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"Standing Outside the Junkie Door" - Service Users' Experiences of Using Community Pharmacies to Access Treatment for Opioid Dependency

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Running Head:

Experiences of methadone users in pharmacy

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Title:

Service Users' Experiences of Using Community Pharmacies to Access Treatment for Opioid Dependency

Abstract

Aim:

To explore experiences of service users attending a community pharmacy to receive opiate replacement therapy (ORT).

Method:

Qualitative study involving seven focus groups undertaken within care centres and prison educational centre in Tayside, Scotland using 41 participants. Thematic analysis undertaken of experiences of different groups of service users and carers.

Results

Participants described the social context surrounding attendance at community pharmacies. Their voices suggested that people prescribed ORT may be treated differently from others accessing care through pharmacies. Participants felt they experienced stigma and discriminatory practices in pharmacies, elsewhere within the healthcare environment, and more generally in society. Participants explained that the way services were organised in pharmacies often denied them the right to confidentiality.

However, there were positive experiences of care. The discriminating factor between good and bad experiences was being treated with dignity and respect.

Conclusion

Participants readily identified examples of poor experiences and of stigma and discrimination, yet valued positive relationships with their pharmacy. Constructive attitudes of pharmacy staff and the ability to form positive relationships improved their experience. The

social exclusion delivered through stigmatisation mitigates against delivery of a recovery agenda and contributes to health inequalities experienced by this marginalised group.

Title:

"Standing outside the Junkie Door" Service Users' Experiences of Using Community Pharmacies to Access Treatment for Opioid Dependency

Introduction

Supervised consumption of Opioid Replacement Therapy (ORT) has been the mainstay of treatment for people who use heroin for some time [1]. Drug users have attended pharmacies in Scotland to receive supervised administration of replacement drugs since the early 1990s. The shared care arrangement, between prescribers, specialist drug treatment services and community pharmacies reduces diversion of methadone into the illicit market and increases access to this treatment [2]. However, across Europe, treatment is mostly conducted in outpatient settings, which can include specialist centres, general practitioners and low-threshold facilities[3].

In practice, this means that service users attend a pharmacy on a daily or regular basis to receive doses of methadone or buprenorphine; this is intended to replace the consumption of heroin. The consumption of the ORT dose may be supervised, or handed to the service user to consume off premises [2]. It is estimated there are 376,136 "problem drug users" in the United Kingdom, and 133,112 people who inject drugs (PWID) [3]. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines PWIDs as "ever injectors" among people tested in drug service settings [5]. In Scotland, approximately 59,000 people are identified as using drugs [6]. The number of opioid users prescribed treatment in 2011/12 was estimated at 149,000 in England and Wales [7]. An estimated figure Scotland would therefore be 22,224 [8].

There is strong evidence that ORT improves a range of important outcomes [9]. Longitudinal studies identify that ORT improves retention in treatment, reduces illicit use of substances and reduces levels of risk behaviours. Reduced criminal activity and improved health and well-being have been reported [10, 11, 12, 13, 14, 15]. There is also evidence of a positive correlation between "treatment dose" (numbers of attendances) and outcome [16]. The

contribution of supervised consumption to recovery may be double-edged: creating a daily structure and reducing use of other opiates, but preventing engagement in recovery activities such as paid work. Supervised consumption is a central component of the United Kingdom policy framework [17]. Policy makers may view long-term maintenance on ORT either as a positive step for harm-minimisation or as a barrier to achieving a drug-free lifestyle: moving ORT users to a drug-free lifestyle remains a challenge[18].

The success of ORT depends on engagement with services and adherence to therapy. The Drug Misuse and Dependence: UK Guidelines on Clinical Management [17] (also known as the Orange Guide) states that directly supervised ORT by a professional for a period of time provides the best guarantee that the medicine is being taken as prescribed. Supervised consumption as part of the recovery process may be protective and associated with a decrease in drug deaths and development of a therapeutic relationship. The journey of recovery may mean the movement to unsupervised consumption over time [19].

In practice, most ORT is delivered by community pharmacists and increasing numbers of pharmacies provide needle exchange services [20]. Pharmacists and dispensing staff are central to the provision of ORT [21]. Service users therefore may have more contact with the pharmacist than any other healthcare worker [22].

