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## Exploring the Daily Lives of People on Methadone Maintenance Treatment: An Occupational Perspective

Katrina Warren, *The University of Western Ontario*

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Health and Rehabilitation Sciences

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# **Exploring the Daily Lives of People on Methadone Maintenance Treatment: An Occupational Perspective**

(Thesis format: Monograph)

by

Katrina Warren

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment  
of the requirements for the degree of  
**Master of Science**

The School of Graduate and Postdoctoral Studies  
The University of Western Ontario  
London, Ontario, Canada

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## **Abstract and Keywords**

A study was undertaken with five people on Methadone Maintenance Treatment (MMT) within London, Ontario. The objectives were to better understand the experiences and daily routines of people on MMT through in-depth exploration of their everyday occupations and the ongoing challenges and barriers they face to accessing treatment. This research employed a qualitative intrinsic case study methodology (Stake, 1995). Using an occupational perspective informed by a framework for occupational justice (Stadnyk et al., 2010), findings are presented according to four themes highlighting key aspects of the participants' experiences: a) a 'descent into chaos', b) 'MMT as a bridge' to recovery from addiction, c) a 'new normal' daily life, and d) hopes for 'moving forward'. These findings illustrate how structural factors and contextual factors interact to create occupational injustices. Thus, MMT practices and policies should consider the occupational implications described in this thesis to enhance patients' experiences and further support their recovery.

**Keywords:** *activities of daily living, addiction, case study, methadone maintenance treatment (MMT), occupation, occupational science, qualitative, routine*

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## **List of Abbreviations**

**ADD** – Attention Deficit Disorder

**BMI** – Body Mass Index

**CPSO** – College of Physicians and Surgeons of Ontario

**EKG** – Electrocardiogram

**DSM-V** – Diagnostic Statistical Manual Fifth Edition

**HCG** – Human Chorion Gonadotropin

**HIV** – Human Immunodeficiency Virus

**HSREB** – Health Science Research Ethics Board

**MMT** – Methadone Maintenance Treatment

**OCD** – Obsessive Compulsive Disorder

**ODSP** – Ontario Disability Support Program

**PTSD** – Post-traumatic stress disorder

**QoL** – Quality of Life

**UDS** – Urine Drug Screening

**VDRL** – Venereal Disease Research Laboratory

**WHO** – World Health Organization

## **Chapter One – Introduction**

### **1.1. Introduction**

In this chapter I introduce the current study of the daily lives of people on Methadone Maintenance Treatment (MMT) in London, Ontario. I first provide background information for the current study including an overview of MMT, and an explanation of how MMT works. I also identify accessibility and daily life issues with regards to MMT. Subsequently, I discuss applying an occupational science perspective to the study of MMT experiences. Following that discussion, I outline the study purpose and objectives. I then introduce myself, my interest in this topic, and my role as a researcher. Lastly, I provide an outline of the following chapters of this thesis.

### **1.2. Background**

Addiction to opioids is a complex substance dependence issue affecting a substantial number of people all over the world. Opioids include naturally occurring opiates and synthetic or semi-synthetic drugs such as heroin, morphine, or oxycodone that act on opioid receptors in the brain and can cause dependence due to their euphoric effect (World Health Organization, 2008). While opioids are effective painkillers that are prescribed by doctors and are safe in the short term, prolonged use, as well as misuse or abuse of opioids can lead to addiction. Opiate use can become a problem when there is no longer a medical reason to do so or when the person is taking more than needed. Drug misuse has been defined as “the taking of a drug which harms, or threatens to harm, the physical or mental health or social well-being of the individual, or another individual or society at large, or which is illegal” (Helbig & McKay, 2003, p. 140).

According to the World Health Organization (WHO) (2008), there are approximately 16 million illicit opioid users worldwide between the ages of 15 and 64. In Canada, there are approximately 80,000 illegal opioid and 30,000 in Ontario alone (Centre for Addiction and

Mental Health, 2012). Rates of opioid-related death increased in Ontario between 1991 and 2010. There were 550 deaths annually in 2010 compared to 127 deaths annually in 1991. About 1 of every 170 deaths in Ontario is now related to opioid use.

Drug use is a serious community issue, particularly in London, Ontario. In a report by Caldarelli, Skellet, and Locker (2014), they explained that between the years of 2008 and 2012, opioid drugs caused more overdoses, emergency room visits, and hospitalizations in London than in the rest of Ontario. They also mentioned that opioid use in London is 1.5 times greater than the average Ontario rate for opioids (Caldarelli, Skellet, & Locker, 2014). Moreover, in 2013, admissions rates to substance misuse and addictions programs were higher in Middlesex-London than Ontario as a whole for people who reported prescription opioids, methamphetamines, and other stimulants as a problem substance on admission (Caldarelli, Skellet, & Locker, 2014).

Harm reduction is a set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use without requiring a change in behaviour (Pates & Riley, 2012). Drug use is acknowledged as opposed to judged and action is supportive rather than punitive. This concept incorporates a focus on keeping people safe, minimizing deaths, diseases, and injuries associated with higher risk behavior (Pauly, 2007). For example, harm reduction emphasizes one's responsibility for staying healthy by using clean needles and proper injection techniques. Another evidence based strategy from the harm reduction model, which is the focus of the current study is known as Methadone Maintenance Treatment (MMT) (Pauly, 2007).

### **1.2.1. Overview of MMT**

Methadone was first discovered in Germany prior to the start of the Second World War, where it was used to control pain (Ontario Ministry of Health and Long Term Care, 2007). Methadone was manufactured as a painkiller when the Allied forces cut off the supply of

morphine to Germany. Following the Second World War, Americans seized the formula and methadone started to be produced by drug companies (Centre for Addiction and Mental Health, 2008). Methadone is a synthetic opioid that is long acting (acts more slowly in the body and for a longer period of time than most other opioids), prevents withdrawal symptoms and reduces or eliminates drug cravings (Anstice, Strike, & Brands, 2009). There are no euphoric effects with methadone, a fact that contributes to lower rates of relapse (Registered Nurses Association of Ontario, 2009). Methadone covers the same receptors in the brain as other opiates as well as endorphins, but does not cause a person to 'get high'. Though it can be used for pain, methadone is most commonly used to stabilize the lives of people who use opioid drugs. Methadone, taken orally, can last anywhere between 24 and 36 hours (The College of Physicians and Surgeons of Ontario, 2011)

MMT is a substitution therapy that replaces the drug that the person is dependent on with a prescribed substance that is pharmacologically similar, but safer when taken as prescribed (The College of Physicians and Surgeons of Ontario, 2011). Methadone treatment for opioid dependence was first practised experimentally in the late 1950s by the Canadian researcher Robert Halliday in Vancouver (Ontario Ministry of Health and Long Term Care, 2007). In the early 1960s, a study conducted in New York by Drs. Marie Nyswander and Vincent P. Dole involved two people with chronic opioid addiction and long criminal histories related to their addiction (Hentoff, 1968). The aim of the study was to show that when the subjects were given enough drugs to satisfy their craving and keep them free of withdrawal, they would no longer commit crimes and would instead be interested in other things. The two subjects were given frequent doses of morphine. The study showed that the subjects had no interest in crime or other drugs, but failed to have much interest in anything else. They would watch television, relax on

the couch, sleep, or ask for their next shot. Nyswander and Dole, ready to give up on their experiment, planned to put the subjects through withdrawal. To do this they put them on methadone and their intent was to gradually taper the dose. On methadone, however, the subjects showed little desire for drugs and more interest in engaging in other activities. With the right dose of methadone, the subjects were comfortable, clear-headed, and able to renew their lives (Hentoff, 1968).

In Ontario, MMT has been available since the 1970s (Centre for Addiction and Mental Health, 2012) but there were initially few doctors authorized to prescribe it and few clinics to dispense it (Centre for Addiction and Mental Health, 2008). In the 1990s, changes were made to make it easier for doctors to provide MMT as the need to reduce the harm of drug use was increasingly recognized. For example, the MMT program of the College of Physicians and Surgeons of Ontario (CPSO) was initiated in 1996 with the aim of improving both patient care and access to treatment (The College of Physicians and Surgeons of Ontario, 2011).

MMT has been shown to be an effective, safe, and cost-effective treatment for opiate addiction (De Maeyer, et al., 2011). It can enable a return-to-normal physiological, psychological, and societal functioning. Patients have weekly contact with a physician and daily contact, until stable, with pharmacists and other health care providers. Additional integrated components such as counselling can give clients more time and opportunity to deal with other important issues while they are in treatment. Since its introduction, MMT remains the most widely used form of treatment for people who are dependent on opioids (De Maeyer, et al., 2011) and research has demonstrated that it is the standard evidence-based treatment for opiate dependent individuals (Conner & Rosen, 2008). Through treatment, people who are addicted to

opioids may thus receive the medical and social support they need to stabilize and improve their lives.

MMT can benefit not only the people receiving the treatment but also their families, their communities, and society as a whole. The cited benefits of MMT include reducing illegal use of opioids, criminal activity, deaths due to overdose, behaviors that increase the risk of Human Immunodeficiency Virus (HIV) transmission through needle use, and public health risks (Centre for Addiction and Mental Health, 2011). MMT may also improve physical and mental health, social functioning, quality of life, pregnancy outcomes, and employment prospects (Centre for Addiction and Mental Health, 2011). The length of treatment varies, from a year or two to twenty years or more, depending on the individual. Daily treatment with methadone may continue indefinitely.

### **1.2.2. How MMT Works**

MMT is typically provided in a community-based setting and administered on an outpatient basis (Erdelyan & Young, 2009). In Ontario, up until July 6, 2015 the CPSO administered MMT and had stringent requirements for many aspects of the program (The College of Physicians and Surgeons of Ontario, n.d.). This included the requirement that patients who are prescribed certain controlled substances, particularly benzodiazepines and opiates, could demonstrate clear documentation and were prescribed these medications in a controlled fashion (usually weekly dispensing). Clinicians can still use these guidelines but they can be interpreted differently, thus in the early phases of treatment they may have to be rigorously applied in order to maintain patient safety. The CPSO also governed the MMT program to ensure that patients did not receive a prescription for methadone from more than one source at a time (The College of Physicians and Surgeons of Ontario, 2011).



The process of receiving MMT involves assessing the individual for suitability for MMT, an addiction and health history, a brief physical examination, urine drug screening (UDS) and other investigations. Firstly, the physician must establish that the patient meets the Diagnostic Statistical Manual Fifth Edition (DSM-V) criteria for opioid use disorder (The College of Physicians and Surgeons of Ontario, 2011). According to the American Psychiatric Association (2013), the DSM-V criteria for opioid use disorder are as follows:

- 1) Opioids are taken in larger amounts or over a longer period than was intended,
- 2) There is a persistent desire or unsuccessful efforts to cut down or control opioid use,
- 3) A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects,
- 4) Craving or a strong desire or urge to use opioids,
- 5) Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home,
- 6) Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids,
- 7) Important social, occupational, or recreational activities are given up or reduce because of opioid use,
- 8) Recurrent opioid use in situations in which it is physically hazardous,
- 9) Continued opiate use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance,
- 10) Tolerance, as defined by either of the following:
  - a) a need for markedly increased amounts of opioids to achieve intoxication or desired effects, or

- b) a markedly diminished effect with continued use of the same amount of an opioid,
- 11) Withdrawal as manifested by either of the following:
- a) the characteristic opioid withdrawal syndrome, or
  - b) opioids are taken to relieve or avoid withdrawal symptoms.

In addition, prior to initiation the physician must also ensure that the patient meets the other suggested criteria for MMT. These include opioid use, lower likelihood of benefit from non-MMT treatments and agreement to terms and conditions of the MMT program (The College of Physicians and Surgeons of Ontario, 2011).

Once individuals seeking treatment had provided informed consent and a signed treatment agreement they were registered with the CPSO under the specific methadone provider or physician. In addition, a treatment agreement states that patients consent to treatment and the provider's rules and expectations (The College of Physicians and Surgeons of Ontario, 2011). Subsequently, a patient's history identifies a pattern of use of all major drug classes, previous addiction treatment history and response, previous attempts to stop on one's own, high risk behaviour, psychiatric history, social situation including housing, supports, child custody, and partner's drug use history (The College of Physicians and Surgeons of Ontario, 2011). A thorough physical examination includes assessment of head and neck, chest, heart, abdomen, genito-urinary system, musculoskeletal system, neurological system, and skin, as well as mental status (The College of Physicians and Surgeons of Ontario, 2011).

UDS is a major component of MMT. Urine samples are collected and tested on a weekly basis to monitor the presence of a variety of illicit drugs. Depending on the clinic, this might include opioids, benzodiazepines, cocaine, amphetamines, and barbiturates (Centre for Addiction and Mental Health, 2008). The UDS will also indicate whether the patient has been compliant

and taking the prescribed methadone. In addition, other laboratory investigations such as Human Immunodeficiency Virus (HIV) and Hepatitis B and C screening are requested and conducted at the time of initiation, annually, and as needed. In order to verify the integrity of the UDS specimen, MMT physicians should supervise or monitor the collection. If this is not possible, the MMT physician can implement other measures such as creatinine or temperature monitoring (The College of Physicians and Surgeons of Ontario, 2011).

Once enrolled in the program the patient obtains a methadone prescription specific to a pharmacy of choice. Methadone is most often administered once a day under medical supervision at the selected pharmacy. The first dose of methadone is within a safe starting range as determined by the physician. The dose is adjusted according to the specific individual and his or her reported opiate use, cravings, and withdrawal complaints. The physician will typically reduce the methadone dose if patients complain of intoxication or have missed three or more consecutive doses because tolerance to opioids may be reduced by placing patients at increased risk of overdose when methadone is reintroduced (College of Physicians and Surgeons of Ontario, 2011).

During the initial stages of treatment, daily contact with the pharmacy and weekly contact with the physician is an important therapeutic alliance for those beginning recovery. As patients gain stability (i.e. abstinence, housing, finance, mental health), patients can earn carry doses. Carry doses, otherwise known as take-home doses, are a privilege. The physicians determine the suitability or appropriateness of carry doses. The criteria for determining this are based on patient safety, community safety, and clinical stability. Thus, patients must be on a stable dose of methadone, have had no recent problematic drug or alcohol use, be compliant with treatment directives, have stable housing and emotional stability and good insight into carry safety issues.

Before patients get carry doses, they must sign a therapeutic carry agreement outlining that they take responsibility for legal expectations (e.g., filing a police report if doses are lost) and for storing the carry doses safely and securely in a locked box.

### **1.2.3. Accessing Treatment and Daily Life on MMT**

Public scepticism and myths about MMT persist and there is a stigma associated with methadone and people who receive MMT (Erdelyan & Young, 2009). A common misconception is that MMT perpetuates drug use and that methadone simply replaces one addiction for another (Registered Nurses Association of Ontario, 2009). Not only is there a lack of respect for the rights of the users, there are also problems with lack of treatment accessibility, which is one of the key global issues with respect to MMT (World Health Organization, 2008). Less than 650,000 people are thought to be receiving substitution treatment globally for opioid dependence, which is less than 10 percent of those in need of treatment (World Health Organization). According to Health Canada (2002), “current efforts to increase access to MMT are linked to continued concerns about the relatively low numbers of people who have access to MMT in Canada, as compared to other countries, such as Australia, that have emphasized methadone maintenance treatment as a key strategy for public health” (p. 19). As of July 2012, approximately 360 physicians in Ontario were prescribing methadone to approximately 38,025 patients for the treatment of opiate dependence (College of Physicians and Surgeons of Ontario, year). It has been estimated that only 25 percent of Canadian opioid-dependent patients are in MMT. Access is quite limited in certain provinces and in non-urban areas (Centre for Addiction and Mental Health, 2012).

Furthermore, people on MMT typically have to go to the clinic or pharmacy of choice every day to get their dose. Although not all pharmacies dispense methadone, patients can

choose from the ones that do. As previously mentioned, some people may continue to be on MMT for life, while others may be able to eventually discontinue. Given the time intensive nature of MMT, it is essential to examine its relationship to other occupations that form part of the patients' daily routines. The following section outlines the relevance and importance of using an occupational science perspective for critically exploring the daily lives of people on MMT.

### **1.3. Applying an Occupational Science Perspective to the Study of MMT Experiences**

This study adopts an occupational lens to develop an understanding of how people on MMT engage in everyday occupations. Grounded in the belief that humans are occupational beings, occupational science can be defined as “the study of the experiences and factors pertaining to human occupation” (Christansen & Townsend, 2010, p. 421). Occupational science provides an increasingly interdisciplinary perspective on occupation and its contribution to the health and well-being of individuals, communities, and societies. Occupation can be defined as self-initiated, self-organised activity, which is contextualised in a specific environment over a span of time (Helbig & McKay, 2003). Thus, understanding the relationship between occupation and health is a particular focus of occupational science along with the interaction of persons with their environments. For this study, the term occupation encompasses people's activities of daily living but also refers more broadly to “engagement or participation in a recognizable everyday life endeavor” (Christiansen & Townsend, 2010, p. 420). Engagement in personally meaningful occupations has been found to positively influence well-being as well as processes of being, becoming and belonging (Whalley Hammel, 2004). According to Wilcock (1998) a dynamic balance between doing and being is central to healthy living. Becoming is dependent on both doing and being and enables occupation. Belonging, connectedness, and interdependence inform the meanings attributed to and derived from the occupations of culturally diverse people

depending on their context (Whalley Hammell, 2014) as peoples' experiences of occupation are also shaped by their context (Christiansen & Townsend, 2010).

Limited literature exists that examines MMT from an occupational perspective. Previous research has however illustrated a complex relationship between addictions and occupation. Helbig and McKay (2003) examined the occupation-based literature to better understand addictive behaviours from an occupational perspective. They argued that addiction should be understood as occupational in nature. They found that some of the issues that may contribute to the cycle of addiction include occupational risk factors such as occupational deprivation, and alienation, both of which will be further described below. Likewise, Heuchemer and Josephsson (2006) argue that occupational imbalance is related to the narrowing repertoire of daily occupations that typifies addiction-related behavior. They explain that "an unhealthy balance of daily occupations may lead to an internal conflict between what people should do and what they want to do" (Heuchemer & Josephsson, 2006, p. 161). This can lead to feelings of self-deprivation, which could result in relapse and continuation of the cycle of addiction. Helbig and McKay (2003) also noted that other contributions to the addiction cycle include the nature of occupation, environmental influences, flow, and boredom. More specifically, with respect to recovery, they noted that "recovery oriented occupations need to provide the recovering addict with new roles, more satisfying and meaningful use of time, and opportunities for self-discovery" (Helbig & McKay, 2003, p. 143).

Similarly, Kiepek and Magalhães (2011) demonstrated that addictions should be considered occupational in nature. They conducted a literature review to determine if activities that are classified as 'addictions' and 'impulse-control disorders' are indeed occupations. They found that these activities give meaning to life, are shaped by environment, organize behaviour

patterns, and connect closely to identity (Kiepek & Magalhães, 2011). Their literature review and synthesis is the only publication in the Journal of Occupational Science that specifically discusses methadone, stating that for people on MMT “change in engagement is determined not only by the physiological effects of the activity on the body, but also by social, legal, and medical factors, as well as personal choices” (Kiepek & Magalhães, 2011, p. 264). MMT is an important and challenging transition that influences patients’ engagement in daily occupations. However, MMT has yet to be explored in depth from an occupational perspective. When Luck and Beagan (2015) explored the transition from smoking to non-smoking, they found that smoking cessation was described as cyclical. It required skill building and occupational competence to support occupational adaptation and engagement in meaningful occupations, and to overcome barriers and occupational losses throughout the transition process (Luck & Beagan, 2015). The current study will use an occupational perspective, specifically informed by the occupational justice framework (Stadnyk, Townsend, & Wilcock, 2010), to identify the challenges faced by patients on methadone as well as how they experience changes in routine and disruptions to occupations while in treatment.

Research in occupational science on the occupational foundations of human existence and on the principles of empowerment and justice sparked the creation of the concept of occupational justice. The concept was first developed to raise concerns about the unfairness of certain people succeeding in the things they do while others struggle living lives that put them at risk. Townsend (1996) initially proposed that practicing justice on a daily basis involved enabling and empowering through occupation. Subsequently, Townsend and Wilcock (2004) articulated that their interests in occupational justice were based on certain beliefs and principles that distinguished the concept of occupational justice from social justice. Occupational justice

offers a unique lens to examine both local and world struggles such as transportation or unemployment from an occupational perspective (Christiansen & Townsend, 2010). An occupational justice framework is thus, a critical approach that is consistent with examining the challenges for individuals on MMT as it is “a justice of difference that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social, class, or other differences” (Nilsson and Townsend, 2008, p. 57). It focuses on “meaningful and purposeful occupations that people want to do, need to do, and can do considering their personal and situational circumstances” (Stadnyk et al., 2010, p. 331). Occupational justice theorists argue that individuals have a unique set of occupational capacities, needs, and routines within the context of their environment. Since occupations are central to human existence, restrictions to participation in occupation can be conceived as a matter of injustice (Durocher, Gibson, & Rappolt, 2014). These restrictions or “occupational injustices are thus socially structured, socially formed conditions that give rise to stressful occupational experiences” (Stadnyk et al., 2010, p. 338).

Stadnyk et al.'s (2010) evolving theory of occupational justice, specifically the Framework for Occupational Justice will guide this study. This framework will be explained in further detail in chapter three. It outlines how structural and contextual factors contribute to occupational justice or injustice. The framework outlines one way of visualizing the relationships between factors impacting occupational justice. According to Stadnyk et al. (2010), there are four overlapping and compounding forms of social exclusion and related occupational rights that influence occupational justice or injustice. Firstly, they referred to occupational alienation as restricting a population from experiencing meaningful and enriching occupations. Secondly, occupational deprivation was defined by Stadnyk et al. (2010) as restricting a population in



diverse contexts such as prisons or care facilities from participating in occupations that would promote their health and well-being. Thirdly, Stadnyk et al. (2010) explained that occupational marginalization restricts a population from experiencing autonomy through lack of choice in occupations. Lastly, occupational imbalance, as previously discussed, restricts a population so that some people have too little to do on a daily basis while others have too much as compared to everyone participating in a range of occupations that promote health and well-being.

According to Kiepek and Magalhães (2011), there is a need for research studies on addiction that integrate scientific inquiry and personal experience, particularly ones that apply qualitative approaches. Helbig and McKay (2003) have also said that occupational science could “help the development of new ideas to improve the health and well-being of individuals, and society as a whole, where lives are impacted by drug and alcohol misuse” (p. 141). The current study contributes to the knowledge base of occupational science by exploring the daily lives of people on MMT. Using an occupational perspective that considers people’s engagement in daily occupations as related to processes of being, becoming and belonging (Whalley Hammel, 2004) will also inform the knowledge base on MMT. It can help better understand how barriers to engagement in daily occupations whilst managing MMT may negatively influence well-being. It can also help to better understand how “people recovering from addictions may redefine the meanings attached to their time use when it is no longer centred on substance use” (Luck & Beagan, 2015, p. 184). I will apply these occupational justice related concepts to a population that has not yet been studied in the occupational science literature. The objectives of the current study are described in the following section.

#### **1.4. Study Purpose/Objectives**

The purpose of this research, conducted using an intrinsic case study methodology (Stake, 1995), was to generate knowledge and raise insight with regards to the disparities, challenges of, and barriers to accessing MMT and carrying out daily routines experienced by individuals while on MMT. The objectives of this study were to: i) describe the challenges and disparities experienced in the everyday occupational lives of methadone patients, ii) map the daily lives of MMT patients and examine the ways in which these individuals orchestrate the use of their time, and iii) examine the routines, spaces, and interactions characterizing the everyday occupational lives of individuals on MMT. These goals were achieved by collecting qualitative data with five participants recruited from a methadone clinic in London, Ontario.

#### **1.5. Self as a Researcher**

In this section I introduce myself and elaborate on my interest in this topic. Further reflection upon my role as researcher in this study is included in section 3.6 of the methodology chapter and section 5.3 of the final chapter.

I am a Master of Science student in Health and Rehabilitation Sciences in the field of Occupational Science. I received my Bachelor of Arts from Brock University in Honours Child and Youth Studies. I also completed courses for the Addiction Certificate program at McMaster University. My research interests include mental health, addiction, and MMT, which stemmed from my time working as a laboratory technician at a methadone clinic.

My experience working with people on MMT involved laboratory duties including checking in patients, collecting urine samples, supervising the collection process, and analyzing urine samples. I was also responsible for administrative tasks such as filing CPSO registration, and inputting profile data on the patient database, which could be used by the clinic for future

research initiatives or clinical data components. In addition, I conducted patient intakes alongside the nurse. My experiences at the clinic sparked my interest in this particular population. During my time there I began to wonder how clients not only access MMT but also carry out their daily routines when they have to go to the pharmacy on a daily basis and to the clinic once a week. I oftentimes put myself in their shoes and thought about how I would be able to engage in other occupations if I was on MMT.

When I started my Master's, I knew that I wanted to do my research on something involving people on MMT. After countless discussions with my supervisory committee, it became clear that those daily routines and challenges to accessing MMT should be the focus of my research. During my time at Western I worked as a Research Assistant on a scoping review of the policies and evidence literature on the work transitions of youth with disabilities enrolled in post-secondary education. This opportunity allowed me to learn the research process involved in the scoping review approach. I was then able to conduct my own scoping review on the daily lives of people on MMT, which is presented in chapter two. Upon completion of this I realized that limited qualitative research exists regarding the daily lives and experiences of people on MMT. Furthermore, I was unable to locate research on MMT that has been framed from an occupational perspective. This reaffirmed my research topic and motivated me to conduct my Master's research critically exploring the challenges and barriers to daily routines and MMT access faced by people on methadone. My identity and my previous experience have influenced my engagement in this research. Thus, this brief description of myself should be kept in mind while reading this thesis since a researcher's positionality is fundamental in qualitative research. My position affected the overall research process including the setting and people being studied, questions being asked, data being collected and its interpretation as well as the overall outcome

(Berger, 2015). My experience working at this specific clinic lead me to conduct my research there. It also shaped the questions that I asked as I had previous experience witnessing the daily struggles and challenges faced by people on the program. Had I not had these experiences, I might have asked very different questions or might not have been as concerned about the occupational aspects faced by this population. An example of how my positionality influenced the research process was that I was familiar with one of the participant's stories as she was a methadone advocate. The following chapters comprising this thesis are outlined in the next and final section of this introductory chapter.

## **1.6. Thesis Outline**

As noted above, chapter two presents a scoping review of the qualitative literature on the daily lives of people on MMT. In this chapter the scoping review methodology is outlined and the key findings identified through the review process are presented. Chapter three outlines the research methodology. This includes the study's ontological and epistemological positioning, the study design, the methods of data collection, management and analysis, ethical considerations, and quality criteria. Chapter four begins with an introduction of each of the participants followed by a description and interpretation of participants' occupational maps. It then presents the findings from the analysis of the data collected from the study. Finally, chapter five consists of a discussion of the study findings in relation to the concept of occupational justice. I then return to my reflection as the study researcher. Lastly, I discuss the study limitations, future research directions, and end with the final conclusions of this research.

## **Chapter Two – Literature Review**

### **2.1. Introduction**

As discussed in the introductory chapter, this study aims to better understand the daily lives and experiences of people on MMT. Thus, this chapter provides a review of the current literature on the daily lives of people on MMT. A scoping review approach was conducted using Arksey and O'Malley's (2005) framework. Scoping reviews aim to rapidly map the key concepts underpinning a research area and the main sources and types of evidence available (Arksey & O'Malley, 2005). This approach helped to identify the breadth and nature of current knowledge and gain greater conceptual clarity about my specific topic. A scoping review was the most appropriate method as MMT is a complex area that, to my knowledge, has not yet been reviewed comprehensively.

The purpose of this scoping review was to identify, synthesize, and examine the literature presenting qualitative evidence regarding the daily lives of people on MMT. The goal was to identify what is known about their routines, draw conclusions, and identify gaps within the current literature. This chapter outlines the scoping review methodology adopted as well as the key findings identified through the review process. Three themes were identified across the literature: 1) stigma, 2) self-concept and identity, and 3) personal relationships. The articles included in this scoping review are listed in Appendix A. Gaps in the literature are also discussed. This chapter concludes with an explanation of how the current study will advance the understanding of the daily lives of people on MMT from an occupational perspective.

### **2.2. Literature Review Methodology**

Arksey and O'Malley's (2005) framework was used to enact the scoping review methodology. The authors explain that a scoping review aims to synthesize, analyze, and map

key concepts in a particular field of interest and to identify gaps within the existing literature. By doing this, conclusions are drawn from existing literature regarding the overall state of research activity and evidence. As opposed to systematic reviews, scoping reviews do not typically include a critical appraisal of the quality of included studies (Arksey, & O'Malley, 2005). Rather, scoping reviews summarize a range of evidence in order to convey the breadth and depth of a field (Levac, Colquhoun, & O'Brien, 2010). Arksey and O'Malley's (2005) five-stage framework for conducting a scoping review entails: 1) identifying the research questions, 2) locating relevant studies, 3) selecting studies, 4) charting the data, and 5) collating, summarizing, and reporting the results. Each of these stages is further described below.

### **2.2.1. Stage 1: Identifying the Research Questions**

This review aimed to examine the scope of the qualitative research literature on the experiences and daily lives of people on MMT. A secondary aim was to identify gaps and new areas for research needed to inform policy and practice. The specific questions guiding this scoping review were:

- 1) What is the scope of the qualitative research literature relevant to the daily lived experience of being on MMT?
  - a. Who researches MMT experiences?
  - b. What kind of research is being conducted?
  - c. What aspects of the lived experience of people on MMT are known?
- 2) What do we know about the way people on MMT manage their daily needs and daily life?

### 2.2.2. Stages 2 and 3: Selection and Identification of Relevant Studies

The six following databases were used in the literature search for relevant articles on the topic of daily lives and experiences for people on MMT: Pubmed, CINAHL, Scopus, Embase, PsychInfo, and Sociological Abstracts. These databases were searched for English language articles published between 1990 and 2014. Qualitative studies were specifically sought as those are more relevant to my objectives of exploring the daily lives and experiences of people on MMT. The year 1990 was chosen as the start of the timeline as there were significant changes regarding the administration of MMT in Canada around the mid-1990s. Initial searches were conducted in consultation with my research supervisors and a research resource librarian at the University of Western Ontario who assisted in determining the most appropriate search terms, search strategies, and databases to use. Search terms (Table 2.1) were developed for each category of interest (i.e. methadone, experience, patient, treatment) and each search term was combined using Boolean operator 'OR'. Each column of search terms was combined using Boolean operator 'AND'.

**Table 2.1. Search terms**

methadone	qualitative experience lifestyle perspective life	patient addict user	treatment therapy maintenance program
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Title, abstract and relevancy screening criteria were used to identify articles important to the focal questions. Articles generated through the search were entered into DistillerSR and all duplicates were removed. Title screening was completed first followed by abstract screening of relevant articles. For title screening, the article was included if it studied people on MMT. For abstract screening, the article was included if it addressed methadone clients, daily life, and

experiences related to people on MMT. While I was the only rater who completed title screening, two raters, myself and a nurse from a MMT clinic, independently reviewed the abstracts for inclusion in order to ensure consensus and consistency. Abstracts were reviewed when relevance was unidentifiable from the title. Any discrepancies or uncertainties in the inclusion or exclusion of articles were discussed and resolved amongst myself and the nurse. In order to do so, we revisited the inclusion and exclusion criteria and guidelines for determining whether or not the articles should be included.

Final selection criteria used a relevancy scale. Studies were included in this review if the daily lives and experiences of people on MMT were discussed within the article. The relevancy criteria scale (Table 2.2.) ranged from 1 (not relevant) to 4 (very relevant).

**Table 2.2. Relevancy criteria**

<p>4. <b>very relevant:</b> research that is a QUALITATIVE STUDY of the management of daily lives and experiences of people on Methadone Maintenance Treatment (or opiate replacement therapy, opiate substitution therapy)</p> <p>3. <b>fairly relevant:</b> research that is a QUALITATIVE OR MIXED METHODS study that explicitly focuses predominantly on the treatment process and the treatment experience and to a lesser extent on daily living</p> <p>2. <b>moderately relevant:</b> BOOK CHAPTER or a DESCRIPTIVE ARTICLE or GENERAL LITERATURE REVIEW with a focus on people on or providers of Methadone Maintenance Therapy</p> <p>1. <b>not relevant:</b> quantitative study, conference proceeding or editorial of commentaries, or a qualitative study about methadone dosing, pharmacokinetics, buprenorphine maintenance treatment or heroin maintenance treatment</p>
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The rating scale was applied to articles once the rater read the full article. Studies that were qualitative and examined management of the daily lives and experiences of people on MMT were rated a four and included in this review. These studies were considered to be the most coherent with the research questions (Arksey & O'Malley, 2005). In accordance with



Arksey and O'Malley's (2005) framework, all relevant research articles on the selected topic were included in the review regardless of research quality (Arksey & O'Malley, 2005).

A total of 5809 studies were obtained from the six databases. Of these 5809, 981 duplicates were excluded. After title screening, 3649 were excluded. Subsequently, 1098 abstracts did not address daily lives or experiences of MMT patients and thus were excluded from the review. After the rating scale was applied to each article 68 more were determined to be excluded. A total of 12 articles achieved a rating of 4 and were included in the scoping review.

### **2.2.3. Stage 4 and 5: Data Extraction and Summarizing Results**

A Microsoft Excel spreadsheet was used to categorize and organize the data extracted from the twelve relevant articles. Information on each paper's authors, year of publication, journal of publication, country where study was conducted, purpose, study methodology and methods, whose perspective was presented and key findings were entered into the spreadsheet. According to Arksey and O'Malley (2005), this organizational strategy is useful in categorizing similar studies to allow for descriptive analysis of the articles such as frequencies of categories and cross referencing of common themes. Qualitative thematic analysis was then conducted using the information gathered from each article.

### **2.3. Results of the Scoping Review**

For the twelve articles, the year of publication ranged from 1998 to 2013. The studies were conducted in the United States (3), Canada (3), the United Kingdom (3), Australia (2), and Ireland (1). The included studies spanned ten different journals. Two articles were from Substance Use and Misuse, two were from Drugs: Education, Prevention and Policy. The remaining eight articles were from: Medical Anthropology, Journal of Social Work Practice, Journal of Gerontological Social Work, Social Science and Medicine, Sociological Forum,

International Journal of Mental Health and Addiction, International Journal of Nursing Studies, and Harm Reduction Journal.

In terms of methodology, articles mainly consisted of grounded theory approaches (N=3). Other articles used phenomenology, ethnography, and narrative inquiry. Various recruitment strategies were used such as contact from previous study or via medical records, as well as advertising through posters, letters, word of mouth, doctor's offices, and medical professionals. The majority of the studies recruited only MMT clients (N=8). Two of the studies sampled older people on MMT and two of the studies sampled both MMT patients and healthcare providers. All twelve of the studies used semi-structured interviews. One study also used focus group interviews, and naturalistic observation in addition to interviews. Specific data extracted from each article can be found in Appendix A.

Throughout the process of charting, summarizing, and collating the findings, recurring themes emerged across the twelve articles. These themes reflected factors that were identified as either impeding or facilitating everyday life during the participants' time on MMT. These themes overlapped and were interwoven throughout all twelve of the articles. The three main themes that were found to dominate the qualitative research literature were stigma, self-concept and identity, and personal relationships.

### **2.3.1. Stigma**

Stigma was found to be one of the most discussed aspects of, and barriers to daily life for people on MMT. Anstice, Strike, and Brands (2009) define the process of stigma as "occurring when a person is labeled, e.g., as a drug addict, in a way that links him or her to negative stereotypes, e.g., of criminality" (p. 795). Through exploration of opiate-dependent individuals' perceptions of and methadone's impact on a good quality of life, De Maeyer et al.'s (2011) study

found that stigmatisation, discrimination, and dependence on methadone as well as the drug's paralysing effects on their emotions contributed negatively to their quality of life. In addition, Conner and Rosen (2008) examined the existence and experiences of stigma in a sample of older adult MMT clients. They found that these MMT clients experienced eight distinct stigmas including drug addiction, aging, taking psychotropic medication, depression, being on MMT, poverty, race, and HIV status. They also found that "respondents who experienced multiple stigmas (three or more) simultaneously reported more negative attitudes about treatment and identified their stigmatizing experiences as further barriers to their treatment-seeking behaviors" (Conner & Rosen, 2008, p. 258).

Likewise, Earnshaw, Smith, and Copenhaver (2013) conducted a study with 12 people receiving MMT at an inner-city methadone treatment site in the Northeastern United States to better understand how drug addiction stigma is experienced among MMT patients and who they are experiencing it from. The results showed that there is prejudice, stereotyping, and discrimination from friends, family, coworkers, employers, and healthcare providers. Similarly, Anstice et al. (2009) found that clients' accounts of supervised methadone consumption were interwoven with their experiences of feeling stigmatized as an MMT client. They found that there is stigma related to accessing services, relationships with staff, and attributes of the dispensing space. Participants in this study noted that they were "patronized, treated with suspicion, and made to wait unnecessarily" (Anstice et al., 2009, p. 800). This barrier of stigma added a number of other challenges and stressors in addition to having trouble making it to the clinic on time, arranging transportation, among other activities.

The routine of supervised consumption of methadone was explored by Radcliffe and Stevens (2008) who found that the routine itself is "seen by some as stigmatising and was also

seen as hindering progress to the desired ‘normal’ life of conventional employment” (p. 1065). Anstice et al. (2009) concluded that reducing stigmatizing experiences may improve MMT outcomes and decrease barriers to treatment. Gourlay, Ricciardelli, and Ridge (2005) examined how different personal and social resources related to participants’ use of both heroin and methadone by conducting in-depth interviews with ten participants between the ages of 25 and 42. According to Gourlay et al. (2005), a higher level of personal and social resources can assist functional types to better cope with the stigma associated with methadone use. Those who were described as functional tended to talk about their heroin and methadone use in ways that minimized it as a stigma and normalized drug use (Gourlay, Ricciardelli, & Ridge, 2005). Interestingly, the stigma associated with MMT can also exist within the MMT client themselves. Neale’s (2008) study found that clients had a preconceived notion that methadone would present similar or worse problems than the heroin or morphine that they were currently using. Overall, stigma is widely discussed throughout the literature and experienced by people in MMT. It is evident that “stigmatization is a powerful force that often interferes with access to MMT” (Smye et al., 2011). The following section will examine the second theme of identity and self-concept.

### **2.3.2. Identity and Self-Concept**

Findings within the twelve articles highlighted ways in which one’s sense of identity or self-concept is important and oftentimes transforms throughout the recovery process as individuals deal with a variety of issues that may include emotional disturbances, relationship turmoil or growth, or career changes. Radcliffe and Stevens (2008) conducted qualitative interviews with 53 people who had problematic issues with drug use but who had dropped out of treatment. Their aim was to explore how the participants described the stigmatisation of drug users and drug services. They found that some drug users carefully manage information about

their discreditable identities by excluding themselves from this category, while acknowledging its validity for other drug users. In other words, some avoided identifying themselves as a ‘junkie’ because it was generally seen as shameful, while others were attracted to this label. The researchers noted that “although several of the respondents interviewed reported the fear of being seen using drug treatment services as a barrier to continuing treatment, they may also have been ashamed to see themselves using such services” (Radcliffe & Stevens, 2008, p. 1069).

Likewise, Gourlay, Ricciardelli, and Ridge (2005) found that participants with a positive self-concept oftentimes had higher levels of resources and supportive social relationships. These positive and functional types also had ‘realistic’ expectations and perceived significant benefits of MMT. Conversely, those with limited resources, social disconnectedness, and a negative self-concept tended to be “conflicted” users. For these ‘unrealistic’ drug users, the harms of MMT were perceived to outweigh the benefits (Gourlay et al., 2005). The researchers concluded that “methadone treatment from the users’ perspective may be more beneficial if users have access to resources, opportunities for personal development, experiences that support positive, ‘non-addict’ or ‘functional’ self-concepts” (Gourlay et al., 2005, p. 1879).

Anstice, Stike, and Brands (2009) analyzed MMT clients’ experiences of supervised methadone consumption. They found that some dispensing contexts helped MMT users manage a stigmatized identity (i.e. passing as ‘normal’ in public) while in other situations the dispensing context made them visible as MMT clients. In another study, Järvinen and Miller (2010) analyzed the MMT program’s implications for patients’ sense of agency and constraint as well as their orientation toward past, present, and future. According to them, the program increases participants’ sense of stability by providing them with methadone which allows them to better address their economic, housing and other daily needs. At the same time, MMT also represents a

context of physical, emotional, and social dependence (Järvinen & Miller, 2010). This dependence and reliance on MMT can have implications for their sense of agency as well as their self-esteem, claiming that “participants’ interpretations of their lives as hopeless and never changing contributed to their sense of inferiority, marginalization, and nonbecoming” (Järvinen & Miller, 2010, p. 821). Overall, identity and self-concept were found to change as participants continued to recover from their addictions. In the next section, the third and final theme of personal relationships is explored.

### **2.3.2. Personal Relationships**

Personal relationships with both family and friends were found by many authors to be important, especially during the recovery process. Family in particular played an important role in maintaining and facilitating treatment. Higgs, Jordens, Maher and Dunlop (2009) conducted a study using grounded theory with 20 ethnic Vietnamese heroin users to examine their perspective of the specific role that family had in treatment. They found that family was a key mediator and could be a source of motivation, grounding, and connectedness. Higgs et al. (2009) contend that people on MMT and in general are typically concerned about what their loved ones think and say. Likewise, Neale (1998) investigated the views and experiences of 80 drug users who were on MMT. Findings from this study indicated that service users were concerned about and often prioritized the impact of methadone on their relationships with both partners and family members as well as their physical and emotional resources, financial circumstances, and health. Many participants highlighted how “improved personal relationships mainly resulted because methadone made drug users more stable and less argumentative” (Neale, 1998, p. 40). In addition, De Maeyer et al. (2011) found that “being integrated to and supported in society, or

even only in their immediate environment, had a positive impact on their quality of life (QoL), including feelings of acceptance and respect” (p. 1249).

Similarly, Gourlay et al. (2005), as previously discussed, found that those who have supportive social relationships are better able to cope with the stigma associated with methadone use. The researchers highlighted that relationships with service providers were also found to be important to people on MMT as they see them on a regular basis. Anstice et al. (2009) found that MMT clients valued pharmacists and dispensing staff who were respectful, discreet, and accommodating. Moreover, according to Ning’s (2005) ethnographic interviews with both clients and staff at a methadone clinic in Toronto, these relationships between service providers and service users are quite complex, as are the service users relationships with each other. They also noted that gossip permeates everyday routines for MMT clients (Ning, 2005). An additional challenge noted for all clients was being in an environment where drugs were oftentimes easily accessible (Higgs et al., 2009).

A common finding in the qualitative evidence from this review was that relationships with friends, family, or health care providers can also have negative and damaging effects. For example, Anstice et al. (2009) found that negative accounts of interactions with pharmacists and dispensing staff tended to focus on feelings of discrimination. Another study by Smye, Browne, Varcoe, and Josewski (2011), used ethnographic methods including interviews and focus groups with 39 Aboriginal MMT clients as well as 24 Aboriginal and non-Aboriginal healthcare providers. They examined how harm reduction and MMT are experienced differently by people depending on how they are positioned and also found that “many participants expressed mistrust with the healthcare system due to everyday experiences both within and outside the system that further marginalize them” (p. 1).

On a similar note, Higgs et al. (2009) found that family relationships can be alienating and fragmenting. These findings are in line with Smith and Rosen (2009) who explored the barriers to the use, maintenance, and expansion of social supports in older methadone clients. They found that difficult personal relationships along with past traumatic experiences lead to lack of trust. As a result of this mistrust, “a process of self-isolating emerged in which individuals, to protect themselves from further harm, would not pursue opportunities to interact with other people” (Smith & Rosen, 2009, p. 663). A lack of trust was identified as a principal barrier to the use, maintenance, and expansion of the social supports of older adult methadone clients (Smith & Rosen, 2009).

#### **2.4. Discussion**

The existing research on the experiences of methadone patients focuses on stigma, identity and self-concepts, as well as personal relationships. There are limited qualitative studies examining the significant impacts of MMT on the daily lives of methadone patients and the way they orchestrate or go about planning their daily routines and engage in daily activities and occupations. There is limited knowledge about how MMT changes people’s routines and what their daily lives are like while using MMT.

Overall, the literature lacks a critical examination of the specific occupational implications of MMT for patients. Some studies do address paid work and explain how a decrease in symptoms enables “regular” occupations, but the literature fails to explain what the daily lives and routines of people on MMT encompass. Domains of occupation that were discussed include work, family, social network, and living situation. Additional occupations that were not discussed include more tacit and mundane activities such as grocery shopping, doing laundry, or taking the bus. Given the importance of occupation in people’s lives, these issues



must be further explored. Thus, findings from my study will highlight the challenges and barriers to accessing MMT as well as how MMT affects individuals' occupations, routines, and time management. Using an occupational perspective, as described in chapter one, will inform this knowledge base and further understanding of the challenges faced by patients on MMT to enhance the ability of treatment providers, service organizations, families, policy makers, and broader society to support these individuals in the recovery process.

## **2.4. Conclusion**

In summary, the literature reviewed in this chapter makes evident the gap in research concerning the occupational implications of people's experiences on MMT. There is limited qualitative research regarding the daily lives and experiences of people on MMT. Existing qualitative literature indicates that MMT clients experience various issues with stigma, self-concept and identity, and personal and family relationships. The significant impacts of MMT on the daily lives and routines of methadone patients have yet to be explored. We have minimal knowledge and understanding about how MMT changes peoples' routines and what their daily lives are like. What we do know is that personal and social support, guidance, and resources are crucial to help this population overcome and avoid the hurdles and restrictions that can arise during MMT. Findings suggest the need for future research of the significant impacts of MMT on the daily lives and routines of methadone patients. According to De Maeyer et al. (2011), "opiate-dependent individuals must be supported in their daily lives by means of practical, social and environmental support, alongside pharmacological treatment, in order to achieve a general feeling of satisfaction" (p. 1254-1255). Studies should explore the challenges, disparities and barriers faced on a daily basis by people on MMT. Therefore, my study aimed to better understand the daily lives and experiences of people on MMT through in-depth exploration of

their everyday occupations and the challenges and barriers they faced to accessing treatment. In the next chapter on methodology, my paradigmatic positioning, methodological approach, methods used, and ethical and quality considerations are described.

## **Chapter Three – Methodology and Methods**

### **3.1. Introduction**

In this chapter, I introduce the study's ontological and epistemological positioning and the study's methodological design and guiding conceptual framework. The methods used are then presented. This includes a description of the boundary setting and participant recruitment, a description of the study site, and data collection methods including semi-structured interviews, occupational mapping, and demographic questionnaires. Data management as well as data analysis are then described. I conclude this chapter with a discussion of ethical considerations and quality criteria. An occupational science perspective informed this research, which aimed to understand the disparities, challenges of, and barriers to accessing MMT and carrying out daily routines while on MMT.

### **3.2. Study Design**

The study design includes my paradigmatic positioning, the occupational justice framework used to guide this study, and the methodological approach adopted. A description and explanation of each of these is included below.

#### **3.2.1. Paradigmatic Positioning**

This study employed a case study methodology situated in a critical theory paradigm as the goal of this qualitative research was to critically examine, raise awareness, and reveal the inequities, tensions, and disparities faced by people on MMT on a daily basis. According to Yin (2003), case study research can be carried out within diverse paradigms. Researchers must examine what their paradigmatic positioning is and apply it to their particular case study (Yin, 2003). Thus, case studies may "adopt a critical position, exposing oppression and driving social change" (Jones & Hocking, 2015, p. 121). Critical theory is concerned with unequal distributions of power and the oppression that results from those distributions (Ponterotto, 2005).

My adoption of a critical theory paradigm location for this study was informed by my particular ontological and epistemological positioning. Ontologically, critical theory is characterized by historical realism, which means that reality is shaped over time by social, political, cultural, economic, and other factors. These factors, though they are historically constructed, become crystallized and are eventually considered to be real or ‘taken for granted’ (Guba & Lincoln, 1994). In my research, the policies and practices of the MMT program in particular were analyzed to identify their influences on the daily lives of people on MMT. The critical theory paradigm was the best fit for addressing my study purpose and research questions.

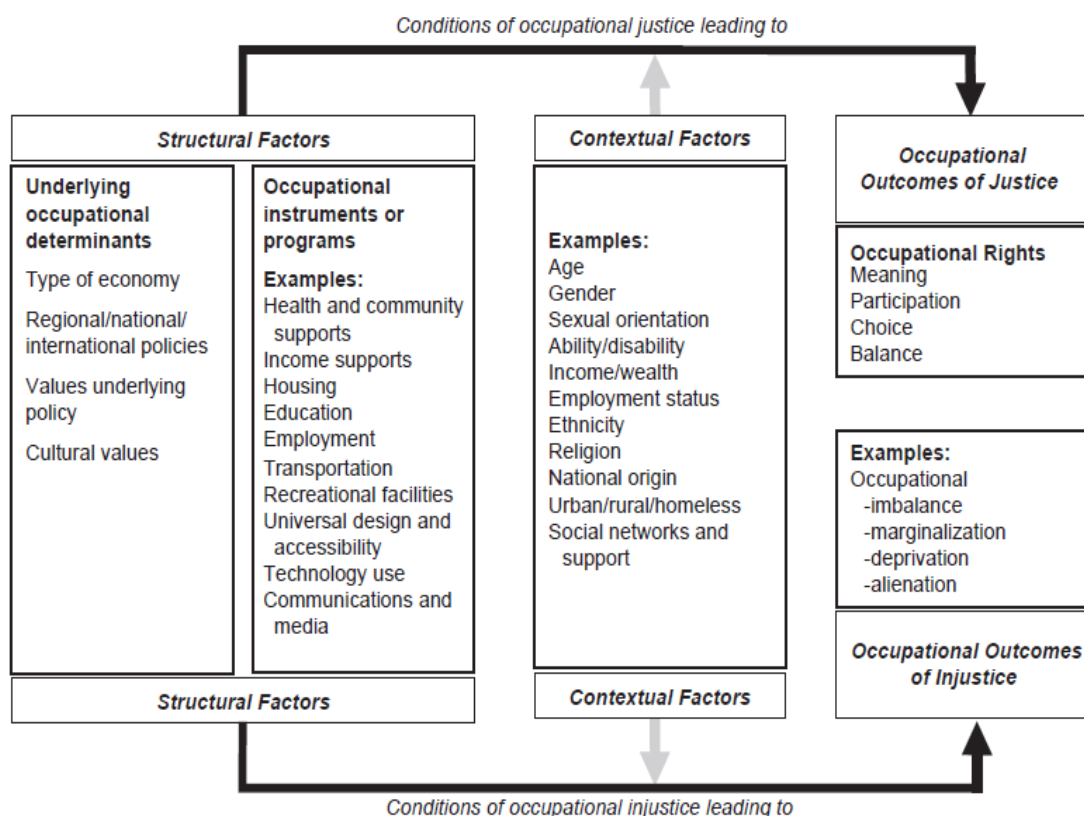
Epistemologically, critical theory is both transactional and subjectivist meaning that “the investigator and the investigated object are assumed to be interactively linked, with the values of the investigator...inevitably influencing the inquiry” (Guba & Lincoln, 1994, p. 110). In critical research, the researcher’s values are central to the task, purpose, and methods of the research (Ponterotto, 2005). The research goal is both dialogic and dialectic (transformative) as the transactional nature of inquiry requires a dialogue between the investigator and the subjects of inquiry (Guba & Lincoln, 1994). In keeping with critical inquiry, as a researcher I sought to learn from the participants so that I can raise awareness about the difficulties and barriers experienced by people on MMT in order to recognize and challenge the injustices they face in society on an everyday basis.

For critical theorists, the goal is to indirectly empower the participants, in this case people on MMT, by “uncovering those forms of subjugated knowledge that point to experiences of suffering, conflict, and collective struggle” (Guba & Lincoln, 1994, p. 110). Through conscious raising people become empowered to engage in making changes or become transformed. By identifying and exploring the taken-for-granted occupations of people on MMT, I aimed to

reveal social and economic processes that contribute to their daily lives. This is referred to as problematizing and is central to any critical theoretical approach (Carpenter & Suto, 2008). By framing this research within a critical lens, in this study I seek to advance the field of occupational science by exploring how people on MMT access treatment and how they carry out everyday occupations, a topic that has not yet been specifically examined from an occupational perspective. Given the issues discussed in section 2.3, such as experiences of stigma, this study is well suited to a critical theoretical approach. Stadnyk et al.'s (2010) framework of occupational injustice and Townsend and Wilcock's (2004) Exploratory Theory of Occupational Justice informed this study. The following section will further describe this framework.

### **3.2.2 Occupational Justice Framework**

As previously mentioned in section 1.3 of chapter one, occupational justice refers to "justice related to opportunities and resources required for occupational participation sufficient to satisfy personal needs and full citizenship" (Stadnyk, Townsend, & Wilcock, 2010, p. 421). Townsend's (2012) article includes the Exploratory Theory of Occupational Justice framework, which stems from Stadnyk et al.'s (2010) original. For an overview of the framework, refer to Figure 3.1.



**Figure 3.1: Framework for Occupational Justice (Townsend, 2012, p. 13)**

This framework illustrates how structural factors combined with contextual factors lead to situations of occupational justice or injustice, which in turn result in occupational outcomes (Durocher, Gibson, & Rappolt, 2014). Structural factors include underlying occupational determinants "such as the type of economy, national and international policies, policy values, and cultural values" (Stadnyk, Townsend, & Wilcock, 2010, p. 336). Occupational determinants are operationalized in occupational forms that are a second set of structural factors. Occupational forms can influence aspects of society and are either inhibited or enhanced by occupational determinants. Some examples of occupational forms are health and community supports, housing, education, and employment. Contextual factors can be defined as "individual, group, or community characteristic that mediate the effect of occupational determinants and forms on outcomes" (Stadnyk, Townsend, & Wilcock, 2010, p. 337). These structural factors are thus

experienced differently by different people depending on their personal contextual circumstances or situation. The examples listed in the columns are not exhaustive and other contextual factors also exist.

Occupational outcomes may be positive or negative (Durocher, Gibson, & Rappolt, 2014) and include occupational rights and injustices. The authors suggest that there are four occupational rights: the right to experience occupation as meaningful, the right to develop through participation in occupations, the right to have a choice in occupations, and the right to benefit from fair privileges for diverse participation in occupations (i.e., balance) (Stadnyk, Townsend, & Wilcock, 2010). If occupational rights are respected, occupational justice is enabled and individuals have the opportunity to participate in meaningful occupations. However, when participation in occupation is hindered because of structural and contextual factors, occupational rights are violated and occupational injustice may arise (Durocher, Gibson, & Rappolt, 2014). Occupational injustice can also result in four overlapping compounding forms of social exclusion. These are occupational alienation, occupational deprivation, occupational marginalization, and occupational imbalance. These concepts were discussed in section 1.3 of chapter one.

Occupational justice is grounded in the beliefs that humans are occupational beings, humans participate in occupations as autonomous agents, that occupational participation is interdependent and contextual, and that it is a determinant of health and quality of life. The principles in this theory outline empowerment through occupation, an inclusive classification of occupations, the enablement of occupational potential, and diversity, inclusion, and shared advantage in occupational participation. The methodology used in the current study will be discussed in the next section.

### **3.2.3. Methodology**

My ontological and epistemological positioning as well as my selected occupational justice framework informed the choice of adopting a critical case study methodology. A case study approach allows for the exploration and description of complex phenomena within their contexts using a variety of data sources (Baxter & Jack, 2008). In the current study I used interviews along with occupational maps and demographics questionnaires. This ensures that the issue is not explored simply through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be understood. Case study methodology can be applied to a diverse range of fields, and is well suited to occupational science as it is concerned with the real-life doings of humans in context (Jones & Hocking, 2015).

According to Yin (2003), a case study design should be considered when the focus of the study is to answer "how" and "why" questions. Case studies are also useful when the researcher wants to cover contextual conditions because they are believed to be relevant to the phenomenon being studied. My research asks how people on MMT access treatment and how they carry out their daily routines while on the program. Therefore, the decision to use a case study approach fit with the aims of the methodology.

The next consideration in case study research is what type of case study will be conducted. Given my interest in the daily lives of people on MMT, I conducted what Stake (1995) categorizes as an intrinsic case study. This particular type of case study is described as being well suited to studying a unique subject matter where the results have limited transferability, but where researchers have a genuine interest in better understanding the case (Baxter & Jack, 2008). I used a holistic, single case design focused on a single group of MMT



patients recruited from one environment (the MMT clinic) in order to focus on their unique situation (daily living on MMT).

The case study approach "provides a means of exploring the particulars of occupations, at the same time as they are bound together as a whole within the contexts in which people go about their everyday lives" (Jones & Hocking, 2015, p. 118). Therefore it is an appropriate qualitative methodology to adopt for this particular study that is situated within occupational science. The methods used in the current study are described in the following section.

### **3.3. Methods**

Critical research employs dialogic methods and approaches that foster conversation (Guba & Lincoln, 1994). According to Jones and Hocking (2015), before data collection begins in case study research, a project management plan should be developed that includes conceptual structure and ethics approval. Ethical considerations will be discussed in section 3.6. The plan also specifies recruitment processes, participant contact details, as well as sequencing of data collection sessions. The boundary setting and participant recruitment for this study are first described below, followed by an outline of the study site and data collection methods.

#### **3.3.1. Boundary setting and participant recruitment**

For this qualitative study, I aimed to recruit a range of five to ten participants. This range was determined by my supervisor and myself. According to Sandelowski (1995a), "an adequate sample size in qualitative research is one that permits-by virtue of not being too large - the deep, case-oriented analysis that is a hallmark of all qualitative inquiry, and that results in - by virtue of not being too small - a new and richly textured understanding of experience" (p. 183). To be included in the study, participants had to:

- 1) be at least 18 years of age or older,

- 2) be English-speaking and able to participate in an interview in English,
- 3) have been on MMT consistently for at least one year to ensure that they could adequately discuss their experiences and the challenges they face while being in this program.

People under the age of 18 were specifically excluded from this study as they are not usually considered for MMT since they need to have documentation that past treatment has failed, opinions from two MMT physicians as well as parental consent (The College of Physicians and Surgeons of Ontario, 2011). Participants were recruited through one of the methadone clinics in London, Ontario (further described in the next sub-section). The city of London, with a population of 366,191 (Statistics Canada, 2011), was selected due to its growing substance abuse rates. According to the City of London (2007), 7 in 33 Londoners used an illicit drug, such as cocaine, ecstasy or methamphetamine. Despite the high number of individuals throughout the city in need, treatment services are highly concentrated in the downtown area, making it difficult for those in the surrounding neighbourhoods to access (Western Journalism, 2011). Yet, substance abuse is not a ‘downtown problem’, nor is it limited to those experiencing poverty or homelessness (City of London, 2012). The clinic that assisted with participant recruitment is located just outside the downtown core and was selected as the main study site based on access and personal connection to, and willingness from the service providers at this site. I work at this clinic as a laboratory technician.

Following approval from the university’s research ethics board, advertisements were posted and distributed throughout the clinic (Appendix B). The gatekeepers at the clinic identified potential participants and provided them with a letter of information (Appendix C). If interested, individuals contacted the researcher via the contact information on the letter of

information. The majority of participants contacted the thesis supervisor by phone rather than email. Potential participants were informed that their decision to participate or not would in no way affect their treatment at the clinic or any other clinic.

This qualitative case study aimed at a depth, rather than a breadth of understanding. Purposeful sampling was used to recruit participants with different socio-demographic characteristics and drug use profiles. According to Baxter and Susan (2008) researchers need to ensure that they applied purposive sampling strategies that are appropriate for their case study. Maximum variation is a frequently employed form of purposeful sampling in qualitative research (Sandelowski, 1995a). Maximum variation, specifically demographic variation (e.g. gender), was achieved by seeking cases that maximize a range of perspectives and differences (Sandelowski, 1995a). The final sample consisted of five adults, between the ages of 27 and 42 who were currently on MMT.

### **3.3.2. Site Description**

The clinic selected is open Monday to Friday and is closed on the weekends. The treatment process at this particular clinic is similar to the general MMT process described in section 1.2.4. However, given that I have worked as a laboratory technician at this clinic, I am familiar with how things are done at this clinic in particular. My role at the clinic is discussed in further detail in section 3.6.

The usual standard of care for the population at this clinic includes three types of visits. The initial visit includes the following: biopsychosocial history including substance abuse history, initial blood work screening including infectious diseases (Hepatitis A, Hepatitis B, Hepatitis C, HIV, venereal disease research laboratory (VDRL), complete blood count, liver functions, etc.), 12 lead electrocardiogram (EKG), initial UDS to assess presence of methadone

and other illicit substances, beta human chorionic gonadotropin (HCG) for females, height, weight, vital signs, body mass index (BMI), physician assessment (DSM-IV criteria for opiate dependence, history, physical, and systems review), registration of patient with the CPSO and obtainment of signed consent, determination of treatment start date and prescription to pharmacy of choice. As discussed in section 1.2.2, MMT physicians can supervise or monitor the collection of urine samples in order to verify the integrity of the UDS specimen (The College of Physicians and Surgeons of Ontario, 2011). Not all clinics require observation during urine testing thus some will supervise and only do witness testing if deemed necessary. At the clinic where the current study was conducted, policies and procedures during the early stabilization phase require bi-weekly and weekly urine screening in order to assess adherence to the program and monitor illicit drug use. UDS screening is less frequent with stability and progress in the program. On average, UDS occurs bi-monthly and in the long-term the MMT program UDS is a monthly requirement. Broad spectrum urine toxicology via outside laboratory services is conducted when assessing relapse and eligibility for carries or the maintenance of carries.

Follow-up visits occur weekly or as determined by the physician. This involves a UDS to determine illicit drug use, presence of methadone, pH and creatinine for credibility of sample. UDS results are reviewed and the patient receives counseling if needed (e.g. with nurse). The patient attends the physician follow-up for prescription renewal. This includes a discussion of ongoing substance use, how long the methadone dose is lasting, withdrawal symptoms, if any, review of the treatment plan, as well as any other services, issues, concerns and goals as needed. The methadone prescription is then provided and the next appointment is scheduled.

Lastly, restart visits consist of a short review of psychosocial history, reason for absence, pattern of use, reassessment of vital signs, laboratory tests as required, UDS, source of income, accommodation, and an update of the patient's file.

### **3.3.3. Data Collection**

Case study methodology traditionally employs multiple data sources (Merriam, 2009; Patton, 1990; Stake, 1995, 2006; Yin, 2009), which "supports trustworthiness and gives diversity and breadth of information" (Jones & Hocking, 2015, p. 125) as well as depth. Three qualitative data collection methods were used during two sessions with each participant that lasted from twenty minutes to two and a half hours: in-depth individual semi-structured interviews; occupational mapping; and demographic questionnaires. Each method of data collection will now be described.

#### **Semi-structured in-depth interviews.**

An audio-taped narrative style in-depth interview was conducted with five participants (see Appendix D for the narrative facilitation questions). Four of the data collection sessions occurred at the clinic and one occurred at a secure location chosen by the participant. Participants were asked to share their stories of daily living, in as much or as little detail as they liked, to emphasize the issues that were important to them. All questions were open-ended and non-directive verbal prompts (e.g. Can you give me an example? Can you tell me more about that?) and non-verbal prompts (e.g. nodding head) were used to support this story telling. I conducted all of the interviews and subsequently completed verbatim transcription of all recordings. Once initial interviews were completed and peer debriefing occurred with my thesis supervisor who reviewed each transcript, all participants were contacted for follow-up interviews to ensure that all areas of the interview were covered. The purpose of these second interviews was to obtain

more detail and clarify certain aspects from the initial interviews. Follow-up questions in these interviews stemmed from previous sessions and occurred by telephone.

### **Occupational mapping.**

Occupational mapping is a form of cognitive mapping. According to Powell (2010), “mapping can offer researchers a view into how people – children, parents, community members – see their world, what is important to them, what their lived social relations are, and where they spend their time” (p. 553). Thus, I added a mapping exercise to my study in order to highlight the everyday activities that participants engaged in and their lived experiences of time and place. During the initial session participants were asked to draw a mental map of the city following the interview, in order to assist in describing where they routinely went and the types of occupations that occurred in those places (e.g. grocery store, workplace). Maps did not have to be to scale and specific place names did not need to be included. This use of a visual method helped the researcher in this study access information that was difficult to access through interview or survey due to the tacit nature of daily activities (Hartman, Mandich, Magalhaes, & Orchard, 2011). For instance, mapping was useful for this particular population as they sometimes have difficulties in completing routine occupations such as doing laundry or going grocery shopping. Occupations such as these are often taken-for-granted parts of a person’s day; articulating the ‘mundane’ within interview contexts can be particularly challenging. The maps helped to identify these routine occupations that participants may not have thought were important enough to explicitly highlight. Visual data can be especially useful in helping participants to express complex or abstract ideas or opinions (Copeland & Agosto, 2012). Participants drew their mental map to detail day-to-day and routine occupations. They could choose to draw whatever they liked. Participants were then asked to explain their maps. This method resulted in a process and

product, including the map itself, which is a form of visual data as well as the discussion about the map which generated further textual data following transcription (Powell, 2010; McLees, 2013; Ball & Gilligan, 2010). See Appendix E for mapping facilitation questions.

### **Demographic questionnaire.**

During the first session I also asked each participant to fill out a demographic questionnaire (see Appendix F) that collected information about their age, gender, marital status, children, level of education, employment status, city of residence, current housing situation, main mode of transportation, duration of opiate use before MMT, current use of opiates, opiate of choice, additional drug use, length of time on MMT, length of time at clinic, and carry status. The information from the questionnaire was used to gather information relevant to describing the sample of study participants. The use of combined techniques for data collection facilitated crystallization and helped to establish further depth of understanding (Copeland & Agosto, 2012).

### **3.4. Data Management**

Identifiable participant information was only included on the hard copy consent forms, which were kept separate from all other raw data. The data from the demographic questionnaires were extracted and put into an Excel spreadsheet to collate and were saved in a computer folder that was password protected. Due to the sensitive nature of the information, it was de-identified and only a code number was included on the hard copy form (e.g. Participant 1). The maps were also identified strictly by code number and kept in a locked office.

The audio taped data from all in-depth interviews were transcribed and anonymized. Any identifying information was removed and pseudonyms were used to protect the participants' identities. Recorded data were then destroyed following transcription to avoid potential voice

identification. All data were only accessible by members of the research team. The three stage approach to data analysis is explained in the next section.

### **3.5. Data Analysis**

In-depth analysis was conducted for each participant's initial interview and follow-up interview. The data collection and analysis occurred concurrently (Baxter & Jack, 2008). In case study methodology, data from multiple sources are converged in the analysis process. Data analysis includes in-depth description of the case (the experience of MMT) and its context, preliminary interpretation of the data and coding, and identification of patterns and connections in the coding (Jones & Hocking, 2015).

The interviews were audio taped, transcribed verbatim and analyzed using a three stage approach. First, whole text analysis was completed by reading and re-reading individual transcripts to get a sense of the whole (Ryan & Russell Bernard, 2003). Sandelowski suggested that this helps the researchers to “get a sense of each interview” (1995a, p. 373). It also enabled me to identify key threads that each participant emphasized. Second, line-by-line coding was completed by the researcher using NVivo to manage the products of the data analysis. Once the coding of transcripts was complete, codes were reorganized into categories and each category was explored to examine its component codes and associated ‘node reports’ to develop key themes. Third, the data were further interpreted using the occupational justice framework described in section 3.2.2. This is a critical approach that is consistent with examining the challenges for individuals on MMT as it aims to address “justice related to opportunities and resources required for occupational participation sufficient to satisfy personal needs” (Christiansen & Townsend, 2010, p. 421).



According to Copeland and Agosto (2012), graphic elicitation techniques should be used in combination with non-graphic techniques (in this case, interviews) that enable participants to provide contextual explanations. Participants' descriptions of their maps, as discussed above, were audio-recorded and transcribed verbatim, and analyzed according to the three stages described above. However, the maps alone became an important form of visual data further informing the research. The maps were initially analyzed individually by identifying and describing the content that was included and how the map was drawn (e.g. types of places, presence of roads). In addition to exploring what was included and how participants drew their maps, I also considered what was absent (e.g. absence of specific places such as pharmacies, friend's houses, or workplaces). The maps were subsequently analyzed by cross comparison (Powell, 2010) which enabled me to further explore the interactions of occupations and MMT.

For the demographic questionnaires, data were collapsed into descriptive categories using Excel (e.g. number of male and female participants, average age range). Subsequently, these data were combined to describe the demographic profile of the five participants. Ethical considerations for this study are presented in the next section.

### **3.6. Ethical Considerations**

Prior to the start of this case study, ethics approval was obtained by the Health Science Research Ethics Board (HSREB) at The University of Western Ontario on November 11, 2014. The ethics approval notice can be found in Appendix G. Informed consent was obtained from all of the participants at the beginning of the first session. The participants could terminate their participation at any point during the study.

Due to the critical nature of this study, additional ethical and practical considerations should also be noted. For instance, as mentioned in the description of myself as a researcher, I

was a laboratory technician at the clinic where the participants were recruited and thus had to remain aware of my dual role as both a researcher and as an employee. In order to reassure the participants, I made sure I prefaced every session by informing the participants that everything they said was completely confidential. In addition, participants were informed that the only people that would be listening to the recording would be me and my thesis supervisor and that recorded data would be destroyed and all identifying information would be removed. Furthermore, participants were free to request that the recorder be turned off at any time or that parts of the transcript be removed. Most importantly, participants were informed that their decision to participate would in no way affect their treatment at the clinic or their standard of care. In the event that a participant became upset or stressed I had a list of addresses and contact information for service providers that I could give them.

I managed this dual role on an ongoing basis throughout the study by engaging in a reflective process. I maintained field notes after each session and throughout the data collection process. My field notes included a detailed description of what I observed, my thoughts on each participant, aspects of the session that I found to be interesting or significant, my feelings about my research progress and the research process in general, and questions that I wanted to consider at a later time or that I wanted to ask my supervisor. These notes facilitated my memory of the session in the field. I also made sure that I was communicating with my supervisor on a regular basis with regards to my progress. We discussed participant recruitment, common themes that were emerging as I continued to collect data, and any questions or concerns that I had. An additional strategy that I integrated into my research was peer examination of the data, which can enhance the overall study quality (Baxter & Jack, 2008). In the next section of this chapter I will discuss the two forms of quality criteria that were addressed in this research.

### 3.7. Quality and Trustworthiness Criteria

Various researchers have developed quality criteria as guidelines to follow when conducting qualitative research. Tracy's (2010) two forms of quality criteria, rich rigor and sincerity, guided this study.

According to Tracy (2010), a study is rich with rigor if the researcher uses sufficient, abundant, and appropriate data, complex theoretical constructs, time in the field, and sampling, context, data collection and analysis processes. To address this criterion in the current study I aimed for depth as opposed to breadth. Though I was subjected to some time constraints, I used multiple methods with each participant and asked appropriate interview questions given my research goals. My aim was to collect more data with a smaller number of participants as opposed to less data with more participants. The context and sample were also appropriate given the goals of the study. I ensured that participants had been on MMT for at least one year so that they could adequately discuss their experiences. Furthermore, I used appropriate procedures in terms of field note style, interviewing practices, and analysis procedures and described these above.

Sincerity, according to Tracy (2010), can be achieved through self-reflexivity and transparency. Firstly, self-reflexivity refers to the subjective values, biases, and inclinations of the researcher. To address this criterion in the current study, I openly acