Substance Use Related Stigma Reduction & Prevention in Fraser Health

Methadone Maintenance Treatment

A Survey of Consumer, Treatment Cohort and Substance Use Service Professional Perspectives

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February 2013

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Acknowledgements

The authors express sincere thanks to the interviewers for their compassionate and skilful conversations. These include Aaron Eyjolfson (University of the Fraser Valley), Justun Miller and Cassie Silva. Tremendous appreciation is extended to Points West Transcription Services and particularly the outstanding qualitative analysis performed by David Ham and Faith Eiboff.

This report has been made possible through a financial contribution from Health Canada through their Drug Treatment Funding Project (DTFP) and administered by Fraser Health's Mental Health & Substance Use Services. The views expressed herein do not necessarily represent the views of Health Canada. We would also like to extend our appreciation to the FH residential SUS Health Service Providers and their clients for graciously offering to be involved in this initiative.

Executive Summary

When I told him I was on methadone, he shunned me. Like, he looked down on me, and he said, "Well, you're not sober, then." (MMT client)

There has been relatively little investigation of the experiences of persons receiving methadone maintenance treatment (**MMT**), particularly in respect to **substance use related stigma**. Further, the perspectives of non-methadone involved treatment cohorts (**COH**) and treatment professionals (**TPR**), regarding MMT, have received little attention. This project surveyed the experiences and perspectives, in respect to Methadone Maintenance, of these three populations (MMT, COH and TPR). Participants were associated with 12 of the 13 Treatment Centres and Stabilization and Transitional Living Residences (STLR's) that constitute Fraser Health's continuum of residential Substance Use Services. A total of 34 participants were interviewed:

- 12 MMT,
- 11 COH and
- 11 TPR

The pool of MMT participants consisted of 7 women and 5 men with an average age of 34. Average duration of methadone treatment was 40 months. COH participants included 6 women and 5 men; average age was 39. The TPR sample consisted of 8 women and 3 men averaging 44 years of age. Three contracted interviewers utilized a semi-structured interview format inviting participants to reflect upon and share their experiences and views of MMT. Interviews were, on average, about 45 minutes in length. A qualitative analysis of the interviews was conducted by two researchers with extensive experience. The analysis was based on the "Framework" approach, described by Ritchie and Spencer (1994).

As might be anticipated with a wide range of ages and treatment sites, a broad spectrum of both supportive and stigmatizing perspectives were shared by participants. The richness of qualitative analysis challenges summarization; however, here are some key findings:

- *92% of MMT participants report having some supportive experiences with SUS, medical and related professionals.*
- *100% of MMT participants report having some positive experiences with treatment cohorts.*
- *67% of MMT participants describe MMT as contributing towards their well being*
- *58% of MMT participants report having some negative stigmatizing treatment from SUS, medical and related professionals (including hospitals).*

- *67% of MMT participants report negative stigmatizing experiences with treatment cohorts.*
- *A significant number of cohorts and SUS professionals consider methadone as a "drug" (a substance of abuse) and not as a legitimate form of pharmacotherapy.*
- *The majority SUS professionals and treatment cohorts believe that the presence of MMT clients triggers treatment cohorts towards relapse.*

Despite the fact that most MMT involved persons report many positive experiences with treatment cohorts and SUS clinicians, the majority also describe negative stigmatizing experiences. A significant proportion of involved professionals and treatment cohorts hold misinformed negative and stigmatizing beliefs and appear to manifest these perspectives in their treatment of MMT involved persons.

There is a lack of empirical evidence about the strength of the relationship between identity transformation, stigma and outcomes; however it is clear that stigma is a significant within the population of FH MMT consumers and there is a sound basis to suspect that this has a detrimental influence on outcomes. The FH continuum of SUS could address current practices (e.g. policies, program language, staff attitudes, quality of welcoming) and those of boundary partners (e.g. physicians, pharmacists, police) towards the reduction of stigma associated with MMT. Further, specific SUS treatment practices could be enriched to support MMT consumers in developing skills and strategies to manage and moderate the influence of societal, cohort, professional and self-stigma.

Introduction

The precise relationship between *experienced substance use related stigma* and variables such as *retention, health* and *other key outcomes* is unclear. Based on a qualitative analysis, there is speculation that sensitivity to stigma through supporting program language and concepts consistent with *positive*, *functional* or *non-addict* client identities, results in better retention and drug use outcomes (Gourlay *et al*, 2005). For example, describing *addiction* as a health challenge rooted in biological function and social problems rather than as a *moral disease* or *pathology*. A synthesis of the literature suggests that persons receiving Methadone Maintenance Treatment (MMT) strongly prefer being treated as "normal people" like other patients, clients and customers (Harris & McElrath, 2012).

Fraser Health's (FH) continuum of Substance Use Services (SUS) responds to a wide range of client needs and concerns, including those of persons involved with MMT. There is good evidence that the majority of persons receiving MMT have experienced stigma and that these experiences have generally detrimental effects on outcomes (Anstice *et al.*, 2012; Doukas, 2011). Stigma is described as having five interrelated components (Link & Phelan, 2006). **One**, the *identification* and *labelling of human differences* (e.g. diagnosis, MMT registration). **Two**, *stereotyping* where the labelled person is associated with socially undesirable qualities (e.g. "methadone patients aren't really clean…they're not strong enough to quit…"). **Three**, the social group generating the labelling creates a *distinction* between "us" (those labelling) and "them" (those labelled). **Four**, those stigmatized *experience discrimination* and a reduction of status. **Five**, the exercise of *power*. This exercise of power can be multi-directional: "labellers" impose certain restrictions on those labelled; and those labelled, push back (e.g. refuse to comply, attack professional motives as self-serving).

There is certainly cause, based on the stream of client anecdotes heard by the authors over the years, to suspect that aspects of these five components of stigma are experienced by MMT consumers in the FH region. To date, no systematic surveys, within FH, have been made of MMT related perspectives of MMT consumers, COH treatment cohorts and SUS clinicians. This survey was directed at collecting perspectives from these three groups with an eye toward developing an appreciation of potentially stigmatizing MMT related perceptions, beliefs, actions and experiences within FH-SUS residential services. It should be emphasized that although great diligence was exercised in the development, implementation and analysis of this survey, there was no intent to generate research, meeting publishable standards, and there was, instead, a persistent intent to thicken appreciation and further heuristic process within FH-SUS.

Method

Sample

Interviews were conducted with 34 participants: 12 persons currently involved with Methadone Maintenance Treatment (MMT); 11 people currently receiving substance use related treatment, but not MMT (COH); and, 11 substance use services treatment professionals (TPR). The MMT group consisted of 7 women and 5 men. Ages ranged from 20 – 63 with an average of age of 34. The range of duration of MMT ranged from 5 – 120 months yielding average of 40 months. There were 5 men and 6 women in the non-methadone cohort group (COH). Ages ranged from 21 – 51, with an average of 39 years. The sample of 8 female and 6 male professionals averaged 44 years in age, with a range of 29 – 64.

In all cases, participants reviewed an overview of the project, the elements of involvement and provided signed consent. The consents underscored that participation is voluntary and withdrawal from this survey is free of conditions (see Appendix A). With the exception of one (less than 6 bed program), all existing Fraser Health SUS (direct and contracted) residential treatment centres and Stabilization and Transitional Living Residences (STLR's) were involved. This survey did not utilize any systematic method of client sampling and instead simply requested that program managers invite clients and staff to participate. Selection, then, at each site, was simply on a "first come, first served" volunteer basis.

Interviews

Three interviewers, one female and two male, conducted all interviews. All three had extensive histories in social service environments requiring high levels of communication skills. Interviewers were orientated about the intent and spirit of this project. Training, specific to the interview format and style, was provided by the project lead. The project lead also reviewed initial interview transcriptions and concluded early in the project that the three interviewers were conducting high quality interviews, which met the intents and objectives of the project.

Each interviewer was assigned four programs and interviewed one MMT client, one COH client and one clinician (TPR) from each. Interviews utilized a set of questions/themes which supported a semi-structured format (see Appendix B). The intent was to ensure that there was consistency with the range of key themes explored, yet there would be ample flexibility to pursue rich participant descriptions. The format incorporated similar, but distinct, questions/themes for each of the three participant groupings (MMT, COH and TPR). The project lead reviewed samples of interviews to ensure that the style and structure was consistent with the needs and aims of this project.

Analysis

A professional transcription service processed the digitally recorded interviews into text documents. These were coded to protect participant identity. The qualitative analysis was performed by two specialists with extensive experience in studies involving matters of social concern. Here is a synopsis of the approach and method.

The analysis was based on the *framework approach*, described by Ritchie and Spencer (1994). This approach is divided into five stages:

- Familiarization: The researchers immerse themselves in the data to get an overview of key ideas, recurrent themes, depth of the data, and the range/diversity of perspectives.
- Identifying a thematic framework: The researchers generate an index of the major themes, drawing on a priori issues, the issues raised by respondents, and analytical themes that emerge from the recurrence and/or pattern of responses. In creating the thematic index, the researchers keep in mind the original research questions and relevance to social policy.
- Indexing: The index is systematically applied to the data (transcripts). This stage naturally involves some level of interpretation.
- Charting: Data from the original source (transcripts) are lifted from their original context and placed into a chart organized by theme. This stage can involve distilling the various quotes provided by a given respondent for a given theme, to summarize their overall perspective on that theme.
- Mapping and interpretation: The researchers analyze the chart(s) and their research notes to answer the research questions. The deliverable generated from this stage can vary depending on the nature of the data and the goals of the research.

The analyses first involved a familiarization stage, which included reading all of the transcripts across the three respondent groups and generating a preliminary index of major themes. Generating this initial index of themes was a way to engage deeply with the data, become familiarized with the key issues and begin to sort out patterns that would guide the development of the finalized thematic indexes for each respondent group. It was decided during this stage that a separate thematic index would be generated for each respondent group (rather than having a single index for all 34 interviews), though there was a large amount of overlap in the codes. Where possible, codes were kept consistent in order to facilitate comparisons across respondent groups.

A finalized thematic index was created for the treatment professionals first, through an iterative process where the researchers made judgments about the meaning and relevance of certain passages, resolved discrepancies in tallying, and explored different ways of grouping the various codes. The finalized index was applied to all of the staff transcripts, and these were

then charted. Charting, mapping, interpretation, and writing all occurred simultaneously, using the interview questions to focus the analyses. The researchers continually checked-in with each other to ensure common understanding and application of the thematic index.

The same method was applied for the other two respondent groups (MMT and COH). While the thematic indexes for all respondent groups were guided by the interview protocols, other significant themes related to MMT that arose, both positive and negative, were coded and included in the analyses. Representative excerpts from the transcripts were chosen to highlight and illustrate the most commonly cited themes that emerged from the data.

Results

One challenge of qualitative analysis is summarizing a broad range of diverse, unique and rich narratives. Tables of key theme prevalence are used here to convey a *grid of the landscape* of participant perspectives.

MMT Involved Clients

The table below displays the tallies regarding support and stigma that MMT clients experienced from various groups. Further details about these themes are provided in the narratives for questions #1-6 and the sub-section on stigma for question #7.

	n	%
Substance use service programs and staff		
Staff are supportive / Stigma is minimal or non-existent	11	92
There are some unsupportive staff	7	58
Medical professionals		
Medical professionals are supportive	11	92
There are some unsupportive medical professionals / There is stigma from medical professionals	7	58
Clients		
Clients are supportive / Stigma is minimal or non-existent	12	100
There are some unsupportive clients / There is stigma from clients	8	67
Stigma from other people (general public, family) exists	9	75

n=12

In respect to SUS clinicians, medical professionals, and clients, there were more comments about people being supportive or respectful than people being unsupportive or disrespectful. In general, the *most frequent reports of support were associated with those directly involved in the substance use cohort and service community*. Most of the examples of stigma or

disrespectful behaviour involved the public, family members, and clients or staff without much exposure to methadone (e.g. COH clients, staff who work in hospitals or general practice).

1. In what ways have Substance Use Service programs and staff (detox, outpatient, current residential treatment…) been helpful or supportive of your needs and involvement with methadone maintenance?

Staff are supportive/stigma from staff is non-existent. Virtually all of the interviewees spoke positively about the substance use service staff and/or mentioned that they felt stigma from staff was non-existent. MMT clients described most staff being respectful, non-judgmental, and helpful in educating others about methadone, critical to their successes in MMT, and supportive, both emotionally and practically. The only interviewee who did not mention supportive staff for this question spoke highly of other medical professionals (e.g. physicians, pharmacists) in response to question #3.

Several of the MMT clients also provided examples of unsupportive staff members, but this was generally an exception rather than the rule and is perhaps not surprising, given the number of substance use service staff that the interviewees have collectively interacted with.

- *I came here, and here they're still pretty supportive. I started coming down on methadone since I've been here. And yeah, here they're more… they want me to get off of it, which is a good thing because I've been wanting to get off of it for a while.*

- *I mean, they're supportive around the fact that they agree with my beliefs around methadone. You know, they don't push it on people, they don't judge people about it, so that's nice.*

- *And then thank God, though, like I said, [the group coordinator] and the people that work here, they're really good when it comes to teaching people about this, and they help me to understand, like, "You deserve and belong here just like everybody else, and what people have to say about all that stuff, that's their truth. It only matters what your truth is."*

- *I would have to say that it was … the treatment centre I'm in right now, that played a huge part in my success.)*

- *They don't treat me any different than anyone else. They respect the fact that we're on medication and that's helping us stay off the street. Totally.*

- *They have helped me. I was really nervous to go down on my methadone, but I needed to. I felt that I needed to go down on my methadone, and they help me,*

encourage me, and say, you know, this is the right place to do it because you're safe here and have all the support I need here.

- *They're awesome. They're good. And the head nurse, she was actually an addict too, so I think she understands, you know? And she's a sweetheart. She's so nice, and I talk to her regularly, not just in the nursing station.*

- *I've never had any problems at all, no. I've always had nothing but full support.)*

One of the interviewees described how staff members who had personal histories with heroin, been on methadone, or knew people on MMT tended to be relatively more understanding.

Other helpful supports. Some of the other supports or characteristics of the treatment programs which interviewees found helpful were:

- Treatment programs that accept clients with children
- Not requiring clients to taper, which allows them to focus on other things
- Access to low-cost counselling at the methadone clinic

For more details on the positive contributions of methadone maintenance in general, see the section "Positive contributions of MMT" for question #7.

2. In what ways have Substance Use Service programs and staff (detox, outpatient, current residential treatment…) been NOT helpful or supportive of your needs and involvement with methadone maintenance?

There are some unsupportive staff. Overall, the feedback about SUS staff members was very positive. However, some interviewees did describe negative interactions with some staff members either at their current treatment centre or at treatment centres in the past.

Only three interviewees described stigmatizing interactions with staff members in their current treatment centre.

- *And so, every now and then I have transportation problems, and the house won't help me out with it. So it's like, "Walk. Try and figure it out your own way." And that is a huge part of my recovery. If they're supposed to be supportive around my recovery, then why say things like that*

- *There was a client here that relapsed on heroin, and I knew that she was high … And when I went in and I said I was triggered by it, they said, "Well, don't you think people are triggered by you because you're on the methadone program?" … Like, why would you even have clients here if you're just going to put them down?*

- *I had to go all the way downtown to get my friggin' dentist work done. … My face is out to here. I have a pounding headache. I'm, like, "I need my methadone. Can you please drive me to Shoppers, please? Can somebody please drive me?" … and they were like … "Like, it's not our problem you need to go to the dentist, and it's not our problem you're on the methadone program." And I was like, "I didn't say it was. I'm asking you to give me a friggin' ride. I just got dental surgery done on my face. Can't you just give me a friggin' ride? Are you kidding me right now?" Like, I was choked. No help at all. And meanwhile, it's hailing and people have to walk with me again somewhere else.*

In a few instances, interviewees spoke positively about staff at the current treatment centre, but talked about staff that they had encountered in *previous* treatment settings who they viewed as less than supportive or helpful.

- *The nurses didn't seem like they knew they were doing. … See the problem is, is that I think that, from my experience, when you go to a daytox, you're not going to get the best care. They're not going to put a doctor who's the best doctor in Canada to work at a daytox. I understand that. But I think I expected a little more just… You know?*

- *When I told him I was on methadone, he shunned me. Like, he looked down on me, and he said, "Well, you're not sober, then."*

Several of the MMT clients also mentioned how certain programs, like NA, or even certain treatment centres would not accept clients on methadone because they are not seen as being "clean".

- *… some places don't allow methadone, and that is really a hindrance, right, because there are people like myself that do want to be on the methadone maintenance program and do it properly …*

- *Like, NA in Kamloops at the nooner I can't collect clean time. I'm not even allowed to share. But I can share if I haven't dranken my methadone that morning and I come to the nooner without drinking it. … They said, "Well, if you're on it for pain management," like say if I got hurt and I'd never done drugs before and I went on methadone because I'm in pain all the time, then I could share, but if I was on it for drug replacement, which I am, and I told them that because I'm honest, then no, I can't.*

3. In what ways have other medical professionals (Physicians, nurses, lab staff, pharmacists…) been helpful or supportive of your needs and involvement with methadone maintenance?

Medical professionals are supportive. Nearly all of the interviewees provided positive comments about the medical professionals (primarily physicians, pharmacists and pharmacy staff). Most clients shared superlatives (e.g. "great", "amazing"), while others described the medical professionals more specifically as informative, competent, caring, polite, non-judgmental, supportive and accommodating.

- *Here, [the doctor] is great. He really cares. He knows what he's doing. And yeah, it's been a great experience.*

- *They've been great. My doctor that I had for, like, seven years was amazing. … And her appointment was really informative. Like, I've never had a methadone appointment like that before, like, her really checking in with me and, like, telling me, like, you need to have, like, extra, umm, support – like, you know what I mean? – with a drug and alcohol counsellor.)*

- *… this doctor that helped me get through this, he was amazing, man. Every time… Like sometimes he would just bump me up to the end of the list just so he could spend an extra few minutes with me, which is rare for a doctor to do because the time for them is very precious. And then he would ask me questions – "Are you still at Phoenix? Are you still doing this? What's the other areas of your life? How's your family life? How's school going?"*

- *Great. They know you by first name, they're very polite, they're very professional, they treat you as if you were just any other person going in there and picking up your prescription. "How you doing? Have a nice day," stuff like that. They're very good that way.*

- *[Name] at the pharmacy and [name] over at Shopper's, they are amazing. They are super, super amazing.*

- *And so home delivery kept me on top of it to have a proper daily schedule. So that is a plus for me, that this pharmacy that I found offered that and that my doctor was willing to write my prescription for home delivery daily.*

- *Everyone that I deal with is always positive, and they say not to try and come down too early, because it could bring up some cravings. So yeah, they just tell me to take my time and make sure that I'm ready, right?*

- *There are some that have been really, really supportive. I was talking to a nurse about methadone, and she actually said, "Good for you." She was… she seemed*

proud to say that someone was on methadone. She can relate to that; she has people in her family that are on it, and she said, "It's helped them a lot, and if it's going to help you, that's great." She was awesome about it.

4. In what ways have other medical professionals (Dr.'s, nurses, lab staff, pharmacists…) been NOT helpful or supportive of your needs and involvement with methadone maintenance?

There are some unsupportive medical professionals/there is stigma from medical professionals. Over half of the interviewees described interactions with medical professionals who were unsupportive, uneducated about methadone, and/or seemed judgmental towards MMT clients. Notably, several of these people referred specifically to physicians and nurses working in hospital settings (and in one case, a family doctor) - medical professionals who might not be as familiar with substance use services. A few people encountered unsupportive staff at pharmacies.

- *I just remember being treated like shit in the hospital, and it already hurts enough. … The nurses were, like, rude, and they treated me like I was a dope fiend. That's exactly how they treated me. They just were like, "Well, we don't know what to do. We can't do anything for you." And this was the attitude, right? "We can't do anything for you because we don't have a methadone doctor here. I don't know what you expect us to do." Like, that was things that they would say to me.*

- *I've been to the hospital. There I've noticed it, where they kind of just don't really care. They leave you to the end, see everybody else, and then there's certain attitudes towards it.*

- *I originally would go to Shopper's to get my methadone and just had a negative… they would look at me like, "Oh, here comes the drug addict" and just roll their eyes. If I was waiting in line, they would ignore me to get me my prescription and just go and deal with everybody else, and I would get ignored, and I'd have to say, "I've been here for 10 minutes now. Can I please get my medication?"*

- *He knows what I'm there for, and he puts it in a binder. I sign it, put my head down, and drink my juice. Every other pharmacist, they'll take me over to the cashier and make me pay. He'll get someone else make me pay.*

- *The hospitals do not like that I'm on methadone. I had one doctor say to me, "Why are you on that?" And I told him, you know, "To help me with my drug use." And he said, "Well, you don't need it." You should get off that as soon as possible. You know, he was just totally negative about it.*

5. In what ways have other clients been respectful of your involvement with methadone maintenance?

Clients are supportive/stigma is minimal or non-existent. When interviewees were asked directly about stigma or respect from other clients, most reported that stigma was either non-existent or minimal.

- *I think for the most part they are respectful in the way that they sort of – how do I say this? – they don't put me down. They don't put themselves on pedestals, you know? If they have questions, they ask me, and if I don't have the answer, I ask Linda, who's the group coordinator, so I don't give wrong information. So, yeah, for the most part it's been respectful, and it's been okay.*

- *Most of the guys were very good though. Most of the guys knew, "Hey, that's for medicine." I heard guys say, "Hey, why you gotta say that to them? This is their medication. This is what's keeping them off the streets from using the drugs." And I appreciated that, because that's all it is. It keeps me from going out and using.*

- *… so if they know and they are curious, they'll ask, but they're never, like, judgmental or anything about it.*

All MMT interviewees mentioned that there was little or no stigma from fellow clients, and/or that their fellow clients were supportive. However, as was the case with the other interview questions, several of these interviewees also provided examples of unsupportive clients. Nevertheless, there seemed to be good support from other clients, particularly from those who had in the past, received MMT, were currently part of the MMT program or were somehow knowledgeable about MMT.

- *But actually I had a couple of friends that used to go with me all the time, every day, just so I could go get my methadone, right? There's clients here that drive me sometimes if I'm feeling not too good.*

- *There's like 12 of us that are on methadone here in (name of resource)and we all, you know, "Go get this guy. Go get that guy. We know where he's at. We gotta leave." But for the most part, everybody's on time. It's amazing. … Yeah, definitely, we talk about it. We always talk about, "Hey, man…" Like, if somebody goes down, we congratulate each other.*

- *For my roommate, I informed her right away that I was on the methadone program, and she had no problem with it. She's like, "My last roommate that just left, she was on it too." She was very helpful for the first week to help remind me that I've got to get up and go. This is the time. I need to be in this spot. She helped me because the first week is kind of hard here.*

- *Pretty much the ones that are on methadone. Or even the ones that have friends or family that are on methadone. And yet I think it's because they understand it. ... They'll say to me, "Good for you." It's not easy to decide to go on methadone knowing that it is something that you'll have to rely on every day. But they'll say, "If it's going to help you in your recovery and help you stay clean, then good for you."*

6. In what ways have other clients been NOT respectful of your involvement with methadone maintenance?

There are some unsupportive clients/there is stigma from clients. Despite the number of positive comments regarding fellow clients, it appeared that interviewees *experienced more judgment from their fellow clients* than from either substance use service staff or medical professionals. As stated earlier, it also seemed that most of the disrespectful behavior was from people who had not had much exposure to methadone or MMT, either personally or through people they know.

- *Well, I know, ultimately, when it comes around to the education that they give other people about, it is really helpful because it's really more about other clients. It's the problem with them that becomes the issue, right? They don't quite get why people are on methadone, or they need an explanation, or they need to understand what methadone's about, or whatever.*

- *They think that because I'm on it, I'm not totally clean. Things like that. I don't know if it's just because they don't know about methadone, like, they don't have that knowledge around it, or if it's because they're kind of above that. You know, they think that if they don't need it to stay clean, why should I need it?*

- *People look at you weird. Like, when I get on a high enough dose, people, you know, are staring at you, making fun of you, and it's, like, "Do you think I friggin' like sitting here nodding out in front of you guys? No, I hate it, and it's embarrassing." But what can I do?*

- *I sometimes feel that they look down on people on methadone because they look at it as you're still taking a substance.*

- *There's one guy that I know that it seems to bother him. He's adamant every time we come back from our run from getting it in the morning, he goes, "Oh, here they are again, all stoned up," you know? I don't get stoned from it. I don't get high from it. ... Well, he was calling us* ***Methastonians, Methastoners*** *and stuff like that.*

A few of the interviewees talked about the lack of understanding among clients who were not on methadone or were unfamiliar with MMT. However, one of the interviewees pointed out that the comments from these clients might emanate from a place of concern:

- *Judgment, yeah. I think only… even people in here, actually, though. They don't understand it. People that didn't have opiates as their drug of choice, like the speedheads and the cokeheads, they always tell me, like, "You gotta get off that shit right away, man. You don't know what it's doing to you" when they're the ones that don't know. … And the ones that don't have any idea, like, I shouldn't say that they're disrespectful. Their heart is in the right place. They just don't understand. They're not so much disrespectful.*

In addition to the comments about judgment from COH clients, one of the interviewees talked about judgment from other MMT clients, which influenced a personal decision not to take clean time while on methadone.

- *Because the weird thing is that even other people who are on methadone, right, they will take it personally because I'm not taking clean time in meetings. You know, say another person in the house who is on methadone goes, "Well, why aren't you taking clean time?" … So they kind of jump the gun and just sort of jump right to that place of, "Well, you know, if you think you're doing something wrong, do you think I'm doing something wrong?"*

Finally, a few of the clients made comments illustrative of self-stigma

- *Pride. My ego. I'm a slave. I'm chemically dependent on something, right?*

- *Because of what I was taught in my early days of recovery, I was taught that methadone is a dope, you know? So I have guilt and shame when it comes to taking methadone even though I'm still in the program. … It makes me feel like I don't deserve to be here like the rest of everybody else. It makes me feel like I'm not worth the program time.*

Any other comments or feedback that you'd like to share about your experiences as a person involved with methadone maintenance?

Stigma in general. The first six questions of the interview protocol asked about ways that specific groups of people (substance use service staff, other medical professionals, other clients) were supportive or not supportive of clients' involvement in MMT. During the course of the interviews, many spoke about the support, or lack thereof, from other groups including family, friends and the public.

- *They still look down at you type of thing, just because they know that you were a heroin addict at one time, even though now you're trying to get your life together on methadone, right? But there's still that stigma, definitely.*

- *It's almost like people who don't get enough education on it, those are the people that kind of look down on people, you know? So, yeah, my mum's husband is... yeah, he did not like the idea of me on methadone. He really looked at it in the same sort of light as heroin, how I first looked at it in my very first experience.*

- *It could be the people on the streets that are using drugs might even label you. It could be just average people out on the streets that know about people on methadone that are talking about it. It comes from a variety of sources.*

- *And there's no possible way that my dad would understand methadone. He thinks just, "Be a man. Quit doing drugs." He doesn't understand withdrawals or anything like that.*

- *Well, for instance, my Mom, she's like, "Why are you on methadone?" And, you know, I'll say, "It's helping me stay clean." And she's like, "Well, but you're not actually clean." ... Like, you know, I still have my sister calling me a* ***junkie*** *because I'm on methadone. So she just pretty much overlooks the fact that I'm not doing drugs. But because I'm still on something that's associated with drugs, she does the same thing. ... Like with all of this going on, sometimes I feel like I would just be better off using. There aren't that many judgements towards using but there are definitely a lot more about methadone.*

- *Yeah, I think that some people do, because they don't understand what it's all about. And they just think that it's another drug.*

Challenges of MMT. The previous sections focused on the experiences of MMT clients interactions with others. The interviewees also talked in depth about their perceptions of MMT as a whole and identified a number of challenges with MMT which are outlined below.

	n	%
MMT is viewed as a barrier to wellness	10	83
MMT clients are overmedicated	6	50
Clients on MMT too long	6	50
MMT is abused/exploited for personal gain	9	75
Hassles of obtaining daily doses of methadone	7	58
Methadone is too easily acquired	7	58
MMT clients trigger others	6	50
Withdrawal from methadone is difficult	5	42
Clients experience negative pharmaceutical effects of methadone	5	42

n=12

MMT is viewed as a barrier to wellness. The majority of the interviewees spoke about how MMT could impede or delay progress towards improved wellness (which was sometimes equated with *sobriety*). Several mentioned when either (a) someone in the treatment centre was on too high of a dose, or (b) they were put on too high of a dose themselves. Some interviewees mentioned that they were prohibited or discouraged from lowering their dosage, even though they preferred to.

- Like, *when I got here they weren't even going to let me lower. Like, "No, you have to stay on 80 mg" when my doctor up in Kamloops was, like, "You need to lower," because if I'm not using it kicks me in the ass. … I'd still try and do group when I was on 80 mg, but I would be falling asleep, so didn't work for me.*

- *Here, in treatment, I'm in class all day, so more low-key things, so I felt myself nodding off every once in a while, and then I knew I was on too high of a dose.*

- *They're just concerned with the doses, people that are on a high dose, that maybe they're not quite ready because the methadone still is numbing you, is still numbing.*

- *He wakes up to go get his methadone, and then he says he's sick, and he doesn't come out of his room all day. So I don't know what his deal is or if he's maybe using while he's on it, or maybe he's thinking he's getting high from it or something. I think he's on the wrong dose, though.*

Several interviewees stated MMT could act as a barrier to wellness by prolonging the duration of dependency, regardless of how the client viewed methadone (a valid medication or a "drug"). Some people talked about MMT as trading one addiction for another. Nearly all of the interviewees mentioned that they wanted to reduce their dosage or taper off methadone.

- *I don't know if the methadone system really works ... Because I think methadone fuelled my addiction and kept me in my addiction even longer than it would have been. ... once I discovered methadone, now there was another drug that I was dependent on.*

- *And I was addicted to heroin first, and then I got addicted to methadone, and I've been on it ever since ... it's just a poor man's heroin ...*

- *It was like I wanted to be off methadone, and there's this huge process to being off methadone. I hate that, you know, because then it gives me time to change my mind, and I didn't want to do that. I just wanted to just be off methadone.*

- *For me the methadone just prolonged my addiction. For me. That's speaking for myself.*

- *It's just a crutch for me right now because I don't feel strong enough to not be on methadone and relapse, but I don't want to be on methadone the rest of my life. I do slowly want to wean myself off, and, yeah, I think that's what everyone should do.*

- *I don't want to be on this for the rest of my life. I don't want to be a slave to a chemical, although it saved my life, right?*

- *So, yeah, after that, actually, things just sort of started to fall apart. Methadone became a substance of choice. Instead of the solution, it became the problem.*

Additionally, several people mentioned that they continued to use other drugs while on the methadone maintenance program. A few of the interviewees talked about how some people will participate in MMT for reasons other than pain management or avoiding illicit opiate use. For example, some spoke about how they sought MMT as they feared that if they went to jail, they would have to suffer through withdrawal from their heroin dependency; reportedly, methadone would be available in jail (and heroin wouldn't) for those on MMT.

- *I can't speak for all addicts, but I think as for heroin addicts, methadone, we don't think of methadone as something that helps us quit drugs. It's just there ... I just wanted to make sure that if I went to jail, I'm not going to be dopesick. That's pretty much it.*

- *I'm still doing all these drugs expecting that my methadone is going to be helping me, and it's not anymore, right? And so I just kept upping it, upping it. That's how I got back up to 80 mg.*

- *And I know you can't really get high while you're on methadone unless you do a lot, so that's what I would do. I would do a lot to try to get high. And then what would*

happen… the dose that was stable at one time wouldn't be stable, so then I have to go up more methadone, and then I tried to do more heroin, and it was just a vicious, vicious cycle.

- *So I continued to use drugs. I continued to use other prescription medications while I was taking methadone and continued to use heroin, and I know that when you're on a very high dose of methadone, heroin doesn't really have much of an effect, right? So I would keep upping my dose with that doctor.*

*MMT is abused/exploited for personal gain***.** The majority of the MMT clients described how the MMT "system" was being abused or exploited. The interviewees talked about staff exploiting the system for profit, pharmacies giving kickbacks in return for their prescriptions, clients selling their methadone on the street and those on MMT with no intention of working towards positive goals.

- *I get 60 dollars in McDonalds cards a month from them. Yeah, I think we all do, so… yeah. I guess that's because they make so much off of the daily dispensers that they kind of give us a little bit of a kickback, right? I hear a lot of people get money. Well, they don't give out money. They give out McDonalds cards. … Some people sell them, obviously, right, for drugs, but… Yeah, I use them.*

- *They use the program to make money … You can get it on the street. And the really sad part about it is that people will water it down and sell it to people that are really sick, and they'll sell it for, like, 28 cents a mg, and it's not even methadone really.*

- *Once it hits the street, the street value is unbelievable. It's like people will sell it for a buck a mil. So that's like 90 mg, you're making $90. And people who aren't regularly on methadone, a dose of methadone is like a shot of heroin.*

- *… but a lot of pharmacies are crooked. I was recently at a pharmacy that watered down my methadone, and I didn't even know until I went to Shopper's and got my prescriptions filled there.*

- *When it comes to small-business pharmacies, stay away from those because they not only water the methadone down, but they don't give you the proper dosage that you're supposed to be taking, and there's a lot of shady stuff that goes on at the smaller methadone… pharmacies.*

A few interviewees described a lack a diligence during the dispensing of methadone or providing methadone prescriptions, enabling people's ability to exploit the system.

- *And, also, another thing was at my office that I go to, they don't do a very good job with the urine tests. Like, people are bringing clean urine off the streets and selling it out of my office so that they can get their carries, so that goes on because the staff don't directly take it or make you empty your bag before you go in, your purse.*

- *… all my experience in the past, you go in the clinic, the doctor doesn't even really care whether you use or not. He writes your script, off you go. "You're just a business to them" kind of way, right? … He's just there to do his job, writes you a scrip, you come back, you do your pee tests. Even if you are stoned or you have drugs in your system, he writes you another prescrip.*

Hassles of obtaining daily doses of methadone. About half of the MMT clients talked about the hassles of obtaining prescriptions and/or making daily trips to get their methadone, as well as the lack of freedom that comes with compliance.

- *Well, I'm getting tired of going every day… having to go to a pharmacy. That's just mental stress after a while.*

- *But it's also a hassle, having to go see the doctor all the time, going to the pharmacy, money too, right?*

- *… because it is hard for going travelling or if you're going out of town, right? You have to get carries, and, yeah, it does become hard sometimes. Especially with my doctor is so hard to get a hold of, and most methadone doctors are because there's not many of them around.*

- *I just wanted to be able to get up, take it here, and get on with my day. Instead, I have to put, like, half an hour, 45 minutes aside to go all the way to the pharmacy, get it, and come back. But now I'm just used to it. I'm okay with it.*

- *Most clinics don't fax your script in anymore, or anything like that. So they actually want you to physically go down to the office, talk to the doctor and get your script. Which means sometimes that can take a couple of hours … [Interviewer: And you're missing your program in the meantime?] Yeah.*

For one of the interviewees, the difficulty of obtaining a methadone prescription led to using heroin for the first time.

- *So the only downfall, I would say, is that because I had never done heroin before, I had heard so much about people comparing methadone to heroin that when I got out of the detox … The problem was that [the methadone doctor] went away on vacation. I didn't know this. So I thought that I'd be able to leave the detox, go straight to her office, get a prescription. That's not how it works. I didn't know all this, though. So by the time I got out of the*

detox, one of the guys that I had left with, he was a heroin user, so it was my very first time using heroin. I left the detox, and within 24 hours I had used heroin for the first time.

Several interviewees spoke about the risks that accompany carries, including: troubles complying with the regimen, using to 'get high', increase the risk of other drug use, fuels apathy, selling illegally, and if it is consumed by others, it can harm or even kill them.

- *I know guys that have done that, that have a week carry, after three/four days, they don't have any more left because they're using it to get… then they're using it to get a buzz. And then, sorry, then what they've gotta do is they have to go the other three days without any methadone, so they're using heroin or an opiate to take the pain away.*

- *It's very easy to abuse, and it's easy to sell, and it'll kill somebody first dose. Do you know what I mean? Like, somebody who's never taken methadone, anything above 30 can actually kill them.*

- *I know a little boy that was 13 and drank his dad's methadone, 150 mg. He died. Like, it's sad.*

- *"Like, take my carries away," I'm like, because I won't drink it, right? So I'm like, "Take it away. I need to come in every day, I need to drink my methadone," because it helps me to not crave as much …*

- *I have six months clean, so when I get home, I can have carries if I choose so. My pharmacy is right across the road and they deliver it to me, so either way. And I think it's actually safer when you have a child to have it delivered daily, right?*

Methadone is too easily acquired. Several interviewees mentioned variations of the theme that methadone is too easily acquired. This included comments that:

- It is too easy to get started on methadone
- Clients are not fully informed of the effects of methadone and methadone withdrawal when being considered for MMT
- Prescriptions are too easy to obtain
- It is too easy to increase dosages of methadone

Here is a sample of quotes reflecting this theme:

- *I wish somebody would have informed me that "These are your options for methadone. One, you can go directly on the program, or, two, you can go to a detox facility and do a seven-day taper there and not be addicted to it for X amount of years." And I wish that the methadone clinic would have also informed me of how addicting it is and the side effects.*

- *Because I find that when you go to the clinic, they don't really tell you anything. Like, you have to ask all the questions. And sometimes... you know, it's overwhelming the first couple of times you go, so you don't really know what to ask. You know?*

- *So as soon as I got out, I went and saw a methadone doctor. And they don't ask you why you want to be on methadone. ... I didn't know what my reason was. They think you're there because you're trying to get off drugs. They don't have no idea that I was using it for other purposes.*

- *I would say that my experience with methadone in this case is I think that it's really just doctors have to be a little bit more cautious, I guess, because my experience is that I could up it as much as I wanted.*

- *Some people kind of thought he maybe gave it away a little bit too easily. Like, if someone wanted to go on methadone, you just came in and you said something, and maybe if you... maybe if you had a hot drug test you could get it, but a lot of times it was just... it seemed to be too accessible.*

- *He lets you prescribe yourself, pretty much, which I don't think should be... that's not a good doctor in a setting where there are addicts. Obviously, if you're here, you're here for a change, but that could be a trigger, you know? "Oh, we know this doctor. If you go in there, he's going to prescribe what we want. So maybe I should do that."*

MMT clients trigger others. Roughly half of the interviewees talked about how MMT clients could trigger other clients in the treatment centre (both those on MMT and those not on MMT).

- *And I could see how that may trigger people too, if I'm nodding off and they're trying to not be in drugs, so that's why I went down on my methadone right away, so I would be respectful of other people.*

- *It's really triggering, especially because that's my drug of choice, heroin, so you know, seeing people that are nodding out kind of brings back all those memories of*

doing drugs or seeing people around you doing drugs, and it has that same effect. So it's really hard to watch.

- *Absolutely, and so that they're not triggering other clients, and they see somebody nodding off, and they want to go out and use, because my first week here that was a big huge trigger for me.*

- *I think that I could see where girls come from when somebody is on a high dose and they're nodding off, because, you know, it's a trigger for some other girls, I would think, right?*

Withdrawal from methadone is difficult. Most MMT clients talked about the difficulties of withdrawing from methadone, speaking either from personal experience or from what they had heard from others. At least one client described how some methadone clients avoid 'weaning off' due to fear of withdrawal symptoms. This could feed into the perception mentioned earlier that MMT can, in some cases, prolong the time to sobriety.

- *And I think I was on 75 or 80 mls, and I had to go through the whole withdrawal of 75 mls of methadone in jail, and I think that was tougher than actually withdrawing from heroin.*

- *I've heard that if you're on methadone it means you're not clean, and when you come off of it, it's pretty much like coming off of the drug itself.*

- *As for the clients that are on methadone, lots of them are scared to come off of it because of either being told by their doctor, I guess, that the withdrawal is going to be horrible, they're not going to be able to get out of bed for three months and stuff.*

- *I've detoxed off a lot of different drugs because I've struggled with drugs from the time that I was, like, 13, 14 years old, but I would say that my methadone withdrawal was one of the worst things that I'd ever experienced.*

Clients experience unwanted methadone side effect. Some of the clients talked about the negative pharmaceutical effects of methadone, both physically and psychologically. These included: sleepiness and nodding off, apathy and feeling "numb", low sex drive, constipation, back pain, damage to bone and teeth, excessive sweating and nausea. As mentioned, some clients claimed that people were on too high of a dose, which impeded their ability to benefit from treatment.

- *It makes you really lazy. It just… Yeah. If you're working, you don't want to go to work. I lost a lot of jobs from being on methadone because it's always there.*

- *The only side effects I get from methadone is the sweating, very, very bad sweating – like, any physical movement, even walking, I sweat, right? – and constipation.*

- *The only negative thing about it is sometimes I find it makes me nauseous… I find that my teeth are really breaking since I've been on the methadone program. I think it's a lot to do with not looking after my teeth for the last few years, but I notice that a lot of people that are on the methadone program say the same thing – that it gets into your teeth.*

Interviewees spoke about how these side effects impinged on others. For example, grogginess and nodding-off were described as triggers for other clients in the treatment centre. One person mentioned that if a client is nodding off and not able to benefit from the treatment program, they are indirectly harming another person who could benefit from it. MMT participation was also cited as affecting clients' loved ones.

- *… we feel that somebody could have had their spot that can stay awake during group, that wants to be here, that is going to be able to follow the program, not fall asleep, that could save somebody's life whereas somebody just maybe physically isn't quite ready to be here. So that's how a lot of girls are taking it …*

- *Yeah, it goes right back to the lazy thing. Like before I was always up having fun with my son. I was always taking him to parks and doing things, but once you're on it, it just takes away the activity life. You don't feel like doing anything. I didn't play games with my son no more.*

Positive contributions of MMT.

	n	%
MMT reduces unhealthy behaviours/negative health outcomes	8	67

n=12

Most of the interviewees identified challenges with MMT, yet also commented that MMT had helped them improve their lives. In a few cases, clients even said that the MMT saved their life or gave them their life back.

- *Sometime in October, I started taking methadone and instantly it helped me out. I had no withdrawals. I started at a lower dosage and I went up to a dosage that I plateaued at where I wasn't feeling sick or anything like that. And I was even managing a job at the time. So it helped me out and I'm still on it 'til today.*

- *Because I know I've heard that it's saved lots of people's lives, and that's a positive thing right there. If it can save somebody's life and it helps them through that*

period of their life that they needed it, it doesn't mean that they're going to be on it for the rest of their life. They can get off of it after they've had treatment, after they've had some counselling.

- *If anything, I'm really grateful for the program. Like, I'm grateful that the second time around I decided to do it properly.)*

- *Oh, because it saved my life, man. Like, without this I'd be screwed. I would definitely be going and using heroin. If you were to take my methadone away from me right now, I would be using.*

- *So on top me being able to... on top of the recovery house being able to give me that life back, methadone gives me the opportunity to almost sort of stabilize myself. I'm back to running in the gym. I'm healthy eating. My mind is not obsessing over killing the pain, and I don't feel high. So that is such an incredible feeling. It's something that I haven't had in a really long time.*

- *The methadone program really is what saved my life. I used to stay out and stay going because I didn't want to wake up being sick, so I would stay out for days and days and days and days. And when I got on the methadone program, I stopped working the streets completely. It was like a big, huge weight lifted off my shoulders. I was able to contact my daughter and my family. Yeah, it just... It was the beginning. It was the first step I needed to take in order to get clean, right?*

Some interviewees described factors which contributed to success in MMT, including having a good support system, taking a holistic approach and being truly motivated and ready for change.

- *You know, behind all these systems working together, having the right doctor, having the right place, it was also the inner part of me that helped me to get up every day and believing that I can do this. That also plays a big part too, you know what I mean, that I can't ignore ...*

- *That very first experience with the program, I wasn't ready, right, because I was manipulating. I was upping my dose. I shouldn't have been doing that. I was using other substances. I was doing all of the things I shouldn't have been doing while on the methadone maintenance program, right? So this time around it's different because I've changed all those behaviours.*

MMT reduces unhealthy behaviours/negative health outcomes. The majority of the interviewees mentioned that MMT reduced unhealthy behaviours and negative outcomes such as:

- the risk of harm from variable opiate purity and adulteration
- disease transmission
- criminal activity to support illicit drug use
- exposure to and use of other street drugs
- the "street lifestyle" (violence, crime, stress)

- *And so it made me feel better and it didn't make me want to go out and steal and do the stuff that I have to do when I'm on heroin.*

- *So a few months before I had started to abuse other substances, I was already in obsession with substances, so what was really shocking to me was that the methadone actually helped with that obsession. It almost gave me this sense of not feeling like I needed to be taking a bunch of pills.*

*Recommendations made by MMT involved clients***.** The following recommendations were provided by interviewees. Many of the described challenges with MMT implicitly lead to recommendations, but only those recommendations, which were explicitly made are included here. In many cases, there may are intersections with the challenges, since several interviewees would mention a challenge, and then later provide a specific suggestion to address that challenge.

- Prohibit carries
- Provide education for clients
- Lower clients' dosages or putting more controls on the higher doses
- Monitor MMT clients more / Be more discriminating before putting people on methadone
- Monitor methadone pharmacies more, particularly the independent ones
- Provide more education and information for clients new to MMT or even just new to a specific clinic, since they may not even know what questions to ask
- Prevent profit-motivated behaviour on the part of doctors and pharmacists
- Have more treatment programs which allow people who are on MMT to participate
- Provide more transportation support for clients to attend MMT related appointments
- Change the intake process to be inclusive of people on methadone for reasons other than opiate use (e.g. as a painkiller)
- Allow prescriptions to be transferred between sites
- Allow travel out of the country while on methadone

Cohort Participants (COH)

1. Some people involved in the methadone maintenance program also receive residential treatment. In your experience, what has this been like for you (any interactions with methadone maintenance cohorts in treatment)?

The table below reflects interviewees' reports of direct experiences with MMT clients.

	n	%
Positive interactions with MMT clients	6	60
MMT challenges in the treatment environment	6	60
MMT clients treated differently	2	20
MMT clients trigger COH clients	2	20

n=10

Positive interactions with MMT clients. The majority of COH clients generally described open, accepting and positive interactions with MMT involved cohorts. COH clients described the treatment environment as positive and non-judgmental, where clients generally support one another and avoid expressing opinions about each other's treatment choices, including MMT.

- *…this program is good for people on methadone, that… at least this place, there isn't any judgment about it, and there's a lot of support…*
- *I've talked a lot with the people who have done methadone, and they congratulate me for not having done it, but other than that I think everyone is trying to stay positive even if they do feel certain negative thoughts about it. It's all about people's recovery, right? So I don't think they want to put those negative thoughts on other people, you know?*
- *So I mean I don't think negatively of them being on it because, for example, some of the women here are mothers, and it would be really hard to take care of your child if you were sick for, you know, that long of a time.*
- *I feel sorry for… You know, it's a really hard road out there for people who get hooked on drugs, and I used to judge them at one time until I became one, and it's not so easy getting out for all kinds of reasons, and I applaud people that show up here, being if they're on methadone, being if they're not on. You know, they're trying their hardest, they're doing their best. And even if they do show up just to get out of the cold, you know, at least they're here. They're not being a nuisance to society, first and utmost, and then they're… They do eventually come around, and they do start working on themselves…*

As one example, a COH client expressed positive support for the use of methadone by other clients in treatment, despite the negative effects often exhibited by MMT clients on higher doses of methadone.

- *I don't mind that they're on methadone. I notice in group that when they're nodding off or they have 'methadone face', as they call it… when people just have this glum look on their face, and they have it… They're looking off into the distance, kind of, with dead eyes, and… or they're just nodding off and just not present, and you have to wake them up sometimes. So you can tell when they're on it sometimes, but I mean, if that's what they have to do to be here, like work on their recovery, then I don't have a problem with it. In my mind, I don't. I think they've made a good step in coming here, right, and being willing to do the step work, and… yeah. So I don't mind them being on methadone.*

COH clients frequently described having positive interactions with MMT clients, and/or with no major problems or issues. In one instance, a COH client described a personal difficulty with an MMT client as a personality clash, rather than a clash with MMT.

- *We just don't get along sometimes, but I guess it's probably just personality clashes rather than the methadone.*

- *My interactions with them have actually been good, really positive. I've been pretty close to them and… Yeah, I don't see any problem with them being on it. I have someone else in my life who's on methadone as well, and… Yeah, I just think if it keeps them off of drugs, then it's, I don't know, not a problem to me.*

- *Mostly positive. I'm a pretty positive person, so it could be different for other people, but personally, myself, I most of the time don't notice that much of a difference with the people other than they're sleepy or they aren't as social.*

- *For me, personally, everything was good, my interaction with them was good. It's just like, you know, with some of them you knew something was going on, right?)*

- *I don't have a problem with it. It's fine. They're good. I like being in here. There are nice people here.*

MMT challenges in the residential environment. Interactions between clients in group settings were often described by COH clients as hinging on the MMT clients' dosage of methadone level and associated functioning. Interviewees discussed the perceived variability in functioning between MMT clients – being unable to tell that some clients were on methadone at all versus others who showed the effects of higher doses, i.e., nodding off.

According to interviewees, MMT clients who were on appropriate and/or decreasing levels of methadone were cited as not as a concern or problem.

- *The people on methadone, I wouldn't know unless I was told that they were coming down from methadone or they were on methadone or that maintenance program had existed for them.*

- *This time it hasn't affected me one bit, one way or the other. My last group had 11 guys in it. I think four of them were on methadone. And one fellow would nod off a bit about maybe an hour to an hour and a half after he took his methadone and then… maybe for half an hour. … So really, in my group, I haven't had anything to complain about at all.*

However, challenges and complaints voiced by COH clients centred largely on the effects of over-medication of MMT clients. MMT clients on higher doses were often described as incoherent, disoriented, drowsy, slurring their words, difficult to communicate with, unable to retain information and uncomfortable to be around when nodding off.

- *I find when people are taking too much of it they're just not all coherent, and they're not retaining any of the information. They're sleeping a lot, they, umm… They're late. Things like that.*

- *And I feel like if people are nodding off, they're on too high of a dose, and it's kind of uncomfortable sometimes to be around when they're just out of it and you can't really talk to them. And they have to go to sleep sometimes during the day because they're so tired.*

- *Umm, the girl that's on methadone, I can always tell once she's gone to get her methadone. Her whole aura changes. She's very tired, she's very lethargic. Sometimes when she's talking she doesn't make any sense.*

Further, several COH clients expressed concern related to the perceived inability of MMT clients on high doses of methadone to fully focus, participate, and contribute to group sessions. This not only appeared to interfere or detract from COH clients' therapy, but was the basis for some negative opinions regarding MMT clients' readiness for treatment. COH clients also questioned MMT clients' lack of initiative around reducing their levels of methadone. Some COH clients were frustrated with MMT clients who appeared to be 'loaded' on methadone, as they observed this to inhibit MMT clients' full effort in recovery.

- *You know, that's kind of a Catch-22, I guess. Sometimes when they're not on it they're hard to handle, you know. They're going through whatever it is that they go through. … They're here in mind, I believe. When they come back from the methadone, they're… they're not in mind. And I believe that they're… they're*

unreachable for treatment, I believe. You know, they might as well just go back out on the street for that matter. There is real people out there that really want to use the program. These people are filling seats. (

- *This is the place I think that they should start to really cut their dose down because this is a safe place to do it. … and I think that people that are on methadone need to take more initiative in getting off the methadone instead of just using it as a substitute to not be sick. I really think that.*

- *We have a group atmosphere here, and if one guy's on methadone and he's nodding off in class, you know, you're kind of looking at them, going, well… You know, it takes away from your focus a little bit, umm, and some people actually say, "Hey, you know, maybe you're on too much," you know, and it just doesn't seem to register, you know.*

- *It's a negative effect… it's frustrating because you see that and you think, "Well, they're high, they're out of their minds, and here they are trying to get treatment," and it just doesn't seem fair to the whole community that we have here.*

One client in an abstinence-based treatment facility expressed a strong opinion about the inclusion of methadone in the therapeutic environment:

- *There's no room for it in treatment, I don't think. You know, if you want to get clean, get clean. … it wouldn't work in a place like this. I mean, you sit in a group. The group therapy here is a real functioning group. If you had half the guys in here on methadone, they don't make any sense.*

*MMT clients are treated differently***.** Other clients expressed that MMT clients appeared to receive special treatment by clinical staff e.g. given room for excuses**,** spend full group therapy sessions focused on methadone-related issues and permitted to nod off and put less effort into recovery.

- *I think people that are medicated, lots of people use their medication as an excuse to get away with a lot of things that they would… say, like I wouldn't get away with, right? They'd be like, "Oh, I'm having a bad day, this and that." And then so they just get to go do whatever they want. But them I'm not, so I have to be like deathly ill. You know what I mean? I can't just have a bad day. It's like, "Well, too bad. Get through the day. You're getting a strike."*

- *Well, guys that are either on heroin or using the methadone program or are… they want to know about the methadone program. The alcoholics, the crack users, in the open topic here – now this is just my experience in the last eight weeks – is when these guys start talking about methadone, and there's one counselor here that allows it, that'll talk the full hour about it, the rest of us just… we can't wait to*

get out of there soon enough. Because we've heard it so many times, and it's pretty much "war storying," is what it is.

- *I think it has an effect of when they're sitting in class. I don't know whether or not they're… Do they hear what's going on? You know what I mean? I don't get it. I look over at somebody that's on methadone and they're just out. And I'm like, "Hey," and they're like… And they're just done again. I'm like, "Are you listening? Are you not listening? I don't understand. "Why can't I sleep in class but you can nod off?" I don't get it. … They should be woken up or something. "Get up, walk around, keep yourself awake. This isn't fair."*

Triggering. Few COH clients reported feeling triggered by MMT clients in the treatment setting. However, the triggering effects of methadone are more likely to affect those with opiate use histories. Of the 11 COH clients interviewed, six were currently in treatment for problems with opiates, such as heroin. Of these, only five had experienced MMT clients in the treatment environment. Two of these five COH clients indicated that they were occasionally triggered when in the presence of MMT clients who were nodding off.

- *There's one girl in here that I'd seen. She was getting a lot and she was falling asleep all over the place, so… Yeah, it was kind of triggering me for other stuff, for the stuff I was using, so… It was like looking at someone on heroin, nodding on and off all the time, you know?*

As might be expected, COH clients who were in treatment for problems with non-opiates, such as alcohol, reported being unaffected by triggers associated with methadone effects. However, several of these clients recognized how it could affect clients addressing heroin or opiate drug problems.

- *I would say it hasn't had an effect, but I think that it probably could for some people, umm, maybe people coming off heroin themselves that aren't on methadone or things like that, umm, wondering, you know, "Oh, maybe I should do that," and maybe sort of creating some doubt in their mind or some thought that maybe they should be on the methadone program as well because at least they're getting some form of a high legally. Umm, it hasn't bothered me to have them in the house with us, but I can say that it could be triggering, umm, for other clients when they were saying, "Oh, I gotta go and get my methadone, I gotta go get my methadone," right? So, I mean, we try not to use words like that in treatment because you don't want to trigger people.*

- *And it doesn't necessarily affect me personally because I am strong in my recovery, but it still gives me a sense like, man, this is… this isn't good. You know? You're here and… and maybe for somebody else as well, like, if they see that it may trigger them to want to be like that, or get high, or something.*

And rather than feeling triggered, several COH clients expressed feeling more disgusted and annoyed by the effects of methadone, particularly the characteristic heroin or 'methadone face' often exhibited by MMT clients on higher doses.

- *I feel bad for them kind of. I'm just like, "Ugh." It kind of grosses me out. I don't mean to be judgmental or anything. I came from the same place, but I just… it's gross to watch. And I'm like, "Wake up, man. Are you kidding me? Be present in your own life. If your methadone's too much for you, cut your dose down."*

- *It looks just gross… it's not the same as if somebody's tired and they fall asleep in class. You get that heroin face. Their face goes all like… and they're just like… They're on the nod. It's like they're high on down, you know what I mean? Because it's the same thing, and just to me, it's just gross. The way they look is just gross. I mean, I've heroin before so I'm not judging. I'm just saying, it's just really not a good look for anybody.*

2. What have you noticed about how other clients have responded to persons involved with methadone maintenance?

	n	%
Positive interactions between others and MMT clients	6	60
Negative interactions between others and MMT clients	4	40
Positive interactions between staff and MMT clients	3	30
Negative interactions between staff and MMT clients	1	10
Stigma from others in treatment	5	50

n = 10

Positive interactions between others and MMT clients. The majority of COH clients reported observing that other clients in the treatment setting generally appeared to be supportive and have positive interactions with MMT clients.

- *Nobody has any angst against it that I've noticed whatsoever. I'm not saying that's for everybody. I'm sure if you interviewed everybody here, you may find someone that has a little bit of angst or something, or a lot – I don't know. I certainly haven't noticed it, and I've talked with a lot of guys and been around a lot of conversations and I've never once come up with that conclusion.*

- *And a lot of people here, or if not everybody, support the people that are on methadone because they see that they're actually still trying to change their life and that they should take clean time…*

- *I've never heard anyone talk about it other than to say that "Yeah, it's really good, so-and-so, that you're coming down off of methadone." I've heard other people express the opinion that it's a drug and that you're on a drug, but not in a negative connotation…*

In general, few problems or negative interactions were observed by COH clients in the treatment setting. One COH client described how individuals are generally focused on their own individual recoveries and rarely discuss MMT amongst themselves. Further, MMT clients taking appropriate/low doses of methadone and functioning well were generally not noticed or even recognised as MMT clients.

- *People are so wrapped up in themselves. … I mean, really, unless you're the object of their antagonism or unless you physically hurt them, they don't even know most people exist. … Like, you know, they're in their head. They have bigger fish to fry in their lives. They're in the treatment centres. They have bigger fish to fry than who's on methadone, right?*

- *I've never heard them say anything bad about the guys in our group that just didn't want to complain about something. A few of them, you wouldn't have even known they were on [methadone].*

Negative interactions between others and MMT clients. A few COH clients described situations in which they, along with other clients, have sometimes reacted to MMT clients' nodding off by laughing, snickering, losing patience and/or reproaching them:

- *But I do see in group when the people are nodding off, and people making expressions and looking over at them, and kind of… A couple times I've snickered. I shouldn't have, but just sometimes the face that they make are like, [makes dazed noise]. It's just kind of funny sometimes.*

- *I guess I have heard people being a little bit impatient with those who are getting methadone treatment because, you know, they're sleepier or tired.*

- *Well, I understand that they can't really help it. Like I know that once it hits you, you're kind of done. You can't really help it, but get up, shake it off. Do something, man, don't just let yourself nod out. Because it's… and like everybody'll look at them, and I feel bad for them because people are laughing at them. And I'll even tell them after the meeting. I'm like, "You look disgusting." I'll tell them because they're my friends, and I'm like, "That's gross. You need to get some cold water or something."*

Several interviewees indicated that other clients can feel offended and disrespected when MMT clients nod off. One COH client described a situation in which the effects of methadone negatively impacted a personal friendship between a COH and MMT client:

- *I was talking to a girl who receives it here, and she was talking to me about how when she was dozing off, she felt that one of the other girls who was leading the meeting became very, like, removed from their friendship after that because it was almost as if she felt… disrespected or like she wasn't taking it seriously.*

Interactions beween staff and MMT clients. COH clients observed that clinical staff were largely positive, supportive and caring with MMT clients in the treatment environment.

- *But here the staff is very understanding about your feelings and you can talk to them about anything, and I think because they're so caring here, that's why they let people in with methadone, because they see that they're obviously making an effort to come in here and change their life, so… Yeah, the staff here is pretty good about that.*

Several COH clients expressed appreciation for having a positive and supportive atmosphere, which facilitates open discussions, including the opportunity to address methadone-related issues during group sessions. However, one interviewee described an instance in a group meeting that discussed triggers, (i.e. how nodding off was affecting two COH clients). Despite supportive staff, the MMT client was described as getting defensive and reactively left the treatment facility. The interviewee described the staff as encouraging and supportive of the MMT client, but the client ultimately believed that she did not fit in.

- *I guess me and another girl just… She wasn't "liking" her nodding off all the time. … I guess she felt like we were just attacking her or something.*

Another COH client described how staff can sometimes appear unresponsive, particularly by ignoring when MMT clients nod off during group sessions.

- *Because they know they're on methadone and they're going to nod out in class, because that's what happens and it's a normal occurrence.*

Stigma. Few COH clients believed that stigma was explicitly directed towards MMT clients by themselves, staff or others. For the most part, COH clients consistently emphasised that the treatment setting was an environment of positive support and non-judgment, inclusive of therapeutic choices. Further, many COH clients expressed that they generally do not openly share their opinions about methadone with others in the treatment setting.

- *It's not something that I would walk up to somebody and start asking about their methadone. Most people are pretty guarded about what they… they'll talk about with other people when it comes to methadone.*

- *I get along with everybody, right. So it's not like I'm not being, I guess, like biased, because it's not like I don't get along with people that are on methadone. So I'm not judging them because I don't like them or something.*

- *But I don't want to be one to judge, because, I mean, if I needed something like that to help me out, to get off drugs and get into treatment, then it would be okay, I think. I wouldn't want people judging me, right?*

Only one COH client explicitly stated that absolutely no negative stigma was attached to MMT clients in the treatment environment.

- *Absolutely no difference between a person on methadone or a person not on methadone. A person is a person, no matter what their motives or what they're doing. … There's just one person that's here doing it, and it made absolutely no difference whatsoever in terms of how I interact with the person or how that person interacts with me. I see nothing changed whatsoever.*

However, several interviewees did recognize stigma directed towards MMT clients in the treatment setting, particularly through examples of derogatory labeling to indicate MMT clients as illicit drug users.

- *Well, there was one fellow that hated [methadone]. He… you know the term '**meth-head**', well, he was talking about these meth-heads, but they're methadone, right?*

- *I've been here almost 60 days now, so I've seen, you know, how people have reacted to it, and I know there's also a little bit of discrimination from the people that aren't on it as well. They're called the '**methadonians**', and they kind of umm, get labeled that way.*

- *I think so. Well, yeah, because it labels you. When you're on methadone, it's like, "heroin addict." Right?*

More subtly, comments around stigma were evidenced through opinions of resentment of MMT clients' readiness for recovery and attendance in treatment programs, opinions on whether they could take clean time, 'unfair' treatment in therapy (e.g. allowed to nod off, not fully participate), and disrespectful reactions to MMT clients if they do nod off (e.g. snickering, laughing).

- *Well, I scratch my head, you know. I guess in a tiny way there's a little, tiny bit of resentment because there's people out there that could use the seat, you know.*

- *I would take some of these people that are like that, and I would stick them all together somewhere until you get them off of methadone.* ***They're not really human.*** *Bottom line is they're not really human. They're still out there. It's just legal in here to do that. That's the only difference.*

- *The majority of the people that I've spoken to or hear talking about methadone here, like I said, couple of them use it as a badge. One new guy came in a couple weeks ago. "I'm on methadone, man. Geez." "Well, so is the other half of the line in the med room, right? So you're nothing special."*

- *It's a joke, right? You take a year cake or a two-year cake, and you're on methadone? You're not clean. You're not clean. It's total abstinence, right? That means that includes methadone, right? So that's just my opinion. Other people can say, "Oh, I'm clean. I can do my 150 mils a day and be fine."*

- *I get a kick out of people on methadone, and they think they're clean. A lot of people do. They come to meetings. "I'm clean. Well, I'm doing methadone, but I'm clean." Well, excuse me, but methadone's synthetic heroin, basically.*

- *… [MMT client] won't take clean time because some people in recovery are against it because they still feel like it's a drug. … Yeah, I think there is a stigma about it, definitely, but not to me.*

In addition, interviewees discussed how methadone is widely perceived as a drug outside of the treatment environment. As such, MMT clients were described as commonly being viewed as continuing addicts or illicit drug users. One interviewee mentioned that as a former MMT client he was treated differently - with more respect and not simply as a 'dope fiend' – because he worked at a regular job. Another COH client described how a friend on MMT experiences stigma by other allied health professionals outside the treatment environment, such as by pharmacists.

- *In my understanding and in my circle of friends outside of treatment, there is a stigma towards it. … Just that it's synthetic heroin.*

- *And like I said, I have quite a few friends that started using methadone instead of heroin, and it just became… like, that was their crutch. Instead of buying heroin, they were getting methadone from the pharmacy instead.*

- *I think sometimes he feels embarrassed about the fact that he's on it, and… Because some people think it's a drug and look down on him, look at him like he's still using, right? … And I think maybe sometimes people even at pharmacies,*

maybe, can look down on people who are going in for methadone. … Yeah, I think there is a stigma about it, definitely, but not to me.

Any other observations or comments about methadone maintenance?

	n	%
Challenges of MMT		
MMT is exploited/abused (within/outside) treatment setting	10	91
MMT is an effective tool for wellness	7	64
MMT continues dependency		
Methadone is perceived as a "drug"	10	91
Clients on MMT too long	10	91
MMT clients are overmedicated	9	82
COH clients would never take methadone	4	36

n=11

Challenges of MMT. Many COH clients described MMT as having two sides. Interviewees were generally supportive and accepting of MMT in the treatment setting – if MMT was used "properly" that is, if MMT clients were on low doses of methadone to function at a normal level, were actively participating in treatment and therapy, and were on a tapering plan to detox quickly and safely from heroin and other opiates, including methadone itself. However, many COH clients expressed conflicted feelings about MMT, particularly due to the widespread opinion that MMT is exploited and abused "at large", both inside and outside of treatment centres and facilities. Interviewees readily pointed to examples in the treatment environment where MMT appeared to work very well, but also where MMT was exploited or abused.

- *Well, I can speak for myself and a couple other of the comrades here that I'm kind of close to, and we kind of look at it, like, you know, you're here to get clean and sober and off of all substances, and even though the '**methadonians**'… methadone program, it works, because I've seen that aspect, too, but, again, it's just the dosage of it. I think a lot of people become addicted to it to a point where they want to get high and, umm, and abusing the amount that they're taking.*

- *It's an addiction and they need their methadone, whereas I've also had the opposite where guys have been coming down off of methadone and buying into treatment and doing really, really well, and thank God for the methadone that they're able to wean themselves off or to make that experience a little less traumatic for them in terms of their addiction and coming off something. My personal beliefs though are that it is a drug and it's just a stopgap kind of measure, and I really would like to see persons completely off of that in terms of treatment.*

- *There are guys who seem to use the program, and then there are the guys who seem to "need it". … I believe they take advantage of it. … They don't seem to respect the program for what it can offer, you know, to bring them down out of the narcotic world. They come back from their run, and they seem to be as high as they were as if they were doing any other narcotic. You know, they're disorientated, they're drowsy, they're… some of them seem incoherent to some degree.*

- *…some people are just here to get their 70 days for a certain reason. Maybe it's court or something and/or they didn't want to go to jail and they'd rather just sleep their time and get the hell out of here as soon as possible, and I think it's abused in that way as well… it worries me because, you know, [exhaling]… if they're here for the right reason and… and it is being abused, people see that, and… it just doesn't settle right in your stomach per se…*

- *Well, just because they lie because they want to still be high, right, so they say… they overshoot how… And I've heard it lots out of their own mouths. They overshoot how much they used so that they don't… so that they can make sure that they still get rocked from their meds.*

MMT fosters dependency. The majority of COH clients perceived methadone as a drug, rather than a medication. In addition, the majority of COH clients expressed that individuals in treatment appeared to be over-medicated, and on MMT for too long. Interviewees often referred to methadone as a synthetic opiate, and it was described as a security blanket, which appeared to work against an individual's recovery by prolonging detox, or by becoming a 'crutch' – exchanging one addiction for another:

- *What it is, is somebody on a drug. That's it, basically. So I'm conversing with them, they're just loaded. That's how I look at it because it's just a drug to me, and it's a very strong one.*

- *You're giving a drug addict dope. It just don't work, you know?*

- *I just feel like… if you have to go on it, you know, there should be some form of a program of decrease to get you off of that, right? You shouldn't be going on years with it, I don't believe, unless you have some sort of physical or mental that… that requires it, right? I mean, we're all addicts, we have to learn how to deal with our addiction, in a safe way. But replacing one addiction with another I don't think is healthy either.*

- *It's kind of back and forth for me, because I do kind of see it as a drug still, though, sometimes, and I feel like people can still get high off it.*

- *But I don't think people should be on methadone for as long as they are. They're just mangled all the time. They just seem wrecked all the time to me.*

- *Some guys I've seen and wouldn't know they've been on methadone but I've seen them in the line-up, at the med line-up, and been right behind them when they get their methadone. And, "oh, geez, I didn't know you were on methadone." "Yeah, I've been for six years." You're kidding me." I don't understand that part of it.*

- *Well, if there was something that they could put me on to get me off of alcohol and it was a replacement for it, a substitute, and… Do you get high off methadone? I don't know. If this thing got me feeling like I do when I'm drunk, would I want to do it for 10 years? Not a chance in hell. Just because it's not killing my liver or pancreas or eating my stomach, no. I'd like to… Yeah, it's all pretty much… I just think it goes on too long.*

- *…people that are on the methadone program, they're sleeping down in the queues, and it seems like they're sleeping an awful lot, and… and dozing off, and, like kind of like the nod as if they were on actual heroin. And I think that's a big concern.*

Several interviewees commented that some of the MMT clients appear to be 'self-medicating,' and showed indications of addiction to methadone. One COH client observed instances in which MMT clients have increased their methadone levels while in treatment. Others have noticed that MMT clients exhibit personality changes, and described them as visibly agitated, fidgety and difficult to deal with prior to their daily methadone dose. One COH client described his roommate as 'jonesing' on a daily basis for his methadone.

- *But if there was jonesing, he was jonesing, right? I mean, there was an obvious need for something he wanted, and he was going to let everybody know, and he wasn't going to let up until he got it. … And you could visibly see when he took his methadone he changed. This was not maintenance. This was… this was getting high because, you know, you can just… But there was something going on with this guy that anybody could tell, going, "This is not just methadone maintenance, this…" You know?*

- *I notice people run really fast to get to that van to be able to get their medicine. I that's because they're feeling sick or because they're addicted to it, I don't know. … But I've notice it, that when that announcement goes they don't want to be late for it, and they seem… when they get back, when they hop out of the van they seem very happy. [chuckles]*

- *There's no monitoring for it, that, you know, just, "Up my level, up my level." And I think people actually become addicted to the methadone itself instead of the actual drug which it's supposed to be, you know, curing, right?*

Some COH clients also specifically expressed the importance of feeling sick and the effects of withdrawal as an integral part of the process of recovery.

- *I'm not putting down anybody that uses methadone. I just think it should be cut down a lot more. I think that people if they're doing it, I think it should only be for a month or two, and you should get cut right off of it until you're done. And if you get a little bit sick, oh well, too bad. Maybe you shouldn't have started doing heroin. Everybody knows that happens.*

- *I see it as a drug. It's a drug. I think that my personal opinion is that people should have to through the withdrawal of being addicted to heroin and maybe they would learn…*

- *But man, you should have to bear some kind of consequence for what you've done. I've had to come down off of heroin. I've had to come down off speed, crack, everything, all by myself, and I learned my frigging lesson. You know what I mean?*

- *I think if they're going to use methadone as a way to come off of it, you should get sick. I understand people not getting sick and I understand it helps the cravings and stuff like that, but I mean, people that are on methadone for years and years, that's ridiculous, man.*

Finally, several COH clients, regardless of their substance of concern, explicitly stated they would never use methadone after their observations of MMT in the treatment setting.

- *I don't have the answer. I wish I did. I'd say for everybody, don't use it. Don't touch it. It's worse than heroin. It's harder to get off.*

Recommendations made by cohorts. COH clients discussed several ideas and suggestions to improve implementation of MMT in residential settings. The following list of recommendations includes only those, which were explicitly mentioned as directly asked for recommendations, and so the reader is cautioned not to interpret this as an exhaustive or representative list.

- Dispense or deliver methadone to treatment facilities, rather than have MMT clients travel off-site everyday for methadone
- Encourage a tapering plan to withdraw individuals from methadone during treatment
- Allow individuals to experience the symptoms of withdrawal
- Detox people from methadone prior to entering treatment centres: integrate into treatment when stabilized, ready and able to focus on recovery (e.g.,
- Introduce a screening program, i.e., a gradual step (tapering) program from methadone into treatment

- Have better monitoring of methadone: ensure people are not 'double-dosing' with other drugs, prevent individuals from initiating and increasing methadone dosage
- Provide education of the physical and mental effects of methadone, and to reduce stigma: group discussions, reading material, involve family members/family support programming
- Separate treatment facilities for methadone clients: methadone-specific detox, tapering program, treatment
- Do more research, bigger studies done to provide consensus, to get to the root of the problem, evidence for better practices – include the people that it's affecting: families, communities

SUS Professionals

1. In your experience, what positive contributions has methadone maintenance made to the treatment environment?

This section includes interviewees' perceptions regarding the strengths of MMT in general and at their particular treatment centres.

	n	%
MMT provides tools for clients' wellness	8	72
MMT reduces unhealthy behaviours/negative health outcomes	6	55
There are benefits of mixing MMT and COH clients	4	36

n=11

MMT provides tools for client wellness. One of the main themes identified by interviewees for the positive contributions of MMT was that it provides tools for wellness. Some staff members spoke positively of MMT, describing it as effective when used properly. M*ost of the interviewees were ambivalent about MMT*, citing both strengths and challenges of MMT; however, even amongst those interviewees who viewed it in generally negative terms, some benefits were acknowledged.

- *You know, I just think it's a tool, and if it's used in an appropriate manner, it's a hell of an effective tool. … And I think that any avenue an addict is given for success, being an opiate user or a heroin… or, you know, a cocaine or methamphetamine user, anything that we can put in our favour as far as giving us a better odd at gaining some sobriety's a good thing.*

- *Their ability to not relapse and go back to their drug of choice, you know? So, yeah, I think there is a positive to the methadone maintenance program. I think it's*

needed in the community. So, yeah, I think it's a good thing, but I guess it doesn't matter what my issues are with it.

- *But overall, I think it's a good thing. … There is so many benefits that outweigh the negatives with the methadone.*

One clinician spoke about how MMT stabilized clients enough so that they could enter treatment and then benefit from program along the course of their stay. By removing MMT clients from the "drug environment" and preventing opiate recidivism and withdrawal, MMT provided a bridge into treatment which could further movement towards abstinence.

- *He uses it to take the addict out of the environment and allow them the chance to get stabilized and then get into the process of being in recovery. And I think that that's being used in a wise manner.*

- *Like the positives of it, like it just stops them from getting dopesick and wanting to leave. It gives them more of a chance to stay here and get sober.*

- *… we see it as if it can help a using addict stabilize long enough to contemplate going to detox, to contemplate doing treatment, it fulfils that continuum prior to entering treatment for us. It's sort of like, so that the client will be stable enough… committed enough to doing recovery, physically well enough to actually participate in recovery, and emotionally available by the time he gets here.*

One of the staff members spoke about how MMT increased access to their recovery programs, thus also serving as a bridge to sobriety.

- *So people have more access to our recovery programs and treatment, and that's what my understanding of harm reduction is – you know, accessing people and being a bridge and getting them in wherever they're at.*

MMT reduces risks and negative health outcomes. Many of the treatment professionals mentioned that MMT reduces a number of overlapping health risks, unhealthy behaviours and negative health outcomes, including:

- risks associated with variable impurity and adulteration
- criminal activity to support drug use
- risks involved in sex work to support drug use
- disease transmission
- death or harm through overdose
- use of other street drugs

- avoidance of other prescribed analgesics for pain relief which the staff member viewed as being worse than methadone (e.g. Demerol, codeine, OxyContin)
- immersion in the unhealthy aspects of "street lifestyle"

Interviewees commented that:

- *I do believe that it serves its purpose for those who are chronic and who are engaging in high-risk behaviour, such as, you know, IV use, uh... you know, crime, high promiscuity, different things like this. I do believe it serves a purpose there by, you know, reducing the damage to the client's self and to general society, right?*

- *And then there's all the underworld that goes with it, the crime, the desperation, the depression, the suicide, the HIV, the AIDS, the needles.*

One of staff reported changes in their clients' health as a result of MMT.

- *So it's... and then for them, it's, health wise, way better. Way better. You look at them. They're gaining weight. Their skin colour is improving. Their memories are improving. They're starting to enjoy a little bit about what's going on around them, rather than the horrors.*

Benefits of mixing MMT and COH clients. Several staff members mentioned that there have been benefits from mixing MMT and COH clients. One of the cited benefits was that these interactions have increased COH clients' understanding of methadone and harm reduction.

- *I see them really opening other people's eyes, too, like their perceptions about it, because, you know, it's a harm-reduction model within an abstinence-based model.*

Another benefit which a couple of staff members mentioned was that those on methadone can be inspired by those who are not on methadone.

- *And I've found a lot of methadone clients, once they get here with clients that aren't on methadone, they do want to decrease or come off of the methadone. ... maybe it's some of the freedoms that clients not on methadone have that they see. ... Like not having to worry about getting the prescription wherever they go.*

Other positive contributions of MMT. One staff member spoke about how they viewed MMT as being cost-effective for society as a whole.

- *… keeping ten guys out of the prison system and having them working, paying taxes, is huge. That's a huge chunk of money, huge. So if you look at dollars and cents down the road, man alive. So methadone, hey. Even if it keeps the guy clean for a year, that's a huge tax savings. … And so if you have a person that's on methadone, they're not as apt to be in a hospital as somebody who's coming down off of heroin all the time or having heroin related sicknesses, okay.*

Another staff member mentioned that working with clients on methadone had increased their own understanding of harm reduction.

- *But you know, just talking and working with clients, I see that, you know, they're trying. They're working hard. It really opened my eyes and my mind to, you know, different forms of, you know, helping people …*

3. In your experience, what challenges have emerged from persons receiving methadone maintenance in the treatment environment?

	n	%
MMT is viewed as a challenge to wellness and treatment	10	91
MMT clients are overmedicated	8	73
Clients on MMT too long	7	64
Stigma		
Stigma is minimal or non-existent	9	82
Stigma exists	6	55
MMT clients trigger COH clients	6	55
Withdrawal from methadone is difficult	6	55
Hassles of obtaining daily doses of methadone	5	45
People are put on methadone too easily/quickly	5	45
MMT is abused/exploited for personal gain	4	36
MMT clients dislike MMT	4	36
Difficulties adjusting MMT dosage in treatment facility	3	27

n=11

MMT is viewed as a challenge to wellness and treatment. The majority of clinical staff described how MMT for extended periods of time and at higher doses can challenge effective treatment and long-term sobriety. Across treatment settings, clinical staff frequently reported that MMT clients are over-medicated. Clients on high doses of methadone were described as being impaired, struggling and emotionally unavailable to fully participate in treatment or focus on their recovery. Perceived to be over-medicated clients were also commonly reported

to have a more difficult time interacting with the group, be unable to cognitively work through their personal concerns and isolate themselves. Staff repeatedly expressed concerns that over-medication limited and reduced the benefits of treatment.

- *Basically, my experience with directly working with the methadone clients is a lot of them appear overmedicated, from, you know, point of entry to the facility and often until they leave.*

- *But we see that quite a bit, that people coming in on a dose where they struggle. They struggle functioning, they struggle staying awake, they struggle. … I mean, it's a struggle on a good day for all the clients, right?*

- *I've never been on methadone, so I can't really speak from you know, personal experience, but what clients have said in the past is they really struggle with being in touch with their feelings. It really… It numbs you, right? Which… A lot of the work that we do with the clients is expressing your feelings in a healthy way, getting in touch with those, you know, the hurt and the pain and all of that stuff, right? So clients have struggled in the past getting in touch with their feelings. That's sort of one of the common things that they bring forward.*

- *One thing that I have concern about is sometimes women are on high doses. We have a very strong policy that they need to be stabilized and on a specific dose or within the limits of what is… you know, of where they can function, so… Sometimes, though, women seem to not react too well to it, and they might be really tired and might have a hard time, kind of sluggish, trying to participate in the program fully. So I think that's a concern.*

- *I think it's rare that they are undermedicated, or rare that their medicate… the methadone amount is… allows them to participate fully in the treatment. … I don't think they're getting the full treatment experience at all. I think they're overmedicated, and I think they miss a good portion of the treatment program due to nodding off.*

- *Sometimes you get the girls that are on way too high of a dose that are sleeping all day and they can't get up for group and are the ones that kind of isolate themselves.*

Many staff viewed extended periods on MMT as a liability by diverting clients away from abstinence, reducing positive behaviour change and healing and increasing the likelihood of relapse. Some interviewees talked about MMT as "swapping one addiction for another".

- *And people getting addicted to methadone, just stop using heroin and they get addicted to methadone, they just take too much of it.*

- *I have seen some people that have been on methadone for many years, and I'm not so sure, in my estimation, that's the best thing.*

- *Most of the girls that we've worked with, you know, they've tried to get off heroin, they've tried to get off other opiates, they've tried to get off whatever they've been taking and just have never been able to do it, right? So they've found that, you know, the methadone is sort of the gentlest way, I guess, the gentlest transition between, you know, getting off the harmful drugs, taking this type of medication and, you know, with the thought that eventually they'll not be on methadone forever, right? Because that can be a barrier too.*

- *And then, of course, the withdrawal symptoms and period from a person coming off of methadone is twice as long as coming off of opiates, for example, right? So, I mean, if you were to use the logics around it, you know, the person… the doctor would probably… or patient would probably be better served by suggesting that the client enter detox and had come off of there versus getting on the methadone because, you know, it takes time to build up tissue tolerance, tissue dependence, and in that time if the person is still having cravings and stuff like that they're going to use more, right?*

- *I see it as a drug swap. I really do. I do. And how good is it for the person if they're on it for year after year after year. And I understand that there will always be certain clients who are receiving it who will never be able to get off of it because they know they'll relapse once they do, and I get that, you know? But it's a double-edged sword. It doesn't matter whether they're on heroin or if they're doing some drug where if they end up taking methadone in place of it, it's still going to hurt them in the long run, health-wise.*

- *So I think that my personal opinion is a lot of people are trading one addiction for another, one that is, in my personal opinion, is worse for them than actually doing the drug to start with.*

- *I have not seen a lot of success as a result of methadone maintenance. I have not seen a lot of success for continued recovery. … Because I don't think that they've had the opportunity to really do the healing necessary for successful recovery from addiction.*

Additionally, a few staff members mentioned that some clients on MMT continue to use other drugs while they're on methadone. Aside from running counter to the intent behind MMT, this can also increase health risks.

- *In other words, the screening that theoretically should be in place isn't in place. They lie to the doctor. … And that creates a horrific accelerated health risk because*

now they're shooting heroin on top of methadone or they're doing crack or cocaine on top of the meth. Now you got an impaired person doing another drug.

One staff member expressed a serious concern that exposure to clients on methadone can lead COH clients to think they should also be on MMT. When this staff member was asked in the interview whether they thought client education on methadone was a good idea, they said they didn't feel it was needed because it could create this kind of curiosity in COH clients.

- *I have seen clients that have come here and requested to go on methadone, or think that they should be on methadone because they've seen other clients on methadone.*

Stigma. The perceptions around stigma were quite mixed. Several staff members mentioned outright that perspectives about MMT varied, with some people strongly supporting it while others think it should be abolished.

- *I mean, some guys are extremely against it and say that it's... that you're not clean. You're still using. But a lot of guys I think have come to the point where they say, hey, whatever it takes. Whatever it takes. ... There's going to be differences in opinions.*

Additionally, staff made comments indicating that they believed that stigma was minimal or non-existent, but would then talk about cases where they felt MMT clients were being stigmatized. Further complicating interpretation, it was pointed out by at least one staff member that differing treatment of MMT and COH clients does not always equal stigma.

A few staff members also noted that stigma around MMT has changed over time, and MMT is more accepted now than when it was first introduced.

- *No, it's kind of become the norm now. When it first started years ago it was a little bit of a challenge, but now it's just kind of the norm.*

When asked directly whether MMT clients experience stigma in the treatment environment, the majority of clinical staff believed that these clients do not experience stigma by staff or other COH clients. Overall, MMT clients are generally not perceived or treated differently by staff or other COH clients.

- *Everybody deserves the chance to get their life back, be it on methadone or not. And that's where my professional opinion comes in, is that everybody deserves this and everybody deserves the same chance and the same opportunity, methadone or not.*

- *No, I don't think there's any… I mean, we have to handle them differently as a client in the sense that they are being administered something to take care of their withdrawal, but as far as the other clients go and/or people, front line workers like myself, I don't think there's any issues really at all. I mean they have to leave to get their doses every day, but that's never really generally a problem. But they have some extra things they have to do, but it's never really a problem.*

- *I think now, from what I can tell, I think it's pretty accepted. That that's one of the courses that guys take to be able to deal with stuff … Me, I think that the clients themselves, I don't think feel that stigma too much anymore.*

- *Everyone that works here is… We're all recovering drug addicts and alcoholics, right? … One of our staff actually was on methadone years ago, right? So she has her own personal experiences that really lend well to helping people through their methadone experiences. And I don't… It's just not an issue for us, right? It's… No, I don't… I can't say that we have personal opinions about it. No, it's just… It's medication.*

However, MMT clients have extra needs and challenges related to the administration of daily methadone, (i.e., transporting off-site to pharmacies), and this sometimes can lead to stigma among MMT clients in some treatment settings.

- *So there's some stigma from other clients. You know, they… A challenge for them is that they need to leave the premises. And I think, you know, tired… feeling tired, and sometimes grumpy.*

Some staff members mentioned that they saw methadone simply as a medication to stabilize clients. However, clients (in particular, those not on methadone) sometimes perceive methadone to be equivalent to illicit drugs and therefore view MMT as continued drug use. In some treatment settings, staff reported that COH clients can be prejudiced, judgmental and resentful of clients on methadone, especially when MMT clients nod off in group sessions. Staff members also talked about the stigma around methadone that exists in the general community, and even among staff who work in the substance use service community.

- *That is a stigma that is placed on methadone clients, that they are in fact taking a drug, and that they are in fact under the influence of a moderated drug.*

- *There's not a huge approval for methadone or a methadone facility in the recovery community, so… I have had people like guest speakers or people that are willing to do something at a volunteer level that will not come to this facility because we have methadone clients. … There's a prejudice. There's a stigma.*

- *There's stigma attached to it sometimes. Sometimes clients are judgmental, I guess, and not as open-minded as we'd hope, because they, you know, see people on methadone and they're nodding out in group.*

- *I think there's a huge stigma around methadone and heroin. I don't really know how much the public knows. And so I don't really know what they think the public knows and how they're perceived.*

- *Yes. Actually, there is a stigma. With some people they don't believe that harm reduction is something that should be done because it's just keeping that person in a state where if they don't receive that medication, they'll just automatically… and actually a lot of people have said even if they're on methadone, they're still going to go out and use, and it has happened, you know, so what's the point? So, yes, there is a stigma.*

- *And then, of course, when it comes to other clients as well, particularly clients who don't understand methadone and the purposes behind it, they sort of develop a stigma around it, as well with the methadone clients, and it sort of ostracizes them a little bit.*

One staff member indicated that self-stigma is active amongst MMT clients, particularly those striving for abstinence. Some MMT clients have expressed wanting to wean off methadone as they do not feel good about continuing the use of a drug and do not have the sense of fully being clean. For example, one staff member described a current client wanting to reduce her methadone dosage:

- *She feels like there's stigma. She feels like she's not taking clean time because she's on methadone, so that is, you know, difficult for her, right?*

Other staff members, in contrast, felt that MMT clients did not experience self-stigma:

- *I think they're very accepting of where they're at. They've never expressed shame or intolerance or… It really is a medication, and that's the way they see it.*

MMT clients trigger COH clients. A primary challenge reported by clinical staff regarding MMT in the treatment environment is the 'triggering' effect of drug use among COH clients. Staff frequently described how MMT clients display similar symptoms to being high on heroin, for example, by *nodding off* shortly after methadone is administered. These effects are often amplified among MMT clients that are prescribed higher doses of methadone.

- *We've had clients on high doses of methadone, and they go on the nod and similar symptoms to being high on heroin.*

Consequently, COH clients are sometimes affected or 'triggered' by clients on methadone as it can remind them of drug use.

- *It's not so much they want the nod, it's that they want whatever's causing it, because it reminds them of using.*

Staff reported that COH clients sometimes complain that they are distracted by MMT clients nodding off, particularly during group classes and therapy sessions.

- *Well, they're nodding out in class. … Well, they just say, you know, "Them nodding off… Her nodding off all the time – it's a trigger." You know, "Why can't she stay awake? It's distracting for us," you know?*

- *I think that the other clients are triggered… by someone nodding off in a group and not fully participating, something happens for an addict in recovery that they question, "Why are they permitted to do that and I'm not? Because I'm not on methadone," or, "Why are they permitted to be under the influence and I'm not?" It's disruptive. It's distracting. It draws attention away from the class or the program at hand.*

The use of methadone among some clients in treatment settings can provoke feelings of jealousy, and although not often reported, can also initiate conflict with COH clients.

- *They're thinking is that they're still allowed to get high, so why aren't we. … I think that is the big one, is you have quarrels between clients, and depending on their dose, the higher the dose then the more physical symptoms that they're going to show.*

- *"The people on methadone are getting to use drugs." They see methadone as a way to get high, right? And they're seeing their… you know, their buddies here, "Well, how come they're allowed to be high and I'm not", right? … Really, it comes down to they're jealous because their buddies are getting high, they think, and they're not, right? So that's sort of the one common theme that comes up from time to time, right?*

In addition, one staff member noted that triggering is an important concern for new COH clients entering treatment:

- *Especially with the new clients, right, that have been here a day or two or three or four days, they're still fresh. It's not so much the clients that are halfway through the program. It's more we've got to be very careful with the new clients, because they're iffy about being here to start with.*

Withdrawal from methadone is difficult. The majority of the staff articulated that withdrawal from methadone is very difficult, with some staff members saying it is *much more difficult and intense than withdrawing from other drugs, such as heroin*. One staff member also described challenges with emotional struggles of hurt and pain that clients often face during withdrawal.

- *It's harder to get off methadone than it is to get off heroin. The withdrawal, and you have to wean yourself off for a long period of time, where heroin you go in detox. Yeah, you're sick for three to five days, and then it's more psychological than actual physical. Where you try and come off methadone cold turkey, and physically it can kill you. So it's something that's definitely under the supervision of a physician, detox, and…*

- *Lots have said it's more difficult to get off methadone than it is to get off heroin and other opiates, right?*

Several clinical staff reported that many MMT clients prefer to avoid decreasing their methadone doses as they are intimidated by the physical withdrawal symptoms associated with tapering.

- *I personally have asked them if they've considered decreasing, and generally the answer is no. They have no desire to decrease. … I think that they are dependent, and I think that they are very fearful of withdrawal from methadone. They are afraid of getting sick.*

- *Here's a phrase**, junkies are wimps**. They do not like pain, and detox has 12 days of pain attached to it. There's no… unless you got knocked out with some kind of medication, slept your way through detox and the other 10 days, by and large there's a bit of pain in detox.*

Hassles of obtaining daily doses of methadone. According to clinical staff, MMT clients must travel off-site to local pharmacies every morning to receive their daily methadone doses. Staff discussed how this can be a hassle and problematic for clients at treatment centres in remote areas, and for facilities in which a 'buddy system' is enforced requiring clients to travel together in pairs or trios. Connecting clients with doctors for methadone carries for weekend passes can also be a challenge to arrange.

- *A challenge for them is we don't have any narcotics on the premises, so they have to go to a pharmacy, leave the premises in the mornings, every morning. Regardless if they're sick or if they're having a bad day or anything, they have to do that as part of their commitment here. So they have to go take the bus to the*

pharmacy, get their juice, and take the bus back. And that affects their chores sometimes and timing throughout the day.

- *We've had a few clients who have not been happy that they have to go, you know, off the premises in the morning to get their methadone. But I think we make it pretty clear, too, to them before they enter the program that that's a requirement.*

- *The women here, they need to always be in a buddy system… so there's two women minimum. So let's say if there's one methadone client here, at the time, we'll have… we'll rotate by room and they'll have to… they'll be assigned to go with them in the mornings, yeah. So that's how it works.*

- *Some challenges go back to the doctors again. Here, they get weekend passes, and it has to… for them to get a carrier or anything for the weekend, it has to be okayed by a doctor. So in sometimes connecting for them to go out on the weekend to get the pass to get the carries to go is sometimes a challenge. … If we can't get a hold of the doctor, then they can't.*

One staff member noted that MMT clients can become irritable if they have difficulty or delays getting to a pharmacy on regular time for their dose, and this can affect others.

- *You know, we have two clients who don't really get along too well, and I kind of attribute some of that to the methadone, because they get kind of snarky at times, you know?*

Another staff member pointed out that having to take daily trips to the pharmacies may expose the clients to further stigmatization.

- *Yeah, well, because I really don't like the idea of us all trooping down there to the drugstore. It's open, and they all stand at the counter and wait. And there's other customers are allowed to come in. And so they're kind of exposed to… I don't know if that's a good way to do it.*

And for some clients, the lack of freedom and hassle of arranging daily pharmacy-runs has precipitated self-discharge:

- *Some of the girls get really irritated with it and then they just… some like leave because they just don't want to deal with it every day. Like the walking down there every day and like… I've seen girls come in and they just… they won't put the energy into going down to get it every day, and it's hard for the staff because they're waiting till the last minute where they have to get rides down there, and it just kind of brings a little bit of chaos for everything.*

One interviewee, in contrast, mentioned that the daily trips to the pharmacy had some benefit.

- *And it's always good for them to get out and get some fresh air anyways, too, right? And it's just… They might be used to having a week's worth of methadone in their fridge at home, and… Which I don't know is always the best thing anyways, right?*

People are involved with MMT too readily. Several staff members expressed concern that, given all of the challenges of MMT described above, methadone was being too easily or too quickly prescribed.

- *But it's just sometimes it seems that it might be… I don't know if "a quick fix" is the right word, but it sometimes seems that people are put on methadone quickly. Because the ramifications of… It's really hard to get off of methadone.*

- *And what I noticed over my practice over the years, it's pretty much being given out pretty much freely to people… which is becoming a problem. But then, again, you know, that's comment on our system as well as it's the same thing with psychotropic medications being given out free and, you know, people not being diagnosed correctly.*

- *Yeah, and also I see that methadone… It's encouraged in detox. If a client's going through withdrawal from heroin, they are encouraged to take methadone while in detox. [Interviewer: And you don't think that's a good thing?] No. No, I think it's a liability.*

One interviewee also felt that there was a bias in terms of promoting MMT, rather than abstinence-based treatments, to vulnerable groups.

- *Because hey, you send a doctor to treatment, we send a doctor to completely abstinence-based treatment. They don't send them for replacement therapy. And I think the same should apply to any other citizen in the province. I mean, the fact that the healthcare system will actually fund a doctor to go to abstinence-based treatment, but won't fund a street addict to go to abstinence-based, is unfair in the system. It's an inequity in the medical system.*

MMT is misused and exploited for personal gain. Several of the interviewees mentioned ways that the methadone maintenance treatment program is abused or exploited for personal gain, on the part of both clients *and* healthcare professionals. For example, a few of the interviewees mentioned that clients on a methadone program can sell their carries on the street.

- *They take their carry, they sell it on the street, do spit meth, and all the stuff that goes with that.*

A couple of staff members speculated that healthcare professionals involved in MMT were at least partially motivated by financial gain.

- *Stuff that's going on downtown Vancouver. Stuff from the guys that are on the methadone about doctors pushing it. About getting paid so much per Triplicate that they hand out. About doctors saying well, you're in pain and things aren't good, so how about try the methadone program?*

One staff member described MMT as a crutch that provides little incentive for individuals to reduce or withdraw from continued drug use, particularly as many MMT clients regard methadone as a medication and believe they are drug free.

- *"I'd rather be on methadone than go to treatment. I'd rather do this than go to jail. I'd rather…" You know, it's like the lesser of evils in their choice.*

Another interviewee spoke in depth about how the system was being exploited by various parties. This person mentioned that in addition to clients selling methadone, some will stay on MMT as they are classified as a person with multiple barriers and so can more easily remain on social assistance. This person also perceived that some staff were cashing in on MMT, even describing a worker in Surrey who gives cash kickbacks in exchange for clients bringing their prescriptions to his particular pharmacy.

- *Because that's where he makes his money. … Like you bring your methadone prescription to him, he will give you money for it. Like he'll take money out of the till and he'll pay addicts to bring their prescriptions there. … I mean, I'm sure that's the exception to the rule, but it's just like any other system. There's loopholes and there's ways to abuse it where certain people are getting very rich off it, off basically the misery of other people. That's what I have a… that's what I have a problem with, because not only are you taking advantage of the system, you're taking advantage of people that have been taken advantage of for so long.*

MMT clients dislike MMT. Many clients on methadone regularly complain to staff of being misinformed and disillusioned about the realities of MMT, including a lack of information of the physical side effects and the difficulty of withdrawing/tapering.

- *Clients don't like methadone by and large. Their reported reaction to methadone is repeatedly, "I don't like how it makes me feel. I don't like what it does to my body. I get achy joints." And as they come off of methadone, they say, "I should have*

never been on it. Somebody didn't tell me the truth about this stuff." Those are the kinds of things they report to us.

- *It's just that I've heard that many, many times from clients that… you know, how difficult it is for them to get off methadone, to wean off the methadone, to not be on it forever.*

- *You know, they get on this with the idea that they're not going to be on it forever, and then when they try… It's really difficult. Lots have said it's more difficult to get off methadone than it is to get off heroin and other opiates, right? I guess where I'm going with it is not so much people are put on it too quickly, but are they really understanding the big picture, right? "This is what it's going to look like."*

However, several staff suggested that clients are often in a poor position to comprehend the bigger picture of MMT when initially prescribed:

- *Remember, most of them said they got onto methadone because they couldn't afford their dope, or were dope-seeking or were dope-sick…*

- *When, you know, they're seeing their methadone doctor and, "This is the picture that I'm creating for you," and, "Hey, this is what I think would really help for you," and, "here's what it's going to look like," right? And I get it, too. I mean, if you're sitting there working with somebody who's, you know, been getting high on heroin every day, selling themselves on the street corner, they might not be able to hear the end story anyways, right?*

Challenges adjusting methadone dosage while in treatment. Several treatment professionals described the difficulty of MMT clients' having their regimen reviewed and managed while in treatment settings. Reported challenges include understaffing, few or no available methadone doctors and difficulties with connecting rural and out-of-town clients with their prescribing physicians.

- *Since we started getting methadone treatment clients, it's changed over the last few years. It started off as… We had a doctor that worked with us, was on staff sort of, that dealt with the methadone clients, but we don't have that anymore. So now the clients have to come in with a 10-week prescription from their prescribing doctor. And it's a little bit challenging sometimes, because a lot of them, once they get into treatment and they want to come down on their methadone, so basically they're doing it on their own at the pharmacy. … they just do it. They will just not drink five mLs at the drugstore. And I've found that a lot of methadone clients, once they get here with clients that aren't on methadone, they do want to decrease or come of the methadone.*

- *It's just kind of a hassle because they have to phone them, and then the drugstore has to wait for this prescribing doctor to put everything through, and… Yeah, it's a little bit of a…*

- *Yeah, and I find with methadone doctors, they have certain hours and that, so sometimes it's hard to connect with them for the clients.*

- *Another thing is it's hard for the girls with their methadone because also the girls come over the island and their methadone doctors are over there and they don't have one over here. Like it's limited for them, and they get new scripts and prescriptions for it, and they don't have a doctor over here for them to go and get their methadone lowered and stuff like that. Like I know that's something that the girls struggle with a lot too.)*

- *And we don't have a methadone doctor here anymore, so that's not available to them. That used to be available every Friday. I think that that is a loss for us, that we don't have a methadone doctor here. I think that that might encourage a decrease in the amount.*

Other challenges. Two staff members mentioned that it can be problematic when MMT services are concentrated in neighbourhoods where there is a high profile of substance use.

- *And then, also while the person is in treatment as well there's the piece around them having to go to the methadone clinics that they're registered with, and there's a lot of drug use there, so they have to go there regularly to get new prescriptions and so on. So that's a major challenge as well for a lot of them that I've seen over the years.*

- *We've been approached over and over, "Can we take some of your clients and move them into safe housing on the downtown eastside?" Just, "Why? I'd rather move them into safe housing in New West or Coquitlam or Surrey." Let's decentralize the problem, because if we ghettoize this, we're going to get exactly what we set out for, a ghetto where the behaviour… the aberrant behaviour is the norm. Whereas if they lived in a community and the aberrant behaviour was not the norm, it's fairly likely they'll change the aberrant behaviour because they have other role models around them. And I think that's why we sat here very – and, I mean, we've been at this for 30 years – very quietly doing our thing.*

One clinician expressed a concern that there is a lack of long-term thinking on how to address problems like drug addiction, due to political cycles.

- *And all the… the biggest thing I think that really gets me, is the fact that they don't educate people about what it looks like 20 years down the road. They only look at it in, like, four year chunks of government sort of, you know, that's… I'm only*

responsible for that period of time. And so after that, well, that's the next government's responsibility, and if we have the same government in power, we're great and that's civic, all the way to provincial, to federal. That's sort of our outlook.

One staff member pointed out the lack of psychosocial support in the provision of MMT in general. This clinician did, however, point out that in their particular treatment centre, staff make an effort to promote social and cultural activities and foster healthy social connections.

- *And all the studies indicate that talk therapy is at the heart of any replacement therapy on the way through. And it's like, well, that isn't... that simply is not part of much of what we see happening. There just simply isn't. It doesn't exist. We probably provide the most intensive talk therapy environment. Now we call it a coffee and a conversation, because addicts don't like the therapy session*

This same staff member also pointed out that success stories aren't always heard as much as the negative stories.

- *We're probably about as compassionate as the world gets, but the world doesn't see much of that. They only hear about the guys that get... that leave here, that they have to hate it because they can't be wrong. [laughs] Okay? So it's like, okay... whereas the guys who do well, I mean, we had... we probably have 150 alumni in the back yard here this afternoon cutting the ribbon and they raised the money to build the shed, right, which is fantastic.*

3. Any other observations or comments about methadone maintenance? Prerequisites for success with MMT.

Although interviewees were not directly asked, some commented about what contributed to successes in MMT. A few people commented on the competent and supportive staff that work in the treatment centres, as well as support between the clients themselves.

One of the staff members pointed out that their centre operated on a social model, providing social and cultural activities for the clients to ease the recovery process. The treatment centre where this person worked is a three- to six-month facility (rather than a 30- or 60-day program), which they said allows staff members to get to know their clients better. This interviewee also spoke about how the focus should be on the addiction, and not necessarily the substance:

- *I look at addictive diseases far more than the substance. So all the tempering and manipulation of the substance is really not going to get at the core of the disease. So what we have is a person with an identified illness falling into a category,*

whether it's some variant of OCD or whatever you would like to label it as, the label doesn't so much matter as, "I have a client with an illness." And for some guys this addiction's going to show up as gambling, for others the addiction's going to show up as a substance, for others it's going to show up as sexual, for others it's going to be Internet. Whatever the manifestation is not the problem. The problem is the underlying addiction.

And if we can identify that and help the client deal with the patterns in his life, the repeated behaviours, the chronic lying, the obsessions, the greed, the lust, the stuff in his life that constantly causes immoral behaviour and help them become moral agents so they don't have the guilt, shame, regret and remorse on the way through, they won't have to revert to the addictions to ameliorate the feelings. And I think, we can get there rather than looking at what the substance issue is, because I mean, if we look at addictions as a substance problem, we'll never solve it.

Another interviewee echoed the primacy of developing relationships with clients towards effective treatment.

- *But as my 20 years of experience in doing this, usually the person has to be [inaudible 10:35] and being in the process of desire to change before any of this stuff is of any use anyway, right? So… And that's where the doctor, I believe, should be more involved in having those conversations with the client before placing them. … So, I mean, I see the medical profession and the folks involved doing what they can according to studies and so on, but I think more interaction needs to be done with the people at the more… higher professional level so there's a greater understanding of exactly what each individual is going through…*

Finally, there was some disagreement as to whether longer-term or shorter-term courses of methadone were most beneficial. One interviewee cited a study saying that the most effective treatment was a two-year withdrawal period and a lifestyle change. Other staff claimed that MMT worked best with very short taper periods.

- *Most success I've heard is when it's used as a short period detox agent coming off of heroin, five, six, seven, 10 days, use the methadone as a replacement, use it as a detoxing agent. Those individuals are happiest with methadone.*

Recommendations from SUS Professionals. Many clinicians offered recommendations for how they would improve the MMT program. This list of recommendations includes only those, which were explicitly mentioned as suggestions by interviewees.

- Provide more education on methadone and MMT. Interviewees sometimes mentioned this as a general suggestion without indicating who the audience for such education would be, and sometimes specified that the education should be for clients or for staff. One staff member said that information resources, such as a mailed-out package, rather than training would be sufficient. Another staff member talked about how client education had already reduced stigma about MMT in their treatment centre. One staff member explicitly stated that they would not recommend methadone education for fear of increasing curiosity in COH clients.
- Decrease the methadone tapering time to a maximum of five years, except in the most extreme cases
- Require clients to be willing to decrease their methadone level by the completion of treatment
- Require clients to detox first before entering treatment
- Provide more opportunities for communication between frontline staff and those who have the power to change programs
- Lower clients' dosage of methadone so they're more able to participate in treatment
- Have more beds available for detox clients
- Have closer monitoring of clients by healthcare staff to see whether the MMT is effective
- Provide more resources for women
- Improve regulation and monitoring of pharmacies providing methadone to ensure they're not abusing the system
- Separate MMT clients from COH clients

Discussion

The College of Physicians & Surgeons of British Columbia guides the provision of MMT in this province and the following observations and recommendations are in no way intended as a commentary on the invaluable service of physicians and the Methadone Maintenance Program (College of Physicians & Surgeons of B.C., 2009). Further, pharmacists and nurses are integral to the success of MMT in B.C. Instead, the following is intended to serve as *vantage points for the continuum of FH-MH &SUS to view developments towards improved outcomes* for consumers.

These interviews and qualitative analyses provide a basis to develop informed perspectives on three key dimensions of interest to FH-SUS:

1. What is the extent and nature of perspectives which suggest that MMT involved persons experience *support, respect and acceptance*?

2. What is the extent and nature of perspectives which suggest that MMT involved persons experience *stigma, oppression, barriers and other related constraints*?

3. What MMT related matters or issues require address or exploration towards changes in system communication, policies and treatment practices?

1. What is the extent and nature of perspectives which suggest that MMT involved persons experience *support, respect and acceptance*?

Based on analysis of the interviews, it is clear that nearly all MMT consumers have experienced supportive interactions. For instance, 92% of MMT consumers report positive experiences with both SUS staff and medical professionals. One hundred percent (100%) of consumers also report having positive experiences with cohorts. Given the nature of qualitative data collection and analysis, *ratios of positive to negative experiences* are difficult to determine, yet it is clear that the sample of MMT consumers held many positive experiences. The project does not shed light on the extent to which these positive experiences *counter* stigmatizing influences.

2. What is the Extent and Nature of Perspectives that Suggest that MMT Involved Persons Experience *Stigma, Oppression, Barriers and other Constraints*?

The majority of MMT clients also report having had negative experience with SUS staff, medical professionals, cohorts and public. Fifty-eight percent (58%) of MMT consumers describe unsupportive interactions with both SUS staff and independent medical professionals. The majority (67%) also report negative, stigmatizing treatment from cohorts. Some MMT consumers described specific programs as being generally negative towards MMT and those involved. Three-quarters of the sample described receiving negative stigmatizing treatment from the public. Many descriptions suggested that negative experiences with others lead to self-directed stigma ("I am dirty") and stigmatizing treatment was even cited as a personal motivation to disengage from MMT.

Numerous cohort statements were made indicating that labelling occurs in treatment (e.g. MMT clients referred to as "**Methastonians**") and there were strong opinions about MMT clients as *obstacles in treatment* ("…**they are not really humans**…'). There were numerous statements by cohorts suggesting beliefs that MMT spares individual from a *beneficial suffering, punishment or lesson* ("…people should have to go through the withdrawal…and maybe they would learn…"). SUS staff expressed potentially stigmatizing opinions about

clients as being over medicated, on MMT too long or even reducing MMT to a "…drug swap…", "…trading one addiction for another…" , or even as '…worse for them than actually…" using illicit opioids. Amongst interviewed staff, 55% reported beliefs that MMT clients triggered cohorts towards relapse.

3. What MMT Related Matters or Issues Require Address or Exploration towards Changes in System Communication, Policies and Treatment Practices?

The analysis of the interviews suggest that a range of prejudices and misunderstandings about opioid replacement therapy, methadone, persons with histories of opiate use, the nature of *addiction* and treatment contribute to stigmatizing experiences for MMT consumers. In respect to stigma reduction, activities and strategies can be tailored towards specific populations and programs:

- MMT consumers
- Treatment cohorts
- SUS Programs (staff, program literature, policies…)
- Health Professionals (physicians, nurses & pharmacists)
- Other boundary partners (corrections, law enforcement, MCFD…)
- Health care system leaders (including elected officials)
- Public

This section of the discussion identifies potential directions to be explored with these groupings.

MMT consumers. This project confirmed that clients participate in *self-stigma*. (e.g. "I need to get off methadone because it makes me dirty"). Setting aside external contributive factors (cohort comments, staff behaviour, application of "unwritten" policies), there does not appear to be much address, within the continuum of services, of supporting MMT consumers in *responding to the experiences and effects of self-stigma*, including associated self-harm and demoralization in the face of being the target of stigma.

A key consideration here is that *recovery* can be conceptualized as a process of *identity transformation* (Doukas, 2011; Hughes *et al*., 2007). That is, health affirming changes correspond with the shift from "user" to "ex-user". A person engages in the process of de-constructing the identity of "user" while developing a new (or re-newed) identity of "ex-user". MMT poses at least two layers of challenges here. One, there are beliefs about MMT which can leave consumers to defining an identity along the lines of "not quite junkie, not quite conventional" (Anstice *et al*., 2009). This survey identified many beliefs consistent with this "hybrid identity". Two, the presumption here is that this quality of perceived identity functions as a barrier to engaging not only with health affirming directions (e.g. resumption of

employment), but self-negating beliefs and a diminished motivation towards identity transformation ("who am I kidding…I'm really no better than when I was using…").

Setting aside the matter of specific counselling strategies, it is important to address a range of ideas and program practices, which could meaningfully support MMT consumers in managing stigma and maintaining their engagement with services and the pursuit of a preferred identity. The relationship between stigmatizing influences, client self-perceptions and outcome is complex and worthy of proper research. There appears to be no noteworthy research regarding "self-stigma", MMT and outcomes. It is likely that there are historical and psychological variables mediating the complex relationship between self-stigma and outcomes. For example, individuals raised in highly critical and denigrating families carry negative self-beliefs, which interact with stigmatizing experiences. Given the high prevalence of adverse childhood experiences (Dube *et al*., 2003) amongst opioid misusing populations and the negative effects upon self-concept and health (Burns *et al*., 2010), stigmatizing influences may have particularly detrimental effects.

Another concern stems from the belief, expressed by some consumers, that MMT is ineffective as it simply becomes another "addictive relationship" and that this fuels an urgency to "get off" methadone. Not to dismiss or to trivialize these experiences and concerns however, this contrasts with the evidence that MMT, for those with significant histories with heroin, can make significant contributions to wellness (Kauffman, 2003). Perhaps stigmatizing experiences (e.g. "…you're just swapping your addiction…it's just another drug…you're not clean…") gives rise to a *mythology* about MMT's efficacy and that this obscures a person's recognition of its potential contribution to improved global well being. If indeed this is a significant stigma driven perception amongst the high-risk population, and if this fuels disengagement from MMT, there may be a very real link between stigma and poor outcomes (e.g. increased mortality, morbidity, criminal activity).

With a caution about reducing the *response to client experienced stigma* to a matter of simply applying therapeutic techniques, cognitive-based strategies (CBT) and mindfulness approaches (Segal *et al*., 2004), similar to those used in the treatment of depression (CARMHA, 2007) and substance dependence disorders (Marlatt *et al*., 2004), can be highly effective in supporting persons in identifying and managing negative thoughts or *self-denigrating stories of identity* (which lead to reactive emotions and harmful behaviour). Ideas and practices associated with *narrative therapies* (Dukas, 2011; Gibson *et al*., 2004; White & Epston, 1990) and *Acceptance & Commitment Therapy* (Hayes, 2004) could also be more systematically integrated into existing programs to support persons in holding their commitment to a preferred life course and to *separate one's identity from stigmatizing labels*. Inclusion of group formats, dedicated to MMT consumers, would provide opportunities to explore, de-construct and collaboratively develop strategies towards managing MMT related stigma.

Treatment cohorts. Analysis of the interviews demonstrated that treatment cohorts participate in MMT mythology and stigma. There appears to be no research specific to how stigmatizing behaviour, on the part of treatment cohorts, gives rise to stigma effects and influences outcomes dynamics. Assuming that cohort behaviour contributes to stigmatizing ecologies, there is the question of how it might be addressed in treatment setting towards improved outcomes for MTT clients.

On one hand, there is the concern that openly addressing the matter in treatments settings (group discussion) would provide opportunities for cohorts to further entrench stigmatizing views ("…they're using and shouldn't be here…they're still dirty…") in the witness of MMT consumers. It might not be possible to effectively counter these stigmatizing statements in a treatment setting. On the other hand, open dialogue, where stigmatizing views are expressed and discussed, renders matters transparent and through the skilled facilitation of constructive discussion, the power of stigmatizing statements de-potentiated. Although there seems to be no specific empirical evidence to make a case here, one way or another, the outcomes of discussions about MMT with residential treatment populations would be highly sensitive to facilitator approach and skill and particular group dynamics. Another direction would be to provide foundational education about MMT, as a starting point, to both MMT and COH clients. This might include basic "objective" information, a summary of the supportive evidence (well established positive effects on global outcomes) and acknowledgement of risks and limitations.

SUS programs. SUS clinician comments suggest that there is considerable misunderstanding about methadone that is a product of *myth* rather than sound evidence or direct experience. For example, 55% of the staff in this survey described methadone as very difficult to withdraw from. These staff were counsellors in residential treatment centres and would likely have little actual experience in witnessing client methadone withdrawal (in contrast to, say, nurses in WMU's). Associated comments about the "pit-falls" of MMT were even referenced to "worse than heroin". Putting aside the details of *methadone withdrawal best practices* (which are primarily matters for physicians, nurses and pharmacists), this survey found that professional SUS clinicians hold stories about MMT that are not based on evidence and seem in line with MMT mythology which portrays methadone as "evil", "undermining", "dirty' or as an inferior "pseudo recovery".

It is clear that some SUS clinicians hold general views about *addiction* and *effective treatment* that are based on myth, distorted facts and stigmatizing beliefs. For example,

> …we can identify that and help the client deal with the patterns in his life, the repeated behaviours, the chronic lying, the obsessions, the greed, the lust, the stuff in his life that constantly causes immoral behaviour and help them become moral agents so they

> don't have the guilt, shame, regret and remorse on the way through, they won't have to revert to the addictions to ameliorate the feelings…

Statements, such as this, suggest that the concern transcends more than just the beliefs about MMT; it is about the very premises on which professionals base their beliefs about the *causes and treatment* of addiction. These types of expressed views, contrast greatly with the evidence supporting biological and social perspectives about the nature of addiction, opioid dependency and treatment effectiveness (Alexander, 2001; Kauffman, 2003; Mate, 2008; Peraheraskis *et al*., 2000; van den Brink & Hassen, 2006)

There is evidence that retention and outcomes are strongly influenced by perceptions of service providers and that non-stigmatizing program language and professional behaviours lead to broader and more positive client identities which are associated with improved outcomes and retention (Gurley *et al*., 2005; Sirey *et al*., 2001). From the lens of the consumer establishing a preferred new identity, experiences of social validation (witnessing) and acceptance by "non-users" are important (Kellogg, 1993). Given that stigma *contributes to experiences* of *rejection and diminished motivation* to work towards transformation and improved outcomes, clinicians ought to hold, and practice from, an informed and mindful appreciation of MMT and what involved clients are all too often up-against.

More broadly, a case can be made that *much of the positive influence* (treatment effects) associated with programs and services are *not so much a direct product of specific treatment elements* (e.g. CBT, methadone, stress management education), but instead a function of *engagement* with services (Hartzler *et al*., 2010; McLellan *et al*., 2007). In contrast to the idea that specific treatment elements lead to or 'cause" improvements, the landmark Australian Treatment Outcome Study (Darke *et al*., 2007; Teeson *et al*., 2007), demonstrated that the *length and extent* of engagement with residential services and methadone programs were predictive of improved outcomes. The *level of service engagement* was more strongly associated with positive outcomes than that of *treatment type*. Simply, the population of persons who were consistently involved with services was better off than those not or marginally engaged with services *independent of the service type*. One implication is that *engagement* should be a fundamental consideration for programs and services. The MMT survey here observed many comments and stories suggesting that stigma inhibited or interfered with engagement. For example, consumer descriptions of how cohort and professional referenced comments to the effect that MMT makes participants "dirty", lead to self-discharge from MMT. Accordingly, programs and services ought to review language and practices to identify stigmatizing influences that risk good engagement.

In light of this concern, there are least two directions to explore: **One,** Core Addiction Practice (CAP); and **two**, stigma specific Knowledge Translation & Exchange (KTE) activities. First, it is

beyond the scope of this survey to revise CAP, but there is relatively little attention to MMT in CAP. Given the role that MMT serves and the primary function of CAP (to provide a sound common foundation for SUS services), it is important to have a robust summary of the nature and role of MMT and of the body of evidence. Due the extent of societal and professional myth and stigma associated with MMT (and "heroin addiction" in general), special attention is warranted in CAP. Second, KTE mechanisms and activities could be utilized to influence change in potentially stigmatizing program elements. This could be done through a diverse range of evidence-informed knowledge exchange methods and developmental evaluation. For example, staff involved in client care at a specific site can under-go a self-assessment, or scan, of MMT practices including engagement with MMT clients. These findings can inform a variety of transformative processes that can de-construct and ultimately shift ideas and practices. For example, staff might identify potentially stigmatizing language (E.g. addict, clean, dirty) and generate mechanisms to monitor and employ preferred alternative ways of speaking.

Effective substance use service provision, including MMT, is not based on cause-effect frameworks; rather, it recognizes that multiple, non-linear events and encounters lead to change. More so, it is usually the confluence of many agencies and providers, rather than one person with one intervention that contributes to helpful outcomes for the MMT client. As a result, other health professionals (e.g. physicians, nurses & pharmacists), other sectors (e.g. corrections, law enforcement, MCFD) decision-makers and leaders (including elected officials) and the public can become 'boundary partners' in MMT service provision. Influencing the beliefs and behaviours of those outside a system's (i.e. SUS) direct influence (boundary partners) is a complex process (Earl et al., 2001). Certainly, the "target" of influence with boundary partners should not necessarily be MMT, but the larger context of examining their practices in relation to compassion, inclusion and engagement of those with substance use histories. Simple education that involves information sharing and awareness campaign activities is appealing: simple to organize; high face validity; concrete and quantifiable elements. Yet, these approaches are generally not associated with significant and durable change in beliefs and behaviour in more complex contexts, such as, working with people with substance use issues (Indiana University, 2012; Link, 2001; Livingston, 2011). Instead, progress emerges through multiple and diverse strategies that respond to all three levels of substance use related stigma: *self, social* and s*ystem* (Livingston, 2011). Large-scale, sustainable improvements in MMT clients' wellbeing requires inter-relational working partnerships that focus on influencing the boundary partners' behaviours and working contexts.

There are numerous examples of these types of positive developments between SUS, civic councils and RCMP (Sandrelli, 2012). A good case in point is that Surrey RCMP routinely contact SUS Outreach regarding "a problem person on drugs" to coordinate service in contrast to arresting and detaining. Each potential boundary partner has unique responsibilities, social identity, dominant paradigms and history that require recognition, respect and

accommodation in the context of an evolving service partnership. The results of this survey support the need to continue and to further explore, and establish, strategies and directions towards stigma reduction with key boundary partners.

Conclusion

The qualitative survey clearly suggests that MMT consumers in SUS residential services carry an extensive stock of stigmatizing experiences. Consumer reports lend support to concerns about stigma influencing MMT drop-out or pressures leading to premature reduction or self-initiated withdrawal from MMT. There is good evidence that premature disengagement from MMT increases risk and the likelihood of poor outcomes. Given that significant durable improvements in outcomes are associated with productive identity transformation, stigma can rob program effectiveness. Conversely, supportive and validating experiences can contribute to good motivation and outcomes. There is a lack of sound empirical evidence about the strength of the relationship between identity transformation, stigma and outcomes; however it is clear that stigma is a significant within the population of FH MMT consumers and there is a sound basis to suspect that this has a detrimental influence on outcomes.

The FH continuum of SUS could address current practices (e.g. policies, program language, staff attitudes) and those of boundary partners (e.g. physicians, pharmacists, police) towards the reduction of stigma associated with MMT. Further, specific SUS treatment practices could be enriched to support MMT consumers in developing skills and strategies to manage and moderate the influence of societal, cohort, professional and self-stigma.

Appendix A

CLIENT EXPERIENCE PROJECT
Summary for Participants

What is this project about?

- *Fraser Health Addictions Services* is committed to learning more about what ***makes a difference*** for the people that we serve.
- For us to learn more about what is most helpful, we are hoping to talk with people one-to-one, who have been involved in Addiction Services, and carefully listen.
- What we learn from listening will help us develop services that are as helpful as they can be.

What will happen?

- You will be contacted by a trained interviewer from the University of the Fraser Valley. They will work with you to find a time and a place where you can meet for a **first interview** (conversation).
- During this interview (lasting 30 to 60 minutes), they will ask you some questions about your experience of the support that you have received. The interviewer will carefully listen.
- Everything that you say is **completely confidential**. The conversation will be recorded so that interviewers can later write-out what you shared. By recording, we can be sure that we 'got it right'.
- The connection between *who you are* and *what you say* will only be known by the Project Team. Your identity will remain confidential. What we learn from you is protected under the *Health Act*.
- After this first interview, you will be invited to meet, at your convenience, for a **second interview** (lasting 30 – 60 minutes) where we can learn about what this process has been like for you, to make sure that we 'got it right' (accurately noted what you shared) and to learn more about any further thoughts that you have.
- You can withdraw from this project at anytime without affecting the services that you might later receive.

How will this make a difference?

- We're always learning how to improve. Although *questionnaires* can help programs collect important client feedback, detailed one-to-one conversations allow us to ***hear the richness of <u>your</u> experiences and wisdom***.
- This type of learning will help ensure that our programs ***continue to improve*** in how we serve people now and in the future.

Questions?

Feel free to ask your interviewer anything at anytime. You are also welcome to call the Fraser Health Project Lead, Mark Goheen, at anytime (604-467-3471 ext. 552602).

Appendix B

CLIENT EXPERIENCE PROJECT: METHADONE MAINTAINANCE SEMI-STRUCTURED INTERVIEW

A. Methadone Maintenance Consumers

1. In what ways have Substance Use Service programs and staff (Detox, outpatient, current residential treatment…) ***been helpful or supportive*** of your needs and involvement with methadone maintenance?

2. In what ways have Substance Use Service programs and staff (Detox, outpatient, current residential treatment…) ***been NOT helpful or supportive*** of your needs and involvement with methadone maintenance?

3. In what ways have other medical professionals (Dr.'s, nurses, lab staff, pharmacists…) ***been helpful or supportive*** of your needs and involvement with methadone maintenance?

4. In what ways have other medical professionals (Dr.'s, nurses, lab staff, pharmacists…) ***been NOT helpful or supportive*** of your needs and involvement with methadone maintenance?

5. In what ways have other clients ***been respectful*** of your involvement with methadone maintenance?

6. In what ways have other clients ***been NOT respectful*** of your involvement with methadone maintenance?

7. Any other comments or feedback that you'd like to share about your experiences as a person involved with methadone maintenance?

B. Treatment Cohorts

1. Some people involved in the methadone maintenance program also receive residential treatment. In your experience, what has this been like for you (any interactions with methadone maintenance cohorts in treatment)?

2. What have you noticed about how other clients have responded to persons involved with methadone maintenance?

3. Any other observations or comments about methadone maintenance?

C. Treatment Professionals

1. In your experience, what positive contributions has methadone maintenance made to the treatment environment.

2. In your experience, what challenges have emerged from persons receiving methadone maintenance in the treatment environment.

3. Any other observations or comments about methadone maintenance?

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This report has been made possible through a financial contribution from Health Canada through their Drug Treatment Funding Project (DTFP) and administered by Fraser Health's Mental Health & Substance Use Services. The views expressed herein do not necessarily represent the views of Health Canada