Despite growing evidence to support the delivery of therapeutic interventions through community pharmacies [23], there is evidence that outcomes obtained with ORT can be improved [24]. A partial explanation for poorer outcomes may lie in service users' interactions within and around community pharmacy services [25, 26, 27, 28, 29]. Stigma, combined with a poor self image and apparent negative treatment may provoke negative behaviour and precipitate conflict [30]. Pharmacists may be reluctant to deal with a group of clients who may sometimes be abusive or intoxicated and may shoplift [2]

Although pharmacy service provision is extensive, there is little contemporary research describing the nature of these interactions with service users, associated problems, or likely

solutions. This study was conducted to explore the current experiences of service users attending a community pharmacy and receiving ORT in Tayside, Scotland.

Method

The study was conducted within care centres and a prison educational centre as part of a local Public Health needs assessment. A focus group methodology was chosen to enable participants to share experiences within a supportive environment. Utilisation of the group dynamic and involvement of participants in group discussions was employed to help manage impulsive behaviour and short attention span [31]. Effective management of these factors was believed to outweigh potential negative aspects of focus group approach including description of group normative experiences and the effect of inherent group hierarchies to suppress subordinate voices [32].

Study documents were submitted to the East of Scotland Research Ethics Service, who confirmed this work did not require Ethical Approval. Caldecott permission was gained to enable access to and analysis of patient information. A topic guide was developed from evidence syntheses and refined during the study (Table1).

Sampling:

The study used a purposive sampling strategy to identify a diversity of likely views [33]. Individuals were eligible for inclusion if they received ORT from a community pharmacy or were the carer of someone prescribed ORT. We aimed to recruit around 40 participants. Recruitment focussed on the following variables:

- Place of Residence –large urban / other urban / accessible small town
- Service Users detained by the Criminal Justice System
- Perspectives of male and female service users
- Perspectives of peer mentors (service users at an advanced stage of recovery)

The sampling strategy was formulated to enable a diversity of views to be obtained, at different places within the network of actors and technologies [34]. Carers were included in the groups, since ORT users experience long-term conditions at an earlier stage than the general population.

Recruitment & consent:

Potential contributors were identified through local support groups and care centres. Each person completed a consent form prior to participation. The patient information sheet was explained to each group by the facilitator to assist those with poor health literacy.

Data collection:

Seven focus groups with 41 participants (Table 2) were undertaken by AR and KM. Sessions were open-ended and ranged from 70–100 minutes. The first focus group served as an internal pilot to test the discussion guide. The seventh focus group with peer mentors, was undertaken to provide perspective on the findings from this study. In the local service configuration, peer mentors are experienced service users who have received ORT for a number of years and are further along a recovery pathway: we listened to their reflections and perspectives on the themes that had emerged.

Analysis:

Data from each focus group were digitally recorded and transcribed verbatim. Both AR and KM undertook the coding and analysis (Box 1). Analysis drew on the constant comparison method, which was operationalised within a general thematic approach [35]. Analysis included five stages: familiarisation (reading and re-reading the transcripts), identifying a thematic framework (a key list of codes); applying the codes to the quotes in the transcripts; creating tables of quotes and comments to compare data across groups; mapping and integrating the key findings into a meaningful whole. Deviant cases were sought to identify opinions which modified or contradicted the analysis [36]

In our analysis we drew on the work of Duff who utilises Actor Network Theory to portray the assemblage of spaces, bodies and effects, to characterise the context of drug use as the interrelation of people and technology [37, 38].

Results

Service users were reflective about the circumstances that led to them receiving ORT from a pharmacy. When asked about their experiences of attending a pharmacy, participants' responses were often passionately voiced. Focus group data demonstrated interactions between different actors and technologies: with pharmacy staff; members of the public; pharmacy premises and adjacent environments; the rules used by the pharmacy to manage demands and workload.

Our analysis identified three key themes (Box 2). These are illustrated with quotes demonstrating typical or divergent responses. Quotes are labelled with participant number, sex and age.

The social context surrounding ORT users

Service users provided vivid descriptions of life on methadone. Participants followed a daily routine of attending pharmacies, obtaining money, and avoiding trouble (Box 3, Participant 16). Some service users reflected on their preoccupation with obtaining drugs, legal and illicit. They felt that the centrality of ORT in their life led to diminished horizons (Box 3, Participant 40). The day-to-day reality of ORT use was one of continuous poverty: lack of money was a constant challenge; searching for enough money to pay for daily expenses; having bus money; the difficulties in maintaining employment (Box 3, Participant 20).

The attraction of ORT waned over time. Some participants explained how methadone and drug use became less important to them and family life and employment increased in importance (Box 3, Participant 33). Participants described how they changed their social networks to move away from drug use; they described the need for a 'normal life' (Box 3, Participant 18).

The interaction with pharmacy service delivery

Service users' often had both positive and negative experiences of community pharmacies. Participants provided accounts of positive relationships and contributions to care but many examples of poor experiences and unpleasant relationships were described.

Experience of stigma

Participants described real and current experiences of stigma. The idea that people would shun them was common. They felt set apart from other members of society (Box 4, Participant 18). Service users sensed this treatment was unjust; other people had chronic conditions such as heart disease and diabetes, which were also self-inflicted, but were not discriminated against (Box 4, Participant 22). People who abused prescription medication (benzodiazepines) were not treated as they were. Service users felt unfairly treated since they had chosen to change, through entering the ORT programme.

Experience of discrimination

Participants felt that use of a range of different practices within pharmacies caused a distinction between people picking up a methadone prescription and people picking up other prescriptions (Box 4, Participant 8). Discrimination was conveyed in numerous ways, including restricted attendance times and additional bureaucracy (Box 4, Participant 20). In two focus groups, service users described how they were asked to leave young children outside the pharmacy. The women's group was particularly reflective on how they were treated differently and used the powerful metaphor of "Apartheid".

The use of a separate entrance or hatch automatically identified them as receiving methadone. Service users described using the hatch to receive their methadone and going to the "normal people's counter" to receive other medication. Even when a service user was prescribed unsupervised consumption of methadone, discriminative practices might prevent them taking their ORT away from the pharmacy (Box 4, Participant 23). Service users were made to sign written agreements by the pharmacy. This was not done with other patient

groups. Participants described using two pharmacies: one to receive ORT and one to obtain their other medicines; to enable them to be treated as other patients were.

The issue of time

The issue of time was consistently raised; the time wasted in pharmacies waiting to receive methadone (Box 4, Participant 34). The use of restricted attendance times was felt to be a unfair (Box 4, Participant 40). To complain about these arrangements risked getting put off the pharmacy list. This practice had real consequences and was used several times to explain why participants could not maintain employment. The attendance pattern meant that employers could guess that their employee was on methadone. The queue for methadone meant being brought into close proximity with undesirable people; drug dealers, people who might steal or create unpleasant situations.

The issue of confidentiality

Service users did not feel that their confidentiality was respected. Confidentiality in the pharmacy was undermined systematically: by the material and physical arrangements, by the procedures utilised to manage patients and through the actions and attitudes of staff members. These arrangements were described by participants using words such as “the junkie door” and “segregation”. Service users described how queuing to receive their methadone identified their reason for attendance to any onlooker. Participants related how staff members spoke about their consumption of methadone within hearing of other patients (Box 4, Participant 18).

Positive experiences of care

Participants readily described care which made a significant contribution to their well-being. An important and recurrent finding from this work was the value of being treated with dignity and respect. Although focus group discussions always began with descriptions of poor experiences and difficult relationships, service users consistently spoke highly of “their pharmacist” and how the pharmacy they currently attended treated them well.

There was good awareness of the nationally organised Minor Ailments Service [39], through which they could access a range of medication for free. A variety of clinical interactions were described, from support with gestational diabetes to management of a traumatic wound (Box 4, Participant 20, Participant 26). Where care was highly regarded, it was because positive relationships with staff were formed and maintained.

Service users' explanations for their experiences

Participants could understand the way that people treated them like this. The reasons arose from their own behaviours (for example shop-lifting), but also through the way they were forced to act through circumstances (experiences of stigma and discrimination) and the lifestyle they had adopted. There was a perception of shared responsibility for their treatment, with an acknowledgement that some service users expected poor treatment and acted accordingly (Box 4 Participant 21). The idea that a public face was assumed by the service user in order to protect their feelings was described several times.

Making things better

Participants expressed a desire to use the same consultation room as other pharmacy users, so that their care could be undertaken in private. It was acknowledged that the numbers of service users using pharmacies made this unlikely. Participants recognised the poor behaviours of a few individuals but there was general resentment that this led to all service users being treated in the same way. Focus group participants wished for the pharmacy service to operate more flexibly and responsively to their needs and support their process of recovery more actively. Participants described the wish to be treated as individuals rather than as a group.

Discussion

Main findings of this study

Participants in this research describe the social context surrounding attendance at community pharmacies: how the assemblage of networks of actors interplays with pharmacy

services. Accounts demonstrate that people prescribed ORT are managed differently from other patients. Service users experience stigma and discrimination in pharmacies, other healthcare settings and generally in society. The organisation of care in pharmacies effectively denies service users confidentiality.

Narratives about negative experiences were tempered by accounts of positive experiences of care. The discriminating factor between positive and negative experiences was that the service user was treated with dignity and respect. Service users easily identify poor experiences but also valued positive relationships with their current pharmacy.

What is already known on this topic?

Perspectives on treatment recovery have been described by other researchers [20, 31, 40, 41, 42, 43]. Evidence that service users are treated as an anti-social group has been reported [44] as has the detrimental consequences of pharmacy service organisation [26].

Participants described a common experience of discrimination and stigmatisation when accessing routine healthcare [45, 46, 47]. The parameters of stigma are well described [48]. The attitudes displayed by healthcare staff may mirror stigmatising attitudes across society [49]. However, stigmatisation mitigates against recovery and continues the health inequalities experienced by this deprived and marginalised group [50, 51, 52].

Most pharmacies in Scotland provide substance misuse services and many have created a separate facility for ORT supervision [53, 54]. This practice may enhance a stigmatised identity, especially when coupled with explicit discrimination and prejudicial attitudes of staff [22, 28]. The use of waiting time to convey discrimination and create dependence is important [26, 27]. The restrictions on access and consequences on employability are described in several places [45, 55]. Employment is a key step in addressing health inequalities and social inclusion [56].

That drug misusers often steal and how this affects their treatment has been reported [55]. A study of attitudes of community pharmacists reported that about ten percent of pharmacists had negative views [53]. Work a decade later reported improved attitudes and increased service provision [21, 57]

What this study adds

This most striking finding of this study is that despite 25 years of service provision, problems with ORT provision remain [53, 57]. Pharmacists may still be ill-prepared to manage difficult situations, when drug using clients behave aggressively or abusively, shoplift or are intoxicated [2]. The stigmatising attitudes experienced by service users are closely linked to policies on prohibition and criminalisation [49]

Limitations of this study

This study draws on the qualitative insights of service users experiencing care within community pharmacies. Use of a focus group methodology was clearly a viable method within the resource constraints of a public health needs assessment; however an ethnographic approach would contribute an alternative route to defining the effects of person place and time [58].

The authors reflected that the strength of some contributions could have been influenced by the group dynamic; descriptions of poor experiences may have been better accepted [31, 32]. The use of a female group was therefore undertaken, since male contributions were observed to dominate. We purposively recruited a group of experienced service users acting as peer mentors, to a final focus group and used this narrative to gain reaction to the findings and comment on themes [59].

Conclusions

Stigma, combined with a poor self image and apparent negative treatment may provoke negative behaviour and precipitate conflict [30]. Pharmacists may be reluctant to deal with a group of clients who may sometimes be abusive or intoxicated and may shoplift [2].

The social exclusion delivered through stigmatisation, mitigates against delivery of a recovery agenda for this multiply deprived and marginalised group [17].

Capitalising on the contribution that community pharmacy can make requires further work to improve the quality of relationships with service users. Service users have expressed the desire for more knowledgeable staff, capable of responding effectively to the issues that they bring [28]. It is likely that education and training as well as role support is required as well as steps to change organisational cultures within pharmacies in particular and healthcare in general [60]. This change however is within the current policy intention for modernising the delivery of pharmaceutical care from community pharmacy [61]. Further research is therefore required to confirm that a positive change in practice is achieved.

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Table 1: Experiences and Views of People Using Pharmacies to Obtain a Methadone Prescription

i. Tea, coffee provided to participants as they arrived. This allowed individuals to talk to each other and establish introductions

ii. Participants were asked to introduce themselves and to say how they would like to be referred to.

iii. The purpose and confidentiality of the research was explained and clarified, along with general guidance to ensure a good quality recording was made (i.e. not talking at the same time as others).

iv. The following questions were used to guide the discussion, with sensitivity to the issues that were important to participants and also to the opportunity of each participant to contribute the issues and observations that were important to them.

Questions	**Justification**
1. Can you tell me about your experiences of obtaining your methadone prescription from a pharmacy? *a) How would you describe your relationship with the pharmacist?* *b) Do you feel you are treated with dignity and respect at all by your community pharmacy?* *c) What positive features of getting treatment at a pharmacy would you like to see more of?* *d) What negative features of getting treatment at a pharmacy would you like to see less of?*	*General views on treatment of substance misusers in pharmacies* *Specific experiences of substance misusers in pharmacies*
2. Are you aware of having a care plan in place with regards to your methadone treatment? *a) Has anyone discussed the content/its meaning? Have you received a copy of your care plan? Would you like to receive a copy of your care plan?* *b) Do you think such a care plan would improve your relationship with the pharmacist?* *c) What types of issues would be important to be discussed as part of the care plan?*	*Making sense of the interaction with the pharmacist* *Establishing aspirations for the content of the service*

v. Group Finish: Participants were asked if there were further issues and observations that they had not been able to contribute. The facilitator gave a summary of the key points covered from field notes and asked participants of the summary covered the issues as they saw them.

Table 2: Participant details

		Number of Participants
Age group at participation	Less than 35 years	17
	35 – 44 years	5
	45 – 54 years	6
	Over 55 years	4
	Did not disclose	9
Sex	Male	31
	Female	10
Participant category	Service User	38
	Carer	3
Number recruited defined by sampling frame	Large Urban Settlement	10
	Other Urban Settlement	10
	Accessible Rural Town	6
	Prison Educational Centre	7
	Women's Group	4
	Peer Mentor's Group	4

Figures

Box 1: Strategies Employed to Ensure Rigour and Trustworthiness

- Deviant cases were sought to falsify theory
- Iterative data collection utilise to ensure emergent themes could be explored
- A checking strategy was used within interviews to check interpretation
- Data analysis was conducted by more than one team member

Box 2- Themes Identified

Theme 1 – The social context surrounding ORT users

Theme 2 – The interaction with pharmacy service delivery

- *Experience of stigma*
- *Experience of discrimination*
- *Issue of time*
- *Issue of confidentiality*
- *Positive Experiences of care*
- *Service Users Explanations for their Experiences*

Theme 3 – Making things better

Box 3: The Social Context of ORT

We are all shoplifters and we have all been stealing to feed wer drug habit. See when you first get out the jail you don't get paid for about a month, so, after 3 days you are skint. Until about a month later you need to walk all the way into the toon, sometimes its 4 or 5 miles just to get your Meth, and then you have to walk home another 4 or 5 mile back or you can go shoplifting to get money for the buses or something. Ken what, its just how it is and that's how ye end up in the jail.
Participant 20, Female 24 years.

It does occupy…it occupies most of yir day and night coz yir always thinking aboot whar yir gona get money. **Participant 38, Male 37 years**

I thought it was a life saver at the start ken I thought it was great when I got on it and I got on it coz I thought it was another drug another charge and I wouldna wake up rattling. I thought I'd get my methadone then I'd go score drugs like 2 fixes, 2 hits sometimes 3 or 4.
That was my world, my hoose, the chemist and the boozer. **Participant 40, Male 35 years**

You are keeping yourself to yourself, you just got outa the jail and you are keeping your head down. You are not going out stealin but you are goin to that chemist. You are taking that chance every day and you are seeing other drug users, right and it's like, encouraging you. You are likely doing it, in a minute. First day out and you are pissed off an somebody offers you something that will be it. **Participant 16, Male 32 years**

And if they know you then thats even worse. That's how I moved to somewhere I'm not from where I dinna know anybody and do you know what it's a hell of a lot better. It's so much better, I dinna get offered at the chemist cause no-one knows is. So even though they see me going through that door because I dinna speak to anybody or give away anything its brilliant honestly. I couldn't have made a better choice for me and my son to go somewhere where they dinna know my past, they dinna know who I am, they don't know what I've done do you know what I mean it's brilliant. **Participant 18, Female 28 years**

A lot of people work that take methadone, a small majority, but they do and they want a normal life. That's how they are on methadone coz they want a normal life they widdnae be on methadone if they didnae want a normal life.
Participant 33, Male 38 years

Box 4: The Organisation of Pharmacy Methadone Services

Experience of Stigma

And I was on the bus the other day and it was an old couple were like *"yeah all they junkies hanging about the chemist and it's the ones who've got kids going in to that bit that I feel sorry for"* now they obviously didn't know that they were talking to like a methadone user. I felt like shit to be honest with you. **Participant 18, Female 28 years**

Yeah because I mean you wouldnae treat somebody different if they were a, a diabetic and they were standing in front of you eating a sweetie, ken I mean you wouldnae say tae them you shouldnae be dain that (mumbles). What's the difference between an addict and somebody that's say self inflicted a lot of heart disease is self inflicted, there's loads of things that are self inflicted so why dae they single out addicts or alcoholics. **Participant 22, Male 37 years**

The Issue of Discrimination

"If there is any more than two in the shop, if there are any more than two drug addicts in the shop, you have got to stand outside until one comes out. You are not allowed any more than two people in the pharmacy at the same time. It doesn't matter if its rain, sleet or snow, you stand outside. She frankly told us that she doesn't want us in there when there's people in there"
Participant 8, Male 32 years

what I mean because it is embarrassing ken you're standing there buzzing this buzzer and you've got to wait until they decide to pick up that phone and let you in so then there could be loads of people walking past you and you're standing there ken they could clearly a' ken that you're going awa' in there for that. Know what I mean. **Participant 20, Female 24 years**

First day she got methadone from the chemist she went tae take it oot the shop she went "thank you". "Oh hang on you need tae take that" she says "ah no I'm unsupervised" and the guy says "Oh no he says I don't do that, as far as I'm concerned I don't want methadone in the streets" **Participant 23, Female 27 years**

The Issue of Time

It's only half an 'oor, well the chemist I'm it you've got to go in efter half 9 in the morning right, you can go in at any time during the day. But it's other chemists, you go in, you've got to be in the 2 'oors and if you're no there for 5 o'clock well in the efternane if you're no there til 5 past 4 and

you're meant to be there by 4 you dinna get yir methadone. That's wrang.

Participant 40, Male 35 years

and some days I'd wait, wait, waiting, wait some mare. I'd be waiting 15 minutes, 20 minutes, 25 minutes in some cases until one day I got pig sick fed up o it coz I would see folk walking in from the doctors surgery and walking out before them walking in after them. I counted half a dozen folk one morning that walked in after the three o them and walked out before them with prescriptions in their hand**. Participant 34, Male 43 years**

The Issue of Confidentiality

A couple of members of staff I would say are good but the rest of them nah, they look doon at you. I'd come off my methadone and went into rehab in November there and came off it and then I went into the chemist, but into the actual normal bit of the chemist and there was a prescription coming up from the DPC for a sleeping tablet 'cause I wasn't sleeping and when I went in the chemist was busy and the lady came over and she was like *"could I help you"* and I said yeah has a prescription come up from the DPC and she was like *"what, for methadone?"* right in front of everybody in that chemist. And I looked at her, and they all knew what I'd just been through, and I'm looking, going, for methadone I dinnae think so, ken what I mean, and I was absolutely, I'd just couldnae believe that she'd done that. **Participant 18, Female 28 years**

Positive Experiences of care

I got bloods ta'en and they think I've got pregnancy diabetes so I went in and was telling the woman that just through conversation and she said maybe it was just something that I ate that day and I said nah a' I had was, I had my methadone then I went right to the doctors to get the blood ta'en and she went well that could be what it was 'cause methadone's got that much sugar.

Participant 20, Female 24 years

Whan eh got stabbed Al did gie me a lot of coz they didnae stitch it, they left it open and it wiz quiet a big wide wound, mind that ain in my groin and it was mair A than the nurses coz eh wiz seeing her every day coz eh was only seeing meh doctors once a week and she wiz gieing me mair advice on how to keep it clean masel, dressings and this that and the next thing. So it was good.

Participant 26, Male 32 years

Service Users Explanations for their Experiences

You've got a lot of drug addicts that are gonna go about with baggage and go "oh I'm an ex drug

addict everybody's looking down their nose at me". They're gonna go about with that attitude and nine times out of ten they're actually attracting that from people they may not have got it from coz they learn to protect themselves. But nine oot of ten because o the way they have been treated they go in wi that attitude because that's the way that they have been treated"

Participant 21, .Male 41 years

Box 5: Making things better

As I say I have no complaints about the pharmacy that I use. They're very good, there's a little consulting room you can sit. They take you into the consulting room you take your methadone and you leave, it's all done in private. If the consulting room's busy they use a wee space they've got through the back but they always ask you very nicely if you don't mind going through there. So, they're great. **Participant 23, Female 27 years**

You don't need anything else if you have got respect. If you get handed your methadone with a smile and asked how you are doing today. **Participant 9, Male 38 years**

In the first instance its likely you would still need to go every day but then again I mean the medicine is there to support your recovery and so it is about how you move forward and it should be fitting into your life as well. I mean the guys spoke earlier about they think it's better that you need to go in every day because they remember the 80's when the streets were awash with methadone and stuff like that but it is a medicine like any other medicine and you know as you recover and as you change you become much more confident then the medicine should, it shouldn't hamper your recovery. **Participant 32, Male 42 years**