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# Methadone Maintenance Treatment and its Psychosocial Effects on Individuals

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Methadone Maintenance Treatment and its Psychosocial Effects on  
Individuals

by  
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Proposal for a Clinical Research Paper

Presented to the Faculty of the

School of Social Work

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St. Paul, Minnesota

in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### **Abstract**

Methadone Maintenance Treatment (MMT) was introduced into the United States in the 1960s to counter the surge of heroin addiction. Since then, MMT's effectiveness in combating heroin addiction and weaning people off methadone itself continues to be questioned. This study examined the psychosocial impact of methadone as a harm reduction approach on individuals that have embraced the program. In this study, the structure and operations of methadone clinics, the differences between methadone and other pharmacological treatments for opioid dependence, as well as the stigma associated with the program were examined. Qualitative semi-structured interviews with Licensed Alcohol and Drug Counselors, an addiction medicine physician, and social workers with extensive experience in the area of MMT were conducted for data analysis and interpretation of facts. Findings from this research reveal that despite the stigma and controversies surrounding methadone maintenance treatment, it is still considered the most effective treatment for opioid addiction. Therefore, these findings will provide useful information about methadone to the general public; and equip clinical social workers the basic knowledge needed in working with clients on the MMT program.

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## Contents

Abstract .....	ii
Acknowledgement .....	iii
Introduction .....	1
Purpose Statement.....	2
Literature Review .....	5
The Beginning .....	5
Methadone Maintenance Treatment (MMT): A Holistic Approach to Addiction Treatment ...	6
Stigmatization of MMT.....	11
The Psychosocial Effects of Methadone .....	13
Conceptual Framework.....	15
What is Methadone? .....	15
Addiction: A Chronic Problem.....	17
Harm Reduction Approach .....	19
Methods.....	22
Research Design.....	22
Sample .....	22
Protection of Human Subjects .....	23
Data Collection Instrument and Process .....	24
Data Analysis Plan .....	25
Strengths and Limitations of the Design .....	26
Results and Findings .....	27
Stigma .....	27
Is addiction a disease?.....	28
Co-Occurring Disorder.....	31
Methadone Maintenance Treatment .....	32
Holistic Approach .....	33
Ethical Consideration.....	34
Discussion .....	36
Implications for social work practice .....	38
Implications for policy .....	40
Implications for research, strengths and limitations.....	42
References .....	45

Appendices .....	49
Appendix A Unsigned Consent Form.....	49
Appendix B Interview Questions .....	51
Appendix C Demographic Questionnaire.....	54

## **CHAPTER**

### **Introduction**

Addiction has been defined as the loss of ability to control or stop the use, obsession with use, and continued use of illicit drugs and alcohol, despite the negative consequences and adverse effects (Inaba & Cohen, 2007). Addiction does not include only illicit drugs; it can also mean addiction to food, internet, and other compulsive behaviors. As a result of this, treatment has been adapted for various forms of addiction. The treatment for alcoholism is different from treatment for sex addiction, and modality for treating heroin addiction is clearly different from treatment models for other addictions. In treating heroin addiction, Methadone Maintenance Treatment (MMT) a harm reduction model, has been found to be the most effective.

Methadone is a long acting synthetic opiate used orally to treat pain and heroin addiction (Inaba & Cohen, 2007). Historically, methadone was discovered in Germany during World War II in 1938 to replace morphine. The first methadone clinic in the world was opened in Vancouver, Canada by Dr. Robert Holiday in the 1960s (Mark, 2004). In the United States, it started as a harm reduction model aimed to curb the epidemic of heroin addiction in New York City in the 1960's (Joseph, Stancliff, & Langrod, 2000). The successes of these pioneer efforts have spread to all the regions of the United States. MMT has helped people to stay out of jail, reconnect with families, keep their jobs, live in safe housing, and eliminate the risk of being infected with diseases (Mark, 2004). On the other hand, its use has also come under serious scrutiny as a result of diversion, illegal dealing, and unethical practices in methadone treatment clinics. This has led to the stigmatization of MMT as a treatment model. This research was used to investigate the

psychosocial functioning of individuals who chose to be in the program, despite the unpopular views associated with programs such as MMT.

### **Purpose Statement**

Opioid dependence has been described as a chronic disease and relapsing condition (Veilleux, Anderson, York & Heinz, 2010). As a result of this, different treatment models have been developed in treating individuals addicted to opioids. The most embraced model in treating opioids addiction is the pharmacological model of treatment. This model of treatment has been described as a harm reduction approach aimed at reducing craving for opioids, reducing withdrawal symptoms, and blocking the euphoric effects of opioids (Veilleux et al., 2010). Four different medications have been found to be successful in the pharmacological treatment of opioid addiction. These are methadone, buprenorphine, levacetylmethadol (LAAM), and heroin (diacetylmorphine) (Veilleux et al., 2010).

Of all these medications, methadone has been described as the most effective treatment for opioid addiction (Veillux et al., 2010). Essentially, methadone has a superior retention rate, it does not create euphoria, but instead kills the euphoric effects of opioids. Above all, it is legally and structurally regulated (Inaba & Cohen, 2007). Methadone clinics are structured in a way to ensure safe and effective dosages, strict regulations to stop diversion, and on site counselling to enhance the psychosocial functioning of patients. This separates methadone as a harm reduction approach from other models of treatment.

The success in using methadone as a harm reduction medication for treating addiction to opiates has largely been attributed to the improvement in the livelihood of

individuals who are on the program. It has been established that methadone maintenance blended with psychosocial interventions improve quality of life, good health and an avoidance of risk behavior related to HIV (Veillux et al., 2010). However, the extent to which well-regulated supervised methadone consumption may influence patient's life experiences is not well understood by society at large, and this has resulted in the stigmatization of methadone as pharmacological treatment for opioid addiction (Antice, Strike, & Brands, 2009).

Around the world methadone has been widely accepted as a standard medical treatment for opiate dependence. In Germany, where it was originally founded, methadone was patented in 1948 after the Second World War and has since then been used as pain killers (Mark, 2004). In Canada the history of methadone is the history of medicine (Mark, 2004). Historically, the first methadone treatment opened in Canada in the 1960s by Dr Robert Holiday (Mark, 2004).

In the United States, it was confirmed by two respected doctors; Marie Nyswander and Vincent Dole who pioneered the program. These doctors found that methadone has worked well as a treatment for opioids dependence (Mark, 2004). In the Netherlands, individuals who are addicted to methadone can participate in the methadone program voluntarily; methadone is offered free of charge, clients are not forced into detoxification, counseling, urine testing or any other characteristics of methadone clinics as we know it in the United States (Meulenbeek, 2000). But it is still very effective in treating opioid dependence.

In all these countries, great successes have been recorded in terms of the enhancement of psychosocial well-being of people who are on the program. Patricia Mark (2004) wrote that some individuals who have embraced the program never have to prostitute, stay out of legal troubles that can lead to jail terms, reconnect individuals with their families, live in a safe housing, and reduce the risk of exposure to infectious diseases from IV administration of illicit drugs. In the United States, methadone was originally introduced to quench the surge of heroin use in New York; since then, it has been found to be safe and effective and has redirected patients to start all over by seeking employment, getting off welfare, going back to school, and leading a positive lifestyle (Joseph, Stancliff, & Langrod,2000).

Despite all the scientific proof of the improvement of psychosocial well-being of people on methadone, the stigma and the negative perception of this model of treatment for opioid addiction have hindered the expansion and effective delivery of services to the community where it is needed, and the accessibility of the program to individuals who are willing to get on the program (Joseph et al., 2000). It has to be observed that the bias at the inception of methadone as a treatment for opioid addiction and in the present time is not different. In fact, there is deficient knowledge about methadone, as an effective medication for treating opioids addiction among therapists, mental health practitioners, nurses and social workers.

Therefore, this piece of work examined methadone as a drug itself, operations of the methadone clinics, and the overall impact of MMT in the enhancement of psychosocial well-being of individuals that have embraced this model of treatment for opioid addiction.

## CHAPTER 2

### Literature Review

#### *The Beginning*

Methadone was first created by the Germans to substitute for morphine; it was used as a pain killer by the German soldiers during the Second World War ("Methadone fast facts," 2006). It was not introduced into the United States until 1947 as an analgesic called Dolophinel. However, methadone as a substitute therapy for opioids did not start in the United States until 1964, after the Rockefeller University began its research. The methadone maintenance research project at Rockefeller University in 1964 started with six male heroin addicts to experiment effectiveness of methadone in treating heroin addiction (Joseph et al., 2000). By 1968, it was estimated that there were over 44,000 patients in New York State and over 179,000 patients nationwide at the time (Joseph et al., 2000). Today, there are thousands of people who are enrolled in methadone programs nationwide and around the world.

From this early history, MMT as a harm reduction model continues to grow with the establishments of methadone clinics across the country. It has been found to help heroin addicts to avoid bruises from needle use, to reduce their cravings, and to block withdrawal symptoms (Inaba & Cohen, 2007). Basically, MMT is a medical response towards the reduction of heroin use, elimination of the criminal activities that come with its use, improvement of people's health, and enhancement of their social productivity (Joseph et al., 2000).

At its inception, the principal goal of the treatment program was to relieve narcotic cravings, encourage abstinence, and block the euphoric effects associated with heroin use (Joseph et al., 2000). As a harm reduction strategy, its primary goal is to

benefit society and those that are enrolled in the program (Inaba & Cohen, 2007).

However, the stigma attached to the program has been a barrier in the expansion of the program and a hindrance in the accessibility of treatment to many who are still using heroin.

***Methadone Maintenance Treatment (MMT): A Holistic Approach to Addiction Treatment***

MMT is different from other addiction treatment practices in its approach and settings. It is a combination of medication, counseling, and medical monitoring. Every MMT center is organized like a medical clinic in which a physician prescribes the adequate doses, the nurses administer the doses, and the counselors are expected to find the root causes of the patient's addiction to illicit drugs (Freeberg, 2013). This team of professionals' work together and help the patients achieve their goal of stability and maintenance. Usually, a treatment plan contains goals and objectives under six dimensions of intoxication and withdrawal, physical and mental health, treatment acceptance, relapse potential, and home environment that are developed collaboratively, and with coping mechanisms adaptable to individual clients are used in processing with individuals during counseling sessions (Freedberg, 2013).

The treatment phases in MMT start with initial screening to admission procedures, comprehensive assessment, induction, maintenance, and consequently Medication Supervised Withdrawal (MSW) phases. Patients are guided through these processes until they become properly integrated into a drug free life style. The initial screening determines an individual's eligibility for the MMT program (Center for Substance Abuse and Treatment [CSAT], 2005). The admission process involves welcoming the patient into the facility, and introducing them to the MMT program

(CSAT, 2005). Just like a medical facility or a clinic, patients are meant to go through the paper work procedure where forms like the consent to treatment, methadone warning, state registry, emergency contact form, and patient's rights and responsibilities are duly signed and dated. These are an important part of treatment procedures that establish a treatment contract between the treatment facility and the patient.

Assessment is an important process in a MMT program. It involves cultural, psychosocial, and chemical health assessments (CSAT, 2005). These comprehensive assessments also cover patients' cultural values, linguistic preferences, religious practices, and sexual orientation (CSAT, 2005). It has to be noted that this comprehensive assessment of eligibility does not involve only chemical health or physical assessments. The assessment also involves the relevant dynamics of patients' family, work, education and the relationship between their addiction and their social functioning (CSAT, 2005). In fact, comprehensive assessment will determine if MMT as a model of treatment is adaptable to an individual client situation.

After the assessments and filling of forms is the induction phase, in which a patient is prescribed an initial dose of methadone. According to CSAT (2005) the induction phase of treatment is the riskiest stage, and it requires proper medical monitoring and continuous assessment. Therefore, patients are expected to visit the clinic on a daily basis for proper assessments by the nurses, the counselor and the physician. This will enable the care team to decide whether to increase their doses or not. In some methadone clinics, these procedures continue for the first ten weeks of their admission till they are moved to the next phase which is the maintenance phase.

It is important to reiterate here that patients are prescribed an initial dose of 30mg of methadone with close monitoring during the induction phase (Joseph et al., 2000). However, there is no single recommended dosage or even fixed range of dosages for all patients but the accurate dosage that will help the patient to stabilize depends upon individual patient system (CSAT, 2005). Therefore, correct and adequate dosage will contribute to a patient's stabilization; a patient is said to be stabilized when he or she no longer exhibits drug-seeking behavior or craving (CSAT, 2005).

Nevertheless, the reactions to the abstinence and withdrawal symptoms will eventually determine the adequate maintenance dose which is different from individual to individual. At this point, patients are graduated from induction phase to maintenance phase of the MMT. A patient is considered to be on a maintenance stage after it has been established that their dose is holding and withdrawal symptoms are wading off. At this stage, a patient is considered to be making progress in their treatment.

The CSAT (2005) wrote that the maintenance stage of opioid pharmacotherapy is a stage when patients are responding and adjusting to the treatment procedure of MMT. It is a stage characterized with patient's abstinence from illicit substances as evidenced by negative urinary analysis, dissociation of patients from individuals who are still using drugs, places where use can occur, and environments that can trigger relapse (CSAT, 2005). It is recommended that counselling with focus on relapse prevention on this stage should be intense.

However, most patients stay for a longer time on maintenance phase before deciding to whether to wean off methadone or still stay on the program to avoid relapse. While on this maintenance phase doses are increased between 5-10mg until an

individual patient attains a comfortable level of functioning between 80-120mg of methadone (Joseph et al., 2000).

An important incentive of the maintenance phase is the privilege offered to patients to take methadone home. This will depend on the following factors; the absence of recent drug use, absence of behavioral issue at the clinic, stability of home environment, possibility that medication will be stored safely, regularity of attendance at the clinic, absence of known criminal activity whether drug related or not, length of time in treatment, regularity of clinic attendance, and less risk of possibility of diversion of methadone (CSAT, 2005). These rules are known as the eight point criteria and it is set by the Federal Government. The performance and levels of psychosocial functioning of patient will lead individual patient to the final and crucial phase of the MMT; which is known as the Medically Supervised Withdrawal (MSW).

MSW can be entered into voluntarily by the patient or by the physician's recommendation. Wherever the decision is coming from in this phase, patients begin to reduce their doses with the appropriate guidance of the treatment team until they are completely weaned off methadone. This is considered a very sensitive stage in which a lot of support is needed. Patients and their significant others are educated on the side effects associated with this phase. Generally, patients are highly vulnerable to relapse under this phase if patients cannot cope with the withdrawal symptoms (CSAT, 2005). If a patient decides to get on MSW, reduce, or taper themselves from methadone voluntarily, it is important to seek the rationale for this decision (CSAT, 2005). It should be explained to a patient that their decision to withdraw from the program should not be as a result of stigmatization of methadone by individuals who know little or nothing

about the program, external pressure from family and friends and the rush to get off the program (CSAT, 2005).

Essentially, the entire treatment team should help the individual patient to navigate through this difficult stage of MMT. Patients on MMT are placed on special relapse prevention assignments and counselling sessions through this stage of the MSW. As previously demonstrated, it is obvious that the MMT is structured to treat addiction at various levels of care so as to ensure that patients are functioning and living the kind of life they hope to live. It has to be observed that MMT is designed to benefit everyone, including pregnant women and the unborn baby, people with co-occurring disorders, and patients with special needs. Joseph et al (2000) reports that MMT is the only authorized program for treating narcotic addiction during pregnancy. This is because it reduces the use of heroin and other illicit drugs during pregnancy (Joseph et al., 2000). It has been established that many patients with opioid dependence have co-occurring mental health disorders, so the appropriate treatment for them is MMT because of the integrated, harmonized, and holistic services they will receive at the clinic in addition to dosing daily (CSAT, 2005).

In the past, substance abuse and mental health treatments are often separated; but in recent times, addiction counselors are trained to recognize the presenting symptoms of co-occurring disorders during intake procedures (CSAT, 2005). Now that these services are combined, people with co-occurring disorder can be treated in MMT clinics. With this approach, MMT looks at the whole person and not the addiction and emphasizes how to better help individuals in order to reintegrate them into the society as a social functioning being.

*Stigmatization of MMT*

In the preceding pages, the different stages of methadone and all-encompassing treatment and availability of MMT for all from holistic perspectives were thoroughly explained and occasionally its benefits were briefly examined; but despite the efforts of those that have dedicated their services as well as their resources, in helping patients to regain their social functioning and achieve their goals in life, MMT carries many stigmas.

One of the most common stigmas against the program is that it is a substitute therapy. That is, a mean of replacing one addiction with another (CSAT, 2005). The contention of the opposition of methadone is that this model of treatment is replacing one addiction with another without exploring and addressing the social and psychological reasons for the addiction and how to improve patient's lifestyle (Kuhn, Swartzwelder & Wilson, 2008). In fact, occurrences like death, crime events near a methadone clinic, as a result of overdose on methadone and illegal diversions of methadone that are associated with individuals who are on MMT have created a bias towards the program.

Freedberg (2012) reports that liquid methadone is leaking into illegal street sales via take home doses; this illegal diversion he added, and the unfortunate incidents that comes with it has created a negative image for MMT resulting into crude stigmatization of the program. Generally, the society is not looking at the positive psychosocial impact of MMT. It is often surprising that some practitioners are often judgmental towards some of their clients who are on methadone. This is due to lack of knowledge and unwillingness to ask questions but rather get consumed in the negative and biased reports from the media. This is the goal that this research intends to achieve. Again, from social justice angle, it is important to understand that those on methadone are the citizens of this

society. They are neighbors, co-workers and our family members, so their dignity should be preserved.

It has also been described as a way of replacing one addiction with another for those that cannot get sober (CSAT, 2005). This stigma affects both the patients and the clinics. For a potential patient, the stigmatization of the program discourages some individuals from registering in the program, and if they do register, they tend to walk away without the completion of the program and consequently they relapse (CSAT, 2005). Individuals who are already enrolled do so in secrecy because of their fear of being suspended or fired and obtaining new employment may be difficult if their status is revealed to current or potential employers (Joseph et al., 2000).

However, the opponents of methadone as a treatment option for opiate dependence failed to recognize the fact that even with psychotherapy and social assistance, clients in abstinence-directed program do relapse, which creates a vital position for the methadone as an harm reduction approach that should be embraced (Dole, 2008).

It has been established that the subjective attitude towards the MMT by some communities has stopped the opening of new clinics where they are needed (CSAT, 2005). Also, the negative media against MMT has overshadowed the success stories of many that are benefiting from the program.

To combat stigma, some terminologies in the MMT should be replaced with more clinical terms. For instance; “dirty and clean” should be replaced with “positive and negative” urinalysis and other drug tests (CSAT, 2005). Staff should be trained to develop the public relations skills to work effectively with the community and the media

(CSAT, 2005). Above all, everything possible should be done to avoid the diversion of methadone into the wrong hands.

### *The Psychosocial Effects of Methadone*

The stigmatization of the MMT has overshadowed positive effects on individuals who are benefiting from the program. There is no doubt that there have been ups and downs since the program was first introduced in New York in 1964. Regardless of these mixed opinions on methadone, the program's benefits to the society are greater than the overblown negative effects. One of the greatest assets of the program is the unrestricted access to recovery services. As Freedberg (2013) wrote, the backbone of MMT is the coordination of services under one roof. In MMT, new patients are required to meet with their counselor on a weekly basis for the first ten weeks. After this period of time they continue to meet counselor on a monthly basis for an ongoing assessment and a review of their social, medical, and mental functioning. Patients enjoy a constant review of their well-being from a holistic approach.

Regardless of the negative image about the program, MMT has helped opiate-dependent individuals to be responsible to their family, keep their jobs, be law abiding, and able to function effectively as responsible citizens in the society (Maeyer, Vanderplasschen, Camfield, Vanheule, Sable, & Brokaert, 2011). Maeyer et al (2011) added that, MMT sets individuals free from the financial and social burdens that are associated with heroin, such as the stress, and the risk involved in getting and using heroin and other opioids. It has been widely accepted that opiate addiction is a disorder, and if all regulations are followed, methadone maintenance is the most effective treatment for opiate addiction (CSAT, 2005).

However, it is important to state here that despite the proven effectiveness of methadone in treating opioid addiction, it can also lead to medical and physiological complications like impaired memory, pulmonary edema, insomnia, nausea, sweating, constipation, and sexual dysfunction. Curran, Klechham, Bearn, Strang, & Wanigarantne, (2001) wrote that “ a single dose of methadone can induce episodic memory in patient who have history of heroin use”(pg. 154). In addition to this, methadone is in itself an addictive drug and requires the supervision of a physician to guide against addiction and excessive seeking of the drug (“Methadone,” n. d.)

Generally, MMT relieves narcotic craving, block the effects of administered heroin, develop tolerance to euphoria, and help individuals to cope and function effectively in the society (Joseph et al., 2000). Clients, who utilized methadone treatment properly, will begin not only to address physical and mental health but also develop a sense of clarity, regain self-esteem, increase their employability, possibly regain peace of mind, and enhanced way of positive lifestyle (Baldino, 2000). However, previous research has examined the stigma associated with the MMT, but few studies found discussing the positive impacts the MMT has on individuals and the society at large. This study investigated MMT as an effective model for treating opioid addiction by posing this question: What are the psychosocial effects of MMT on individuals?

## CHAPTER III

### Conceptual Framework

#### *What is Methadone?*

Methadone has generally been described as a synthetic opioid. Dole & Nyswander (1965) described methadone as a full opioid agonist (as cited in Veillux et al., 2010, p. 159). It is a synthetic opioid that is orally active and has a long duration of action (Antice et al., 2009). In another description, Joseph et al. (2000) defined methadone as a long acting agonist with a half –life of about 24 to 36 hours. The most active ingredient in methadone is called methadone hydrochloride. (Drug Policy Alliance [DPA], 2006). Methadone is a long-acting opioid medication that is used as a pain reliever and, together with counseling and other psychosocial services, it is used to treat individuals addicted to heroin and certain prescription drugs (CSAT ,2005).

Methadone has been found to be effective in treating opioid addiction if used effectively and as prescribed by the Physician. Methadone does not create euphoria, sedation or sickness from withdrawal (DPA, 2006). Inaba & Cohen (2007) wrote that methadone was specifically created and synthetically designed to substitute a legal opiate for an illegal one. Methadone comes in different forms; tablets, powder, or liquid which has to be taken orally and on a daily dose to be effective (DPA, 2006). Dole, Nyswander, & Creek (1966) wrote that methadone does not create sedation and distortion in affect, but instead creates stability in individual lives.

The advantage of methadone over heroin is that it is taken orally and not through the IV and the dose is prescribed and managed by a qualified physician in the field of chemical dependency (Kuhn, Swartzwelder, & Wilson, 2008). Whatever form it comes in or whatever method of administration, what is important is that methadone maintenance

as an harm reduction approach works and improves the livelihood of individuals who will ordinarily overdose or live a meaningless life as a result of addiction to heroin or other opiates (Kuhn et al., 2008).

However, certain characteristics set methadone apart from all other medications used in treating addiction to opioids. Catania (2006), wrote that methadone lasts longer and makes the individual stable when the dose is right, and patients on methadone do not feel any significant sense of being high or dope sick. As written earlier, it is important to note here that there are other medications used in treating opioid dependence. These include; Buprenorphine, Levacetylmethadol, and Heroin (diacetylmorphine). While these have also been found to be effective treatments, methadone seems to be outstanding in terms of treatment retention, crushing the effects of heroin, cocaine, and flexible dosing (Veillux, et al., 2010). As a result of these significant factors that separates methadone from all other substitute treatment for opioid treatment, MMT is considered the standard medical treatment for opiate dependence treatment in most countries of the world (Meyer et al., 2011).

It is important to reiterate that methadone is also addicting and must be monitored closely to avoid overdose and illegal diversion (Inaba & Cohen, 2007). It has to be stated that despite the stigma and controversy methadone has kept many from their harmful way of life through maintenance and accurate doses; ultimately methadone is more effective than focusing on abstinence or total recovery, which is often difficult to achieve (Inaba & Cohen, 2007).

**Addiction: A Chronic Problem**

Addiction as defined by Inaba & Cohen (2007) is a progressive disease process that is characterized by loss of control over use, obsession with use, continued use despite adverse consequences, denial there are problems, and a powerful tendency to relapse. In another perspective, McGovern (2010) wrote that addiction has been categorized as a disease that comes with biological, psychological and social roots. McGovern's (2010) definition of addiction as a disease is in consonance with medical model. The medical model describes addiction as a chronic, progressive, relapsing, and incurable disease that is as a result of addiction to a specific substance (Inaba & Cohen, 2007).

CSAT (2005) described addiction as a physical dependence on and the subjective need or craving for illicit substances to experience its positive effects or to avoid the severe symptoms of withdrawal from the substance. However, Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association [APA], 2000) looked at addiction from a different perspective. In the DSM, the word addiction was avoided; instead the substance abuse and dependence were used to explain the concept of addiction in a more detailed analysis (Kranzler & Li, 2008). These two criteria, dependence and substance abuse, are used more or less to diagnose substance use disorders to all of substances that are commonly used in usually a large quantity by individuals (Kranzler & Li, 2008). It is important to note here that dependence or addiction can only be diagnosed after a careful consideration of use of such a substance and the effects this has on individuals' jobs, families, troubles with the law, and of course the continue use despite these consequences (APA, 2000).

The failure to control the use of one or more drugs, continuation of use despite significant harmful consequences, and recurrent failure to control or cut down the use; these are the key factors that distinguished addiction from recreational use (Goodman,2008). However, scientists have linked addiction problems to the human system. Research has shown that engaging in drug use, eating, or engaging in sexual behavior are all associated with intrapsychic levels of dopamine (Goodman, 2008). Dopamine is a neurotransmitter that can be found in the brain which plays a major role in addiction and substance dependence (Inaba & Cohen, 2007). Dopamine is present in every brain; therefore addiction is so powerful that it mobilizes all brain functions and any human being could become a drug addict (Kuhn et al., 2008).

However, there are many reasons people turn to addiction or drug use. Bowden (1971) wrote that boredom, curiosity, diminished self-esteem, problems with interpersonal relationships, family disruption, ignorance of opioid effects, and the pleasure of a fantasized world are some of the causes of addiction (as cited Platt,1986 p.188). Therefore, people use drugs for different reasons. To some individuals the reasons for their use of drugs remain unknown. Falling into drug use is particularly easy for some youth, who want to fit in, some out of curiosity and some as written earlier to kill boredom and idleness. Individuals tend to give the same reasons for their addiction. Most addicts use drugs to escape or avoid an unpleasant existence, to cope with mood adjustments, and to have a sense of belonging (Platt, 1986). Again, addiction is chronic; it can make individuals leave their jobs, families, and basic life sustaining principles (Kuhn et al., 2008).

Addiction to opioids, which is the focus of this research, has been viewed as a disease that results when the excessive use of opioids has made significant changes to the brain. In fact, the craving to use is often overwhelming and the addicted individual often loses control of the use of opioid and life functions even when it causes harm (CSAT, 2005). While the addiction to opioids has been seen as a chronic disease which cannot be cured but can be managed, it has been argued that the medication assisted treatment is the best form of treatment for opioid addiction (CSAT, 2005). Whatever definition that can be given to addiction, it is important to state that treatment for addiction should be culturally compatible, medically relevant, and modality should be compatible to the clinical care of people suffering from these conditions (Kranzler & Li, 2008). This is the composition of methadone maintenance treatment, which is an adaptable form of treatment for opioid addiction.

### ***Harm Reduction Approach***

There are various treatment models for addiction to opioids, alcohol, and other compulsive behavior. Most treatment models preach abstinence while it has been proven that abstinence can hardly be achieved especially when it relates to addiction to opioids. According to Inaba and Cohen (2007), “harm reduction is a tertiary prevention and treatment technique that tries to minimize the medical and social problems associated with drug use rather than making abstinence the primary goal” (Inaba & Cohen, 2007, p. 563).

It is essentially a prevention method by the authority, government, departments, agencies and non-governmental organization to stop the progression of drug use, restore peoples’ health, and help them find alternate ways of thinking and living sober and stable

life again (Inaba & Cohen, 2007). Riley et al (1999) wrote that harm reduction is a treatment model and a deliberate or a pragmatic attempt at minimizing the negative social, economic, and health related consequences of drug use without necessarily insisting on abstinence (as cited in Jarven, 2008,p. 975). Jarven (2008) wrote that it is an ideal and pragmatic way of dealing with drug problems than traditional abstinence oriented drug addiction treatment.

There are many ways in which the harm reduction approach has been carried out. This is different from country to country and community to community and it often depends on the intensity of the drug epidemic. It is worthy to note that the harm reduction approach has been endorsed the world over even in a more conservative society to fight the epidemic of drug use. A good example is Iran where methadone is fully backed by the government; and addicts are treated as patients and not criminals, and methadone is made available to inmates who need it in jail (Miller, 2006). Mostly, it involves, providing drug education, instituting needles exchanges, decriminalizing the use of drugs, providing resources to lessen the consequences of abuse and of course using drug substitution programs like the methadone maintenance treatment (Inaba & Cohen, 2007).

However, there have been controversies and criticisms against the harm reduction approach. Most criticized of all these methods of harm reduction is the MMT. The proponents of abstinence model of opioid treatment oppose the program because they believe drug abuse should not be treated with another addicting drug (Inaba & Cohen, 2007). The supporters of “abstinence or nothing” hold the firm belief that methadone is a substitute for heroin and not an end in itself (McGovern, 2010). Some even believe that

it is a form of helping individuals who are not ready for change, to be taking methadone which they may be on for very long time to come.

On the other hand, the proponents of harm reduction stated that harm reduction approach has been used in treating heroin addiction in form of MMT and has been reducing crime related to drug use, reducing heroin use, reducing transmission of blood-borne viruses, and improving mental and physical health of individuals who were addicted to heroin. Nevertheless, harm reduction inform of opioid agonist treatment or methadone maintenance treatment is the strongest evidenced based intervention in the treatment of opioid dependence (McGovern, 2010).

## CHAPTER IV

### Methods

#### *Research Design*

This study traced the history of methadone, operations of methadone clinics, the stigma associated with MMT and more importantly, the psychosocial impact of methadone on individuals. Therefore, a qualitative research method was used and data were gathered through interviews that were conducted using the semi-structured questions. Data for this research were gathered through words, descriptions, and narratives from interviews that were conducted with addiction counselors, registered nurse, and social workers with experience in the field of addiction counseling, co-occurring disorders and most especially in the MMT. A medical physician with experience in MMT was also interviewed so as to examine the impact of his expertise on patients and his practices.

#### *Sample*

In order to achieve the goal of this research, six addiction practitioners including: addiction medicine physician, licensed alcohol and drug counselors, mental health practitioners, and licensed clinical social workers that specialize in addiction counseling were carefully selected for interview through the use of Snowball Sampling Technique. Interview questions were structured with the intention of exploring themes that support or argue against methadone as an alternative therapy for addiction treatment. Rather than general questions in Addiction Counseling, the questions were more specific about MMT programs.

It has to be stated that not all professionals in the field of addiction counseling endorse MMT, therefore efforts were made to balance diverse views by selecting individuals with different opinions about methadone. Again, the experiences of these individuals selected for the interview ranged from ten years of practicing in the field of addiction counseling or mental health practices. Also, these individuals were made to fill out a demographic questionnaire in which their age range, educational background, and number of years of their experiences were administered. In all, six professionals from diverse backgrounds were interviewed for this research.

### ***Protection of Human Subjects***

To conform to the St. Catherine University Institutional Review Board (SCUIRB), the consent form was reviewed in detail and signed by the interviewee before the interviews were conducted. The consent form contains information about the research topic and the research question (See Appendix B for the letter of consent). This was also approved by the committee chair, Rajean Paul Moone before the interview. This ensured compliance with the SCUIRB rules governing research and protection of human subjects' guidelines. The respondents' names were omitted from all documents related to this research. Also, the interviews were recorded and this can threaten confidentiality and anonymity. Therefore, special codes known only by the researcher were used to protect the identity of interviewees on all recordings and materials relating to this research. Also, during data analysis the recordings were kept on a secure, password protected computer. More importantly, the recorded conversations were discarded after the completion of the presentation. It is important to state that all necessary steps to meet the SCU's IRB standards were taken.

***Data Collection Instrument and Process***

For data collection, interviews were conducted using semi-structured questions that lasted for approximately sixty minutes and were recorded. The interview questions were examined and corrected by the committee chair before the actual interview. The questions are available in Appendix C.

Rather than general questions in addiction counseling, the questions were more specific about MMT programs. The respondents' experiences in the field of addiction counseling were part of the questions and their position on harm reduction approach was challenged. The stigma faced by those in the MMT program was also be examined. An important question about the steps to curb stigmatization of MMT was also part of the interview questions. More importantly, the barriers faced by the program as a whole and individuals who are trying to stay sober through the MMT were part of the questions. Also, participants were asked to fill out a demographic questionnaire before the interview (See Appendix D). Above all, the psychosocial impacts of MMT on their clients were examined. The interviews were transcribed for the purpose of coding, data collection, data management and data analysis.

It is important to note here that the focus of this research is addiction to opiates and MMT as a proven effective method in the treatment of addiction to opiates. Hence, professionals interviewed were individuals who are knowledgeable in the field of addiction counseling, especially methadone maintenance clinics. They were contacted via electronic mail and phone, appointments were scheduled, and interviews were carried out at an agreed site.

***Data Analysis Plan***

As written by Padgett (2008), no specific method or approach is the best or required for data analysis in qualitative research. Therefore, data for this research were gathered during the interviews with addiction counselors, addiction physician, registered nurse, and social workers using grounded theory. This theory is an inductive technique which takes the transcript data and codes it, first closely reflecting on the actual words and then creating more abstract themes from the codes; the themes developed are abstract enough to form and construct theory (Monnette et al., 2011). It is a research methodology for developing theory by allowing this theory to emerge from the data or be grounded in the data (Monnette et. al, 2011).

To create code and themes, interviews were transcribed and read thoroughly. It is important to emphasize that the transcription were personally handled to establish intimacy with the data (Padgett, 1998). This intimacy and personal evaluation of interview techniques were helpful to develop code and themes. Again, manual analysis carried out in the course of this research, created an in-depth insight into details of the interview, so similarities and differences in the opinions of the interviewees were identified (Maeyer et al., 2011).

To analyze the data from interview; coding was used. Coding is the process of identifying bits and pieces of information in the interview; correlating them to concepts, themes, and headings around which the findings, discussions and final reports were organized (Padgett,1998).Therefore, details of the interview as it regards to responses to the semi-structured questions were carefully analyzed line by line. Efforts were made to identify key concepts, themes, and related words in the recorded audio tapes.

***Strengths and Limitations of the Design***

Contrary to the popular views of opponents of qualitative research method, the method is neither haphazard nor a conception of the researcher's whims, but it is purely creativity (Padgett, 1998). Qualitative studies offer comparable analysis on their analytic procedures and they are usually a good read (Padgett, 1998). In fact, the qualitative method was chosen for this study because through structured interview, it was easy to understand addiction counseling practitioners positions on the sensitive issues surrounding methadone, the policies of their agencies as it affects methadone and harm reduction, and framework within which they operate as it affects their clientele who are on methadone (Monette et al., 2011).

However, it is important to note that responses to interview questions are sometimes based on individual perception and views which could be sometimes subjective and can threaten reliability and validity of data. This is one of the limitations of qualitative design. As Monette et al.(2011) wrote one of the limitations of the qualitative method of data gathering is that personal attitudes of interviewees, their values, and objections or support for methadone can distort the findings for this research. In addition to this, individuals chemical dependency philosophy varies; some advocate for abstinence, while some are in support of harm reduction and some support whatever works for the client; all these can impact opinions of interviewees. That is why efforts were made to select diverse views. Hence, a balance of views was achieved and limitations of qualitative method of research design were addressed.

## CHAPTER V

### Results and Findings

The purpose of this study is to examine the psychosocial impact of methadone on individuals. Interviews were conducted and participants were asked questions that are specifically related to MMT. After six qualitative interviews with licensed alcohol and drug counselors, a chemical health social worker, a registered nurse and an addiction physician, the following themes were developed: stigma, disease concept, co-occurring disorder, lack of knowledge about methadone and ethical considerations. This section will examine the themes developed from the interviews.

#### *Stigma*

One of the themes identified in the course of this research is stigma. All respondents stated that the public disregard the benefits of the program; instead the focus is on the little negativity that is associated with the program. During the interview, one of the respondent stated that “MMT is viewed poorly. People believe it is a drug of choice from heroin to Methadone.”

Another respondent stated that:

Well. As a Registered Nurse we don't stigmatized patients. We don't treat people differently based on their diagnosis. When we see patients that are addicted to narcotics we believe it is a situation they cannot help, we believe something is wrong somewhere and we try to get them help as much as we can. That is why they end up in methadone clinic. It is a medical issue that needs medical attention. On the street people will call them addict and stuff but medically we don't see that.

In a different interview, the respondent stated that:

The stigma prevents many people from seeking treatment. The other major barrier is the cost to the patient. There is also confidentiality and people worry about their information.

Similar to this is, is the fact that:

There is stigma within the community even within other providers. Some Doctors do hesitate to work with clients simply because they are on methadone. This is as a result of lack of knowledge. Doctors look at them as addicts. That is stereotype and is the biggest barrier. They just know the negative stigmas, stereotypes, negative information, everyone knows someone who dies of methadone or illegally using methadone and you are going to have professionals who will not stand for what is right or what could be positive.

### *Is addiction a disease?*

Another theme that was very common during the interviews with respondents was disease concept. Categorizing addiction as a disease is as controversial as every other social issues in the United States and elsewhere. The earliest call for disease concept of drug and alcohol was made by Benjamin Rush (Goodwin & Gabrielli, 1997 as cited by Inaba & Cohen).

Since, this time there have been controversies about the concept and opinions have been divided on the subject of defining addiction as a disease. The debate over whether to describe or treat addiction as disease has affected not only individuals' suffering from addiction but also the policy makers and addiction professionals (White,

2000).

The advocates of the disease concept held the opinion that it will offer precision in problem diagnosis, selection of effective treatment, culturally adaptable intervention and client centered treatment (White, 2000). As a society, “it will enable us to review our system of judgment in which an individual is viewed as an addict who is suffering from a disease and offered healthcare resources while another person with the same problem is judged as a criminal and is incarcerated” (White, 2000, p. 2). Again, the supporters of the call for defining and categorizing addiction as a disease are of the opinion that doing so will “replace moral censure and criminal punishment of the alcoholic/addict with unprejudiced access to health care institutions; it will relieve guilt, and increase help seeking behavior” (White, 2001, p. 23). They believe that defining addiction as a disease is a means of affirming that there is a problem and making individual identify and agree to the problem, while the society will also recognize the problem and develop the structures to address the problem (White, 2000 ).

To the oppositions, this argument does not stand up against criticism. Their contention is that defining addiction or alcoholism as a disease will create room for addicted individuals to make excuse for their sinful behavior of drinking and using illicit drugs which is considered a blasphemy against God (White, 2000). To those that hold this belief, addiction to substances is not only a sin but a moral failure. Again, rather than perceiving addiction as a disease, they contended that addiction and drunkenness is a sin against God and can not be cured not by counseling, Minnesota model of treatment, or MMT but only through religious means (White, 2000). They argued that, the concept of addiction as a disease is scientifically indefensible, it strips individuals in treatment of

their freedom and responsibility, it does not provide adequate relapse prevention strategies, it stigmatizes individuals and it has survived because of people who are financially profiting from it (White, 2001).

However, White (2000) states that the push to categorize addiction did not start today and many terms like moral disease, disease induced by a vice, intemperance, odious disease and many more have been used in the past to explain alcoholism and drug addiction. White (2001) pointed out that three major significant events led many to renew the call for defining addiction as a disease in the modern times. These are; the emergence of therapeutic community as a treatment modality for drug addiction, the perception of opiate addiction and methadone maintenance as an effective treatment by the pioneers of MMT and lastly the widely embraced Minnesota Model of treatment which perceived and treated addiction as a primary disease (White, 2000)

Going by different opinions, it is likely that these arguments, criticisms and counter criticisms will continue for a very long time; it is however important to pay attention to what professionals in the field say during the interview.

It is one of those issues where people have emotional arguments as opposed to scientific arguments. That is another barrier or problem. The other issue is that the use of opioids is not legal while the use of alcohol is legal. So there is an interface with the criminal part of the society that does not occur with alcohol. That makes it more of a different situation for the person using and a person trying to get out of it. Addiction should be seen as a medical issue we don't blame people for getting sick. Addiction is a disease and it is treatable. It is difficult but people still get treated.

Another respondent agreed to the assertion of addiction as a disease and MMT as a panacea to opioid addiction:

I think it is a disease. It takes life time to combat but medication can help. You can't just treat the symptoms or other issues; you got to treat the whole person.

### ***Co-Occurring Disorder***

Another important theme that was identified during this research was co-occurring disorder. The quotes below validate the opinion of the respondents on the issue of co-occurring disorders:

You know most people once they become addicted to something, typically they have mental health diagnosis because of the things they go through because of their addiction, they have family problems, relationship problems, marital problems, people are depressed because of drug and alcohol, and some started using because of mental health issues.

One respondent added that co-occurring disorder should be treated simultaneously:

All those diagnosis of mental health diseases has to be treated as best as they can. Many of them are parts of the disease process. Often the bipolar people will use alcohol and drugs in their manic face. And the same way with clinical depression and they may use them as a way to medicate themselves for depression. The usual wisdom about alcohol is that you can't treat all these other problems but you can treat addiction if you can find a way to treat it then other things will get better. And is the same way with the opioids if you can stop this problem, and then they have a chance to deal with other mental health issues. It

should be treated concurrently; you have to treat the whole person.

***Lack of Knowledge about Methadone***

One of the most prominent themes used overwhelmingly in this analysis is the lack of knowledge about methadone. Some of the respondents stated that they need more information about the program while some gave a brief and concise description of the MMT:

It is a harm reduction model and what it does is to give client the opportunity to avoid relapse and gradually manage withdrawal symptoms so they don't feel sick and have the opportunity to put their life together. It is truly a medically assisted recovery program.

On the other hand, there have been strong criticisms among professionals about the effectiveness of MMT in helping people to achieve sobriety. It is perceived as reinforcing bad behavior rather than addressing the main issue. This, they believe is interfering with individuals resolve to achieve sobriety.

One respondent stated that:

It is the easier and softer way for people struggling with addiction to avoid addressing the main issue in their life. It is more of a situation where people don't want to address the issue in their life. Instead they say I have a physical addiction; maybe I am not an addict I just have a physical dependence; which was as a result of addiction to pain medication prescribed to me after a surgery. Also, they can say that because my medication run out and the Doctor will not refill so I can get heroin in Minnesota it is cheap and easy to get then I became heroin addict. I want

to get out of it I am not an addict may be methadone will help. But it goes beyond that. I think it is easier for client to say I just want methadone to replace the illicit drugs. The fact is that they don't want to deal with other crap in their life and then they stay on it. Essentially they are missing the point because they are prolonging their disease and they are making it worse.

Another respondent stated that;

Why using chemicals instead of addressing the main issue. This needs to be addressed by doing the difficult work. They need to know that life is a lot easier than trying to maintain replacement therapy and they become dependent and come back and say I need more, I need more and they end up overdosing on it. It will be nice if client can get into a long term treatment than the MMT.

### ***Holistic Approach***

In this theme, respondent explained the differences between traditional addiction programs and MMT. One respondent made an extensive juxtaposition of MMT and other modality of addiction treatment facilities. This respondent also viewed MMT as more of organized health institution:

It is a form of treatment where you handle relapses differently from other traditional treatment centers. With MMT, we get the opportunity to work overtime to really deal with the problem. So, there are psychosocial issues which need to be addressed to help people get off addiction faster. You have to look at individual how do they get there and how can we get them off. You treat the whole person.

*Ethical Consideration*

Practitioners in the field of addiction often faced greater challenges in their daily activities because of the stigma placed on MMT by the clients, family members, and the society at large. In enrollment, practitioners have to consider the age, sex, cultural background, and quite often the sexual orientation of individuals. For an underage, there are always clinical concerns and clients are often transferred to another facility or higher level of care.

For female clients, pregnancy test is carried out during the initial intake. If the client is pregnant, it requires serious monitoring and intensive coordination is required between the medical director and the client's physician as well as careful and medically correct dosage. As Baldino (2000) wrote, methadone clinic doctors are expected to ensure that methadone is a medically safe treatment option for the mother and the unborn child. Ethically, it will be safer for pregnant patients and underage individuals to consider hospitalization, detoxification or an inpatient treatment so as to enable them taper off methadone rather than to seek treatment in a methadone clinic (Baldino, 2000).

Quite often, social workers, counselors and addiction physicians find themselves in ethical decision making dilemma as to whether individual who is an underage and pregnant woman should be enrolled in the MMT programs. Respondents reacted differently to this question. It has to be noted that respondents' had a harmonious thoughts about how to handle enrollment of minors and pregnant in the methadone program. They collectively stated that minors who are struggling with heroin addiction should be sent to higher levels of care:

Methadone should be given in a way that it will protect both the mother and the child. For underage I make no attempt to treat them. I will refer those patients to psych unit. I don't know what the treatment should be. I have not even thought about 14-15 year olds using heroin.

Another interviewee states that:

It is kind of outside view of methadone. It is same as adult taking methadone as well. The ethical consideration is that it should be hard to get an underage on methadone. I will send them to treatment; a long term treatment instead of substitute drug or methadone. That will be my ethical standpoint. I will send them to long term treatment. I will not like to put more chemical into their systems.

## CHAPTER VI

### Discussion

The identified themes were taken from the interview with the respondents for this research. Stigma was an important topic discussed extensively by the respondents. Everything around the treatment is done in secrecy, and patient information is guided and treated with utmost confidentiality as dictated by the federal rules. This secrecy is as a result of the stigma associated with the methadone treatment and mishandling of the drug itself. Mostly, people believe that methadone is another drug which some people are on for the rest of their lives. Therefore, it is considered a drug of choice or another illicit drug.

Holistic Approach is another theme discovered in the course of this research. MMT takes a holistic approach to the patient's plight. The combination of psychotherapy, counseling, and nursing services all under one roof is a great benefit to the patients. The respondent states that the counselors have an opportunity to work with patients over a long period of time for proper monitoring of their psychosocial activities. In the past, addiction and mental health problems were treated differently. In the present time, treatment is done simultaneously. In every MMT, the mental health status of clients is an integral part of services rendered to clients. The aim is to ensure that clients are functioning effectively in every aspect of their life.

Also, the respondents have harmonious response to whether addiction should be categorized, viewed, and treat as a disease. In my own opinion there is no question, addiction is a disease. On the other hand, many of the literatures reviewed did agree differently. While, some consider addiction as a moral failure that should not be treated

or define as a disease; another school of thought sees it as problem that needs to be treated using the holistic and treatment centered approach. Of great importance, is the ethical consideration of MMT as it affects individuals' especially pregnant women and underage clients. Also, respondents hold different views about abstinence based treatment and medication assisted treatment. For some, the MMT is viewed as a way to enhance or reinforce bad behavior. On the other hand, some respondents believe that abstinence and sobriety is not easy to come by and it has to be through a systematic procedure to avoid relapse.

However, these themes are related to the research question: What are the psychosocial effects of methadone maintenance treatment on individuals? Basically, the main goal behind the MMT harm reduction model is to give clients the opportunity to avoid relapse and gradually manage withdrawal symptoms so they don't feel sick and have the opportunity to put their lives together. Methadone helps people to function, to keep jobs, mend their relationships and contain their withdrawal symptoms. Theme I addressed the stigma that are associated with MMT. On one hand, there are some who believe that using methadone as a substitute for heroin is an addiction itself. The oppositions of MMT are using the unethical behavior of some practitioners, and diversion of methadone by patients as valid points for their arguments. It has to be stated that the positive psychosocial effects of MMT far outweigh the criticisms. These themes collectively explain the meaning of MMT, the biased perception of the program, and its positive impacts on the enrolled patients in the program.

Findings from the respondents interviewed and reviewed literatures led to identification of similarities between MMT practitioners' thoughts and scholarly findings.

In the course of the interview, the respondents explained that MMT is viewed poorly because of the stigma attached to it. This has been a big problem affecting the growth of the MMT as a program. MMT is often viewed as a substitute therapy. That is, a means of replacing one addiction with another (CSAT, 2012). In addition to this, the respondents and the reviewed literatures agreed that MMT enhances the effective functioning of patients. It gives patients the opportunity to manage and alleviate the withdrawal symptoms from heroin and other opiates, help individuals to function effectively, reconnect with their families, and manage to live with more stability without heroin (CSAT, 2005, Freeberg, 2013, Mark, 2004).

Furthermore, sources used confirm that MMT programs employ holistic approach in treating patients. MMT gives counselors the opportunity to work with clients over a long period of time, which enables practitioners to help individuals who have addiction problems find the root cause of their addiction problems, plan their treatment, and move them closer to their sobriety and goal of abstinence (Freeberg, 2013,[ personal communication],March,2013).

Generally, the findings from the respondents and the supporting literature from relevant topics were found to be consistent with one another. This is due to experiences of the respondents in the field, and the wide range of related literatures used in the study.

### ***Implications for social work practice***

Before this study, little was known about MMT by the researcher. The substance abuse field and the public are more focused on the traditional model of treatment. The stigma of MMT is reported more often than its overall benefits to the clients and society. For example, every automobile or motorcycle accidents out there is often linked to

methadone and reported by news media. For these reasons, few social workers will like to work with clients on the MMT program. These findings have broadened the researcher's scope in MMT.

The findings of MMT pointed to the fact that individuals on methadone could be our neighbors, our friends, our children's Sunday school teachers, our managers, the addiction counselors, or our family members (Mark, 2004). Hence, they are fellow citizens of the society who are willing to make a change, quit illicit drugs, and live a better life. These people need our care and support as they resolve to reintegrate into the society and a drug free life style. It is important for social workers in methadone clinics to recognize that clients in methadone clinic wants solution focused therapy, honesty and unbiased treatment.

This research also points to the fact that there is immense lack of knowledge in the areas of methadone as an effective treatment for opioid addiction. Therefore, it is essential for social workers to upgrade their knowledge about this option of treatment. As stated earlier, there is no doubt that social workers are likely to find themselves as practitioners for clients suffering from addiction to opioid at any point in time. In clinical practices; social workers will be working to enhance the social functioning of clients as well as treating their addiction to opioid. Therefore, there is need to pursue further knowledge in this area of addiction treatment so social workers can better serve clients who will need funding, advocacy, counseling, and support. This education could be in form of continuing education, in house- training, or better yet upgrading their overall knowledge with an additional degree in chemical dependency.

An important implication of this study is the multiple role of a social worker working in a methadone clinic. The worker is often perceived as a social worker, counselor, case manager, and sometimes a therapist who is required to help resolve the multiple problems of clients. Hence, it is imperative for social workers to possess strong skills of consultation and networking with other workers in the healthcare system for effective coordination of care for clientele.

### ***Implications for policy***

The operators of methadone clinics often operate within a constant strict and tough rules from the government through the Drug Enforcement and Administration Agency (DEA), negative perception by the society, and the clients they serve; this can be associated with the stigma that is associated with the industry that have been largely discussed in every segment of this research. This has greatly affected MMT programs flexibility and ability to respond to patients needs in such key areas as dosing, counseling, and engaging physicians and other professionals in treating heroin addiction (Center for Disease Prevention and Control [CDC], 2002). Therefore, there is more to be done at policy levels by policy makers in terms of friendly policies and educating the public about the importance and benefits of methadone as against the negativity often aired on radio and television.

At policy levels, the rate of counselor to client ratio at every methadone clinic seemed to be disproportionate; precisely 1- 50 clients per state of Minnesota regulations. With this high volume of case loads, counselors do more paper work than actually meeting with clients; counselors end up transfer this pressure to their clients to become totally drug free as quickly as possible. This is often counterproductive to the ethical

standard of social work profession and the betterment of the client (Baldino, 2000). This explains the extraordinarily high rate of turnover in methadone clinics and the reasons why counselors or chemical health social workers will like to take other jobs that are less stressful with better compensation (Baldino, 2000). Therefore, it is important to review the case loads or ratio of workers to clients. There is the need to bring the case load to a manageable level; so social workers can have more counseling time with clients, spend more time in reviewing treatment plan and reduce fatigue and possible burnout.

Another policy implication includes the never ending debate about whether addiction to heroin is a disease just like alcoholism. Much attention is paid to alcoholism which has resulted into neglecting much more dangerous addiction to heroin. As Balbino (2000) wrote, “when people become addicted to heroin, using the drug becomes their primary purpose in life, because of the chronic and progressive nature of opioid addiction, users eventually become physically dependent on heroin and experience severe withdrawal symptoms if they are denied access to the drug.” (Baldino, 2010, p. 59). Therefore, the policy makers should take the lead in formulating and reviewing existing policies that emphasize and strengthen methadone as an effective treatment for the disease of opioid addiction.

Of great importance is the certification and qualification as well as competency of counselors and social workers in the area of MMT. It is important to states that not all social workers are expertise in the field of addiction counseling. Their role goes beyond that of a case manager, hospital social worker, school social worker but an addiction counselor who is expected to be vastly knowledgeable not only in the field of addiction but specifically about methadone maintenance treatment. Therefore, the current

qualifications to work as an addiction counselor in an MMT establishment should be reviewed in terms of training, certification, and continuing education so as to ensure that individuals have a basic knowledge required to work in a methadone clinic.

***Implications for research, strengths and limitations***

This research points to the fact that MMT is an important option for the recovery and sobriety process for people with heroin and opioid addictions. It is also a fact that more is known about the stigma attached to the program than the positive effects on our society. Social workers sometimes, find it difficult to approve MMT patients for funding treatment because of a fear of diversion, proving that they have little knowledge about MMT. Therefore, this research will enhance social workers versatility in the area of substance abuse, MMT in particular.

An important strength of this research is the selection of participants. Participants were selected based on their expertise and knowledge about MMT. To balance views on MMT, these interviewees were also selected based on their philosophy of treatment for opioid addiction. Therefore, there were opposing views involved in this research which has generated balanced views of participants and the researcher on methadone.

While selection of participants in this research is strength, it is also a weakness. It is a sample of six participants from different professional background but a client or participant in the MMT program was not interviewed thus the claim that MMT is an effective treatment for opioid addiction may not be generalizable. This is for the future researcher to compare and contrast the effectiveness of methadone with other opioid addiction medications like suboxone and naltrexone.

There have been a lot of researches done regarding MMT's history. Its effectiveness has also been extensively researched, but the process of weaning individuals off the drug is relatively under- researched. As Freeberg (2013) reports, for a nonprofit methadone clinic, the goal is to get people to treatment and wean them off methadone. In for profit making clinics however, the ultimate aim is not to wean them off the drug, but to sustain the inflow of cash. This area needs to be examined. One of the respondents' states that little is known about how quickly is possible for individuals to taper off methadone:

I don't think we know enough about methadone. For five years now what I know is that they want to get them off at a certain time but this is not happening. Once they switch from narcotics to methadone. They stay on methadone till they die. I have seen a few patients that die on methadone. While this has not been possible I don't know. These are the things they need to let us know to educate us more about methadone.

With more research in the area of weaning patients off methadone, the stigma and the poor view can be corrected, and more people are likely to join the treatment. Therefore, the use of heroin and other opioids can be reduced. From other perspectives:

There is a lot of research on pharmaceutical side. I don't know if there is much research in counseling and strategy in helping people to prevent them from relapse. We need to find out if counseling actually help people to leave a sober life without using. I don't know what the research is on various strategies, which works better, how long counseling should take.

Therefore, several questions about future research were examined during this study. The participants stated that little is known about methadone and more research is needed not only on why people join the MMT but to get them off the program and still sustain their sobriety. Also, participants stated that more research is needed in the areas of effectiveness of counseling. They want such study to include the length of counseling, what theories and model of counseling is effective for the MMT clients.

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## Appendices

### Appendix A: Unsigned Consent Form

#### CONSENT FORM

#### SAINT CATHERINE UNIVERSITY The Methadone Maintenance Treatment and its psychosocial Effects on Individuals

I am conducting a study about the psychosocial effects of methadone maintenance treatment on individuals who are in recovery for opioid addiction. I invite you to participate in this research. You were selected as a possible participant because of a release you signed stating your interest in any research in addiction counseling that impact the recovery process. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Fatai A. Popoola, a graduate student at the School of Social Work, College of St. Catherine/University of St. Thomas and supervised by Rajean Paul Moone Ph.D., LNHA.

#### **Background Information:**

The purpose of this study is to examine how the program has impacted the psychosocial well-being of individuals who perceive the methadone maintenance program as a recovery process from dependency on opioids and other illicit drugs.

#### **Procedures:**

If you agree to be in this study; you will participate in a 60-75 minutes long interview. This interview will be recorded and transcribed. The results of the transcribed interview will be presented to the public during the St Catherine University/ St Thomas University, School of Social Work Clinical Research Presentations. Participants will be notified ahead that interviews will be conducted in a conference or private room of a public library at a convenient location and time for the participant. They will also be notified that this interview will last 60-75 minutes and it will be recorded and transcribed later. For confidentiality, participants will be assured that the recorded interview will be stored safely in a password protected computer.

#### **Risks and Benefits of Being in the Study:**

The study has minimal risk. I will be asking questions on your role as an addiction Counselor, clinical social worker, mental health practitioner and addiction physician. The interview will focus on your professional role. I will be asking about your work, your therapy techniques, and how you set relapse prevention goals for clients.

The study has no direct benefits. It will only enlighten the public about the program in general and how it has helped sobriety for the people that have been through the program.

**Confidentiality:**

The records of this study will be kept confidential. As a classroom protocol, I will not publish any of this material. Research records will be kept in a safe place. I will delete any identifying information from the transcript. Findings from the recorded transcript will be presented during the Clinical Research Presentations on May 19, 2014. The recordings and transcript will be destroyed after the presentations.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used.

**Contact and Questions**

My name is Fatai A. Popoola. You may ask any questions you have now. If you have questions later, you may contact me at 651-214-0975. You may also contact Dr. John Schmitt, Chair of the Saint Catherine University Institutional Review Board at 651-960-7739 or the research advisor Rajean Paul Moone on 651-235-0346 with any questions or concerns.

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audio taped.

\_\_\_\_\_  
**Signature of Study Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Study Participant**

\_\_\_\_\_  
**Signature of Researcher**

\_\_\_\_\_  
**Date**

## Appendix B Interview Questions

### Proposed Questions for Qualitative Research

#### Questions for Professional Respondent:

**Preamble:** At what point in your career do you come in contact with Methadone Maintenance Treatment.

1. What is your philosophy of Chemical Dependency?
2. Can you describe your professional experiences related to the MMT program?
3. What sparked your interest in the area of Methadone Maintenance Treatment program?
4. What are the differences between Methadone Maintenance Program and other Addiction Counseling programs?
5. What are the common cravings for people with heroin addictions?
6. Are there different ethical protocols for children and adults in MMT enrollment, placements, and prescriptions?
7. What are the barriers faced by individuals in MMT?
8. Can you talk about the stigmas that are associated with the MMT?
9. Are these stigmas associated with Methadone different from culture to culture?
10. What is important for the public to know about MMT and the stigma that comes with it?
11. What is important for Counselors to know about addiction and mental health?
12. What areas related to this topic are in need of more research, knowledge, and personnel?
13. Do you have any final thoughts that you'd like to express relating to this topic?

**The Psychosocial Impact of Methadone Maintenance Treatment on individuals  
Information and Consent Letter**

Dear,

Name of Participant:

I invite you to participate in a research study investigating the psychosocial impact of methadone on individuals. This study is being conducted by Fatai A. Popoola BEd LADC, a graduate student at the St Catherine University\University of St. Thomas School of Social Work under the supervision of Rajejan Paul Moone Ph.D., LNHA. You are selected to participate in this research because of your professional experience in addiction and drug abuse. Please read this letter before you decide to participate in this research.

The purpose of this study is to examine how the program has impacted the psychosocial well-being of individuals who perceive the Methadone Maintenance Treatment as a recovery process from dependency on opioid and other illicit drugs.

If you agree to be in this study; you will participate in a 75 minutes long interview. The interview will be arranged at a public library closer to your convenience location and time. This interview will be recorded and transcribed. The results of the transcribed interview will be presented to the public during the St Catherine University\St Thomas University, School of Social Work Clinical Research Presentations.

The study has minimal risk. I will be asking questions on your role as an addiction counselor, clinical social worker, mental health practitioner or addiction practitioner. The interview will focus on your professional role. I will be asking about your work, your therapy techniques, and how you set relapse prevention goals for clients. Also, the study has no direct benefits. It will only enlighten the public about the program in general and how it has helped to achieve sobriety for the people that have been through the program.

The records of this study will be kept confidential. As a classroom protocol, I will not publish any of this material. Research records will be kept in a safe place. I will delete any identifying information from the transcript. Findings from the recorded transcript will be presented during the Clinical Research Presentations on May 19, 2014. The recordings and transcript will be destroyed after the presentations.

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used.

If you have questions, you may contact me at 651-214-0975. You can also contact my research advisor Rajean Paul Moone Ph.D on 651-235-0346 or the Saint Catherine University Institutional Review Board at 651-960-6204 with any questions or concerns. I thank you for considering your participation in this proposed research.

Sincerely,

Fatai A. Popoola

**Appendix C Demographic Questionnaire**

Your response to these questions is important please circle one answer.

**Genders**

Male  
Female

**Age group**

18-29  
30-49  
50-64  
65 and older

**Race Ethnicity**

White  
Black  
Hispanic  
Other

**Educational attainment**

Associate Degree  
Bachelor's degree  
Graduate

**Professional Licensure**

LICSW  
LADC  
LMFT