to improved self-image:

And, to me, um, these takeaways have made a big difference in my life. Like, it lets me know that the doctor trusts me, you know what I mean. And that's, to me, that's sort of like a judgment of where I'm at, type thing. By how many takeaways he'll let me have, it's showing me how much he trusts me.

(Sid, client, regional NSW)

I'm really glad that there are takeaways and I've been given the trust to have takeaways. I think it's a real sign of and trust between a doctor and patient. Um, and I feel really privileged that they feel that I've progressed enough, because I look at when I first got on the program to now, and I think that, yeah, I do deserve to have takeaways now, because I'm doing the right thing [...] there's not many ways that they can show you that you're doing well on the methadone program, because you just come in and pick up every day. But that's one way of getting a bit of a reward.

(Sam, client, regional Vic)

And it does make you feel a lot like people are starting to trust you finally. And that trust is one thing that's ... totally taken away when you're using all the time [...] And to have that, even just little things like that to build that trust up means a lot. Hell of a lot. And it's

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.

(Moir, 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.

Discussion

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 The diversion of methadone

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 medication was less widespread than was often suggested:

It's not as common as people tend to make out. That's another one of those myths. A lot of people like to say, 'Oh, I sold me 'done; that's where I got the money to get a shot.' You know, they might have got the money somewhere else. It's just a nice, easy story to tell people, you know.

(Danny, client, metropolitan NSW)

This explanation highlights the possibility, as will be explored below, that diversion sometimes operates as a cover to explain other perhaps less accepted means of obtaining money, such as theft or sex work.

While a wide variety of reasons for selling methadone were cited by New South Wales clients, there was a fairly broad consensus that methadone was often sold to generate the funds to buy other drugs, including—but not only—injecting drugs:

It's not just, like, for a shot of drugs, you know. It could be pills or alcohol or whatever, you know.

(Alison, client, metropolitan NSW)

It would be a mistake, however, to conclude from this that all diversion occurs as a means of accessing heroin. Diversion

was also understood in the context of those unwilling to enter treatment. According to some participants, illicitly

‘I think they sell it because [...] they'd much rather not [do anything] really illegal like stealing or doing anything bad for their money.’

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 desperation for drug money, particularly when withdrawal symptoms were present. Similarly, participants also indicated that, in times of financial need, takeaways provided relatively easy access to cash, reducing the impetus to participate in other activities perceived to be more dangerous or less socially acceptable. Indeed, a view of methadone as currency was common in the data:

It's a commodity which is practically like cash. If you've got a deal of heroin in your flat or house or you've got a bottle of methadone, it's like having cash, really [...] Because [...] being on a benefit, a full-time benefit, you just can't live on \$200 a week.

(Danny, client, metropolitan NSW)

This extract reflects similar comments made by many other participants. It highlights the ways in which impoverishment leads to the conceptualisation of personal possessions, including methadone doses, in terms of dollar value. Takeaway doses, especially larger ones, constitute a valuable commodity, and clients tend to know exactly what their methadone would fetch on the open market:

It's a dollar a mil [millilitre] at the moment. I'm on 140 mils. That's \$140 to go without my methadone for the day. Like, that's a nice income isn't it?

(Dave, client, metropolitan NSW)

Related to this, many participants cited the ability to finance other daily necessities as an important motive for selling doses. In particular, difficulty in meeting the

material needs of children was identified by several (mostly female) clients as a motive:

They might need it [extra money], like, if their kids are going to school.

(Alison, client, metropolitan NSW)

The only other reason is to maybe buy nappies for the baby. You know.

(Faith, client, metropolitan NSW)

I think they sell it because [...] they'd much rather not [do anything] really illegal like stealing or doing anything bad for their money. They think, 'Well, what can I do for money? I've got no money; my kids are hungry. I'll sell my takeaways.'

(Danny, client, metropolitan NSW)

Other motivations for diversion were also identified by the clients. These related to meeting the needs and demands of associates or partners. Some participants, for example, reported the practice of selling part, or all, of a dose as a result of encountering a friend who was in withdrawal and lacked the money to purchase heroin. Others attributed some diversion to the pressure clients sometimes experienced from others wishing to obtain their doses. According to this view, some clients, usually women, were menaced either by partners or by other people waiting near clinics and pharmacies to buy takeaways.

Of course, the market for methadone is as dependent upon buyers as it is on sellers. Participants were also asked to describe motivations for the *purchase* of illicit methadone. Responses included:

- the desire among some on the program for more methadone than they were being prescribed, sometimes for injecting purposes
- the fact that methadone was cheaper than heroin and longer lasting, assisting some, for instance, to sleep more soundly
- the tendency among some to favour methadone over heroin as somehow cleaner and more respectable (associated with 'hospitals' rather than 'alleyways')
- the desire to access methadone among those who had been expelled from programs, or who did not wish to submit to the rules and regulations of the program as a whole.

The most common reason given for the purchase of illicit methadone, however, related to the difficulty some saw in complying with what were often viewed as the unreasonable constraints of the program. Inevitably, it was argued, some clients found the program too restrictive, preferring to drop out of treatment altogether. Alternatively, they were expelled for non-compliance. As Danny observed:

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

‘[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.’

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)

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

and then spat out on exiting the clinic or pharmacy. To make diversion more difficult, doses are regularly crushed by dosing staff, often to a fine powder, and the service user is expected to hold the powder under the tongue for approximately ten minutes before leaving the premises. In practice, this time frame is often much shorter and, according to our data, this means that some clients are then able to spit out the slurry and sell it on. The results of this for those purchasing to inject have been alluded to by Debbie above.

Discussion

The data presented here reveal a range of reasons why people sell and buy methadone. Some of these, such as a lack of interest in highly regimented treatment programs, can potentially be addressed through changes to program design and policy. Others, such as the economic disadvantage and stigma experienced by many clients, and the associated inclination to see methadone as a commodity, require more far-reaching structural change.

Many clients are impoverished, have limited or no access to legitimate means of financial support beyond government benefits, and have limited ability to raise money at short notice. Diversion is one strategy to which clients in financial difficulties may resort in order to avoid the risks and dangers involved in alternative avenues of acquiring funds. While the sale of methadone clearly carries some risks, these risks may be perceived as, and in reality be, lower than those associated with their other options.

The data also indicate that large takeaway doses increase opportunities for diversion. This might suggest either that doses should be kept to a minimum or that those on high doses should be given access to fewer takeaways. Such conclusions would, however, ignore the benefits of sufficient takeaways for retention in treatment and minimisation of heroin use. British research (Neale, 1998) suggests that policies around takeaways in general may be too rigid. While the high toxicity of methadone means that minimising its unregulated circulation is sensible, the data signals that not all the effects of diversion are negative. Illicit methadone consumption appears to have a role in creating interest among clients in enrolling in a program, and in reducing crime committed to finance heroin purchase.

Importantly, the interview data suggest that the illicit market in methadone (that is, purchasing) is at least partly fuelled by the policies and regulations of treatment programs themselves. If diversion is to be reduced, more low-threshold programs such as that operated by the Kirketon Road Centre in Kings Cross, Sydney, may be necessary. These would not necessarily provide more takeaways but would offer more flexibility in terms of pick-up times, and

provide an environment in which the emphasis was less on urine testing and security measures, and more on outreach, follow-up and integration into primary health services.

By far the most important finding from this research on diversion concerns the specific effects of the different policies on methadone provision in New South Wales and Victoria. The data show that diversion is not simply a function of the availability of methadone takeaways. The form taken by the takeaways and, specifically, the practice of *diluting takeaways*, emerged in the data as a significant factor in the diversion of pharmacotherapies for injecting purposes. Indeed, there are strong indications that the effects of implementing a policy of dilution as a means of minimising methadone diversion for injection are not as straightforward as they are often presumed to be, and are not all desirable. In short, it is possible that one effect of Victoria's policy of dilution is not simply to minimise methadone injection and the harms associated with it, but to displace injecting practice onto other, potentially even less desirable substances and processes, that is, the injection of expectorated buprenorphine slurry.⁴ While Jenkinson et al. do not canvass this relationship in their 2005 article, 'Buprenorphine diversion and injection in Melbourne, Australia', it is possible to read their data along these lines. They find that buprenorphine injectors are more likely to have injected other drugs as well. Greater frequency of buprenorphine injection is correlated with more drugs injected, the exception being methadone. From this point of view, it is possible to conjecture that some drug users have an especially strong interest in injecting and will inject most drugs it is possible to inject. In Victoria, among the opioid pharmacotherapy drugs, this appears to include crushed buprenorphine tablets more than diluted methadone. Would the rates of buprenorphine injection drop if methadone injection were possible? This is not clear, but it is known that Victoria has an especially high rate of buprenorphine injection, (Jenkinson et al., 2005; Breen et al., 2003) and differs from most other states in diluting its methadone.

While firm causal conclusions cannot be drawn from these data, they do suggest that, rather than minimising injecting and the harms associated with it, dilution of methadone is at best displacing the practice, at worst, exacerbating its implications, by redirecting injecting practice onto saliva-tainted buprenorphine slurry, a potentially even less desirable substance and process. There is an urgent need for further research in this area.

4 The contention of participants that methadone is only relatively infrequently bought and sold in Melbourne concurs with research (Lintzeris et al., 1999), as does the observation that Melbourne has a high rate of buprenorphine injection (Jenkinson et al., 2005; Breen et al., 2003).

3 The role of takeaways in maintaining treatment confidentiality

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

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

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.

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 Hank's reference to 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 their treatment status? In this context, secrecy becomes

institutionalised, while the stigma and discrimination behind clients' unwillingness to disclose go unchallenged.

Discussion

Recipients of medical services are generally considered to be entitled to confidential treatment. Because of the stigma and discrimination associated with injecting drug use and drug treatment, confidentiality is of especial concern to MMT clients. Despite this, adequate provisions to protect the confidentiality and privacy of service users do not appear to be in place. Queuing and waiting endanger confidentiality on a daily basis, and awareness among service providers of the importance of confidentiality does not appear to be as high as it could be. In this context, takeaways need to be recognised as central to clients' right to privacy in that they allow clients to attend dosing points less frequently. In this respect, as well as in others outlined in Section 1, they make a valuable contribution to quality of care.

It should, however, also be noted that some of the problems described in this section could be improved through measures other than the provision of takeaways. For example, longer opening hours for clinics and increased staffing levels at both clinics and pharmacies would reduce queuing, which, in its visibility, always threatens confidentiality. Likewise, training might raise service providers' awareness of the issue of confidentiality and lead to arrangements that better protect clients.

4 Methadone maintenance treatment in rural and regional areas

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

‘[I]f they want to go on a program they have to be able to travel.’

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 sure they're, they're still interested.

(Pamela, nurse, regional NSW)

Similarly, a pharmacist in a small Victorian town of approximately 3000 residents found that she had to turn away potential clients. Only after she found a business partner and extended her opening hours could she service the previously unmet demand.

There were also divergent accounts of accessibility of treatment services for clients in rural areas. Some participants noted the distance that many clients had to travel to reach a dosing point when they lived in rural areas:

The distance is, the travelling is, an issue because a lot of these people can't afford even to live in town because of rent, so they go and rent a farmhouse, which means they're out of town and that they have to have a car to drive into town. And, um, petrol prices are horrific in the country, so it is an issue about the travelling. But there's only so many pharmacies that do this, so if they want to go on a program they have to be able to travel.

(Sandra, pharmacist, regional Vic)

BOB: I've got people who travel from [two regional towns].

INTERVIEWER: And how far away from here are [those towns]?

BOB: Three-quarters of an hour ... And some of those people can't drive, so they have to catch the school bus.

(Bob, pharmacist, regional NSW)

On the other hand, there's a perception that access to treatment can sometimes be better in small towns than in cities or larger regional centres:

Well, I think it can actually be sometimes easier and sometimes harder. I mean, for clients who live in [this

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

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

treatment programs, isolation and lack of support can also be an issue for those who do:

[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, those same attributes that underwrite the fragility of rural programs are also often their strengths, especially in terms of consistency and familiarity in care. On this latter point, one participant commented:

I guess we get to see almost the totality, whereas, in, you know, maybe in a bigger centre they might go to here, they might go to there, they might get scripts here and there and see a different doctor, but basically we're the, we're, we've got a captive audience here.

(Nathan, pharmacist, regional Vic)

In some cases it may not be the geographical location but simply the vagaries of state divisions that hinder effective service provision. One GP described the implementation of an unorthodox arrangement designed to preserve threatened methadone maintenance treatment programs in two adjacent state border towns, one in Victoria and one in New South Wales. Having struggled to keep enough staff to service demand for treatment, both towns found a solution only when state boundaries were ignored and the GP agreed to allocate some of his time to running a methadone program out of a community health centre in each town. This resulted in his working simultaneously in both jurisdictions, a non-standard arrangement of which he said:

I understand that it took quite a bit of organising and, ah, negotiating, and was seen as being something sort of fairly unusual. But [community health workers in both towns] were basically saying, 'Look, you know, if we don't do this we've got no capacity to expand in terms of methadone service provision in this, in this town', in the face of, obviously, increasing demand.

(Derek, GP, regional Vic)

Derek's story illustrates the frequently cited need for 'creative solutions', which was another participant's term

for the numerous similarly inventive practices she has seen or instigated.

Discussion

This is a small group of participants from which to draw conclusions, and the specific experiences and concerns described cannot be considered representative of everyone working in rural and regional settings. In keeping with the small sample size, the conclusions drawn from the data are fairly modest in scope. Perhaps the most obvious point to emerge from the data collected is that geographical issues have a wide range of effects on program delivery, some positive, some negative.

In relation to both the issues of the availability of treatment and of access to dosing points, the impact of rural geography is determined by a range of conditions and features including public transport, housing cost, petrol prices and business arrangements. Rural or regional locality does not determine treatment delivery in predictable ways. Rather, the conditions under which methadone treatment is provided in a particular location are generated in response to phenomena beyond the land itself. These include dominant modes of sociality, the availability of technology, national and regional politics and commercial decisions, as well as conditions elsewhere. For instance, pharmacy cartels can limit the range of services, reliance on pharmacies can mean few or no free places, isolation can attract those clients really motivated to stay away from heroin, and the nature of (frequently itinerant or seasonal) work in rural areas can lead to changes in service users' dosing needs and circumstances.

In this respect it is not possible to generalise about how geographical isolation operates in the case of individual treatment programs. The specific issues that arise in the case of each program are a function of these other conditions and contexts. It is essential to acknowledge this diversity and not oversimplify the complexities of program development, design and delivery in rural and regional settings. Nor should the importance of the innovative work that often needs to be done to keep methadone programs going in these areas be underestimated. It is apparent throughout these interviews that flexibility and the ability to respond to specific and sometimes swiftly changing conditions and circumstances are considered to be central elements in the effective response to the demands of methadone treatment service provision in rural areas of Australia.

5 Policy and guidelines: differences in interpretation

Each Australian state and territory has its own guidelines on the provision of takeaway methadone doses. At the time of data collection for this study, there were significant differences between the guidelines in Victoria and those in New South Wales. As well as differences in the conditions of access to takeaways, there were also differences in the administration of takeaways. In comparison with New South Wales regulations, Victorian regulations were more restrictive; access to takeaways was more limited and any additional takeaways had to be applied for

I still have friends that are getting five takeaways because of their doctor, you know.

through a permit system (see Appendix 1). Policies and guidelines do not wholly determine the experience of treatment, for clients or professionals, however. This section considers the regulations guiding the provision of takeaway doses in MMT programs in New South Wales and Victoria, and draws particular attention to the ways in which these rules and guidelines are understood and applied.

The data discussed in this section were gathered through interviews with clients, GPs, pharmacists, clinic staff and policy makers in metropolitan and regional New South Wales and Victoria ($n = 85$; the composition of the sample is detailed in the 'Introduction'). At the time the research was conducted, guidelines in New South Wales and Victoria stipulated that the maximum number of weekly regular takeaways were four and one respectively. Our data show that these guidelines were used and interpreted in different ways. Furthermore, the differences in interpretation did not necessarily depend on which state participants were located in.

Inconsistency in the application of regulations on takeaways was an important issue in the interviews. Both clients and professionals reported inconsistencies in access to takeaways, as well as variations in other rules such as frequency of urine

testing. This was the case in both New South Wales and Victoria, despite the differences in state guidelines:

I still have friends that are getting five takeaways because of their doctor, you know.

(Jenny, client, metropolitan NSW)

Yeah, no, a mate of mine, he managed to scam five, five or six a week out of them. I don't know how he did it. It was, yeah, five a week [...] 'Cause [his dose] went up and down too. He was my flatmate, and I don't know how he got, I think he could bloody sell snow to Eskimos, he's that kind of guy, you know.

(Joel, client, metropolitan Vic)

We've still got people who have got five takeaways a week. We've got one guy who gets four takeaways in one hit and then often gets another four a day after.

(William, pharmacist, metropolitan NSW)

We have a very strange situation where we have someone who is, um, who picks up his methadone weekly [...] And it's been working fine for years. He doesn't sell, he doesn't, he just, you know, he just gets his seven bottles and takes, you know, picks them up every Tuesday and he's happy.

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

A number of the interviewees working in the area of policy framed this problem of inconsistency as an issue of compliance. For example Colin, says:

Look, to me it's about adherence, not regulation, you know. I mean, regulation effectively doesn't work in the health system.

(Colin, policy worker, metropolitan NSW)

Rather than limiting analysis to the question of compliance, however, it is productive to examine the ways in which different modes of interpretation of guidelines give rise to differences in their administration. Analysis of the accounts of participants indicates that the guidelines are interpreted in at least two ways: as law and as suggestion. For example, Diane, a nurse in a public

clinic in New South Wales, describes her reading of directives around takeaways, which specify, among other things, the length of time on treatment before takeaways are to be prescribed:

We had the little methadone book, and how you could have one after three months and then one again one month after. I used to live by it, you know. I'd read it and when the one year goes over you can give the third one and then the two years goes over and you get the fourth. They changed the guidelines and I gather the reason was there were some GPs who were prescribing five takeaways, um, a week and they clamped down.

(Diane, nurse, metropolitan NSW)

Dominic, a pharmacist, is explicit in stating that the guidelines are in fact not guidelines, but law:

They used to be [...] a guide, as it says. Now they've got some legislative back-up so those guidelines can be enforced, so in actual fact they're not guidelines, they're actually laws.

(Dominic, pharmacist, metropolitan NSW)

Interpreting the guidelines as strictly prescriptive and legally binding, Diane and Dominic are conscious of the weight behind them. This interpretation of the guidelines as law brings with it the prospect of sanctions, of consequences for failing to comply. It has an impact on their own practices and perspectives: the regulations are learned and 'lived by', applied precisely.

The second mode of interpretation is based on an approach of active interpretation and selective use of the guidelines. In contrast to readings of the guidelines as directing action, this mode sees them as guidance, or even suggestion. Rosemary, a doctor from New South Wales, expresses ambivalence about the content of the guidelines and the way they function in practice. She acknowledges their general usefulness, but also repudiates any need for them to be more strictly controlled, or given more weight through legal or other regulatory measures:

The guidelines are difficult, they can be useful, and I guess that's what guidelines are about, it's about being useful. But I don't see that they need to be more harshly enforced.

(Rosemary, doctor, metropolitan NSW)

These dual modes of interpretation, as law or suggestion, are also evident in the Victorian data as well.⁵ In Victoria

prior to June 2006, the system of permits for prescribing takeaways above the number specified in the guidelines appears to have cemented the guidelines as law for some, while offering a greater flexibility in the application of those guidelines for others. Some GPs reported that the permit system was more procedural than substantive. Kurt, for example, explains the system thus:

KURT: It's kind of, it's a pro forma where you, so you tick a box if they're stable and you've spoken to the chemist and, you know, you've told the person the, the dangers of having someone else taking their methadone. Um, and we fax it to DPU, and they, they usually do their own check. They, they might ring the pharmacy, they might check how long they've been on methadone [...] and then they let us know if it's approved.

INTERVIEWER: Does it happen often that it's knocked back?

KURT: Ah, no, only occasionally.

(Kurt, GP, metropolitan NSW)

Others interpret permits and extra takeaways as available in exceptional circumstances only:

HOWARD: Well, I don't routinely apply for more than that which is approved, because they're not going to be approved, ah, unless there's a particular reason of quite, ah, some degree of substance.

INTERVIEWER: Do you find that, um, people ask you to allow takeaways beyond the guidelines, or do people—

HOWARD: No. Well, if they do, they very soon get put straight. They don't ask twice, if they do ask.

(Howard, GP, regional Vic)

Compared with the system in New South Wales, the Victorian permit system constituted an extra level of regulation. The accounts of participants indicated that the permit system in Victoria was subject to the same vagaries of interpretation as the basic guidelines, and thus also employed to differing ends. Practitioners who considered guidelines to be suggestions, or guiding best practice, routinely sought prescription of takeaways beyond the guidelines through permits. Those who interpreted the function of the guidelines as being one of strict direction seldom sought permits. Ultimately then, the permit system worked to restrict access to takeaways for some, while increasing access for others. Instead of ensuring standardisation, this additional level of regulation appears to have contributed to the variability and inconsistencies of access to takeaways in that state.

It would be difficult to overstate the importance of access to takeaways and of consistent standards of treatment to many of the services users interviewed in this study.

⁵ It should be noted that while health care workers in both New South Wales and Victoria discussed regulations, they were usually discussing separate sets of regulatory practices. In New South Wales, for example, when GPs complained about policies being too strict or procedures over-regulated they were complaining about the New South Wales guidelines, whereas in Victoria health care workers tended to be complaining about Victoria's permit system.

Differences in access to takeaways are frequently communicated between clients. Clients who find that their access is reduced, or less than that of others, experience this as a punitive situation (see Section 1). The regulations governing treatment work to constitute clients through representation and practice, and this is evident in treatment in very practical ways. Interpretation of the guidelines is the mechanism through which clients receive takeaways or do not, submit to urine tests regularly or do not, and are treated with the same expectations and respect as users of any other services, or are not.

Inconsistencies in takeaway provision and access are brought about in part by state-specific guidelines, and Victorian clients were until recently allowed fewer takeaways than those in New South Wales. Inconsistency in service provision is also an effect of the guidelines being read, interpreted and acted on differently. This section has drawn attention to the two different modes of interpreting the guidelines—as law and as suggestion—which emerged throughout the data. These differences in interpretation and consequent application of guidelines give rise to differences in treatment service provision among professionals and, more importantly, for clients.

Discussion

Clients and professionals both propose changes to the regulation of methadone that could minimise inconsistencies and make treatment more uniform. One solution, proposed by some health care workers, is to regulate more thoroughly: to make takeaways more difficult to get, adopt new testing regimes, or police the activities of doctors more vigorously. Such a solution aims to make interpretation redundant, or prevent interpretive acts playing any role in treatment decisions.

We argue that acknowledging the inevitability of interpretation is a more productive approach. Fields as diverse as semiotics, philosophy, policy studies, ethnography and evidence-based medicine show that reading is always an act of interpretation and translation (Barthes, 1982; Benjamin, 1955/1992; Derrida, 1971/1982; Johnson & Hagström, 2005; Nutley et al., 2003; Wood et al., 1998; Wright & Morgan, 1990). Discussion of the importance of clinical judgment in methadone treatment can obscure the fact that judgments are always being made in treatment. The application of clinical guidelines and other regulations in a treatment setting always involves decision making and choice. What are sometimes called strict readings are also acts of interpretation: reading the guidelines as law is an active choice. It is an act of interpretation that produces,

ironically, a refusal to interpret, an act of interpretation that produces a literal reading. Furthermore, data from participants interviewed in this study indicate that even stricter regulations would be interpreted as variously as are the current ones.

Policies that recommend more or less testing, or more or fewer takeaways, have an enormous impact on clients' experiences of treatment, as do the ways in which those recommendations are interpreted. There is no doubt that greater uniformity of policy implementation would make a significant difference to clients. The application of clinical guidelines is also implicated in issues wider than those of access to takeaways. Effective implementation of guidelines should be considered in terms of quality of treatment and standards of delivery by which professionals and settings can be assessed. But it is important to also take account of the rationales underpinning the different modes of interpretation, and the various factors underwriting treatment decisions. The content of policies and guidelines, while extremely important, will never prevent or supplant the activity and choice of the health professionals interpreting and applying those policies and guidelines.

There are numerous potential influences on interpretation of MMT regulations and treatment decisions. A wealth of research on the clinical encounter and on illicit drug users shows that what goes on between individual clients and individual health care workers is inflected with broader social, cultural and political forces and meanings. Relationships are not conducted, and decisions are not made, in isolation. Social understandings of drugs and drug users are present in treatment settings. What is considered to be true about drug users (for example, that they are dangerous and dishonest) affects their treatment at the hands of health professionals and others. This is not to say that all acts of interpretation are based on negative stereotypes and work to the disadvantage of the client. On the contrary, some interpretations are based on the recognition that drug users are stigmatised and have entitlements that are often denied them.

It is important to understand policies and guidelines, both what they say and how they are used, in terms of these broader social and political forces. When considering the benefits and disadvantages of takeaways in different policy jurisdictions, it is important to consider not only the practical and theoretical operations of things like permits, contracts and systems for assessing client stability (although all of these things are important). The meanings given by health professionals to drugs and drug users, and how these meanings influence the uses to which permits, contracts, assessment forms and guidelines are put, must also be taken into account.

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Appendix 1: Takeaway dosing timelines

Prior to 2006

New South Wales	Victoria
No takeaways during first 3 months.	No takeaways for first 2 months.
2 takeaways from Month 4 to Month 12 (not consecutive days).	1 takeaway per week thereafter.
3 takeaways from Month 13 to end of Year 2 (max. of 2 consecutive days).	In exceptional circumstances, 3 takeaways (consecutive days), but only for 1 week per month.
4 takeaways from beginning of Year 3 (max. of two consecutive days).	
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 onwards

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

Appendix 2: Publications and presentations

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.

Refereed journal articles

The chronotope of the queue: methadone maintenance treatment and the production of time, space and subjects

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 to, and in provocation of, certain kinds of subjects. In doing so, the paper uses Australian interview data on everyday experiences of methadone dosing to look at methadone maintenance treatment in terms of two sets of theoretical concepts: Mikhail Bakhtin's chronotope; and Karen Barad's formulations of the space–time manifold and of what she calls iterative intra-activity. The paper argues that in the context of the methadone dosing point, time and space co-produce each other as a chronotope of the queue, and that this chronotope helps materialise particular methadone subjects. Often, these are the very kinds of subjects considered undesirable; that is, the 'unproductive', the 'disorderly', the 'illicit'. In light of this, the paper asks whether the demands of the clinic and its convention of queuing reproduce, rather than depart from, the model of waiting and dependence widely seen as characteristic of lifestyles associated with regular heroin use. In concluding, the paper considers the policy and practice implications of the chronotope and of its role in methadone maintenance treatment.

Valuing methadone take-away doses: the contribution of service-user perspectives to policy and practice

Carla Treloar, Suzanne Fraser, kylie valentine

Drugs: Education Prevention & Policy, 2007: 14(1), 61–74.

Unlike health policy in the United Kingdom, Australian health policy does not provide a strong endorsement for the involvement of service users in the design, delivery and evaluation of drug treatment services. There has been no research into service users' views on the contentious issue of methadone take-away doses. This study explores the value of take-away doses from the service user perspective and highlights the contributions that service user involvement can make to further drug treatment planning, delivery and evaluation. Twenty-five methadone clients were interviewed about the value of methadone take-away doses. Benefits cited by participants included convenience, less travelling and lower costs, protection of confidentiality, less restriction on employment, and less tangible issues related to feelings of 'normality' and flexibility in daily life patterns. Feeling trusted as a methadone client was also an important benefit of being allowed take-away doses. The inclusion of service user perspectives is important for ensuring that services are not mis-targeted and that evaluations of those services do not underestimate or misrepresent their value to clients. This is particularly important in any policy around illicit drug use where public and political opinion is often a key driver in decision making.

Methadone maintenance treatment and making up people

kylie valentine

Sociology, 2007: 14(3), 497–514.

This paper considers the operations of methadone maintenance treatment through the use of concepts proposed by actor-network theory and historical ontology. The former provokes

a concern with the co-constitution of treatment regimes by various actors, including non-human actants. The latter provokes a concern with the creation of new identities. Analysis of methadone often examines treatment as a nether world, and clients as neither addicted nor autonomous. The analysis undertaken here instead emphasises what is produced in methadone maintenance treatment, rather than the inexactness of existing categories. It considers four identities produced through methadone treatment: the dissatisfied customer; the stable user; the individual in need of guidance; and the lay carer. This analysis enables a study of what and who is produced through treatment in terms that problematise simple distinctions between good and bad, addicted and independent, stable and chaotic.

Speaking addictions: substitution, metaphor and authenticity in newspaper representations of methadone treatment

Suzanne Fraser

Contemporary Drug Problems [in press]

Press coverage of addiction tends to be prolific if not always accurate or considered. In this paper I examine the ways in which methadone treatment is reported in three respected daily newspapers, the *New York Times*, the *Times* (London) and the *Sydney Morning Herald*. To conduct this analysis I focus on the role of metaphor, asking what impact the use of metaphor—both to figure methadone and to mobilise it as a figure for other phenomena—has in this context. In the process I consider the status of metaphor itself within Western liberal discourse, and trace the ways in which methadone treatment can be seen not only as a resource for, and object of, metaphorical description and production, but itself as a kind of metaphor—a *metaphor for heroin*. In concluding I argue that methadone is aligned in the print media with inauthenticity, disorder and the feminine, and I link this with methadone's implicit ontological status as always already metaphor.

Further articles are under review or in preparation.

Presentations

Fraser, S. (2006, April). *The chronotope of the queue: Methadone maintenance treatment and the production of space, time and subjects*. Paper presented at the 9th Social Research Conference on HIV, Hepatitis C and Related Diseases, StigmaPleasurePractice, Sydney.

Fraser, S. (2006, April). *The chronotope of the queue: Methadone maintenance treatment and the production of space, time and subjects*. Paper presented at the European Association for the Study of Science and Technology Conference 2006, Reviewing Humanness: Bodies, Technologies and Spaces, Lausanne, Switzerland.

Fraser, S. (2006, August). *Intimacy and isolation: Methadone maintenance treatment in rural Victoria*. Keynote address presented to the 7th Rural Victorian Drug and Alcohol Conference, Warrnambool.

Fraser, S. (2006, November). *Diversion and injection of opioid pharmacotherapies in Australia: How and why and what role for policy?* Paper presented at the Australasian Professional Society on Alcohol and Other Drugs Conference 2006, Cairns.

Fraser, S., & valentine, k. (2004, November). *Understandings of takeaway dosing in methadone maintenance in NSW*. Paper presented at the Australasian Professional Society on Alcohol and Other Drugs Conference 2004, Beyond the Drug, incorporating the National Methadone Conference, Fremantle.

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.

Fraser, S., & valentine, k. (2005, November). *Confidentiality and disclosure in methadone maintenance treatment in NSW: The role of takeaways*. Paper presented at the Australasian Professional Society on Alcohol and Other Drugs Conference 2005, Science, Practice, Experience, Melbourne.

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.

valentine, k., & Fraser, S. (2005, June). *Telling stories about methadone*. Paper presented at COMET-VELIM 2005, Diversity of Discourse Communities in Health: Power, Politics and Risk, Sydney.

valentine, k., & Fraser, S. (2005, November). *Methadone and market corrections*. Paper presented at the Cultural Studies Association of Australasia Annual Conference 2005, Culture Fix, Sydney.

valentine, k., & Fraser, S. (2006, November). *Practitioner and policy views on methadone maintenance treatment guidelines in NSW and Victoria*. Paper presented at the Australasian Professional Society on Alcohol and Other Drugs Conference 2006, Cairns.

valentine, k., & Fraser, S. (2006, December). *Pleasure and dependence: Rethinking problematic drug use*. Paper presented at Dangerous Consumptions IV, Commodification, Pleasure, Difference, Canberra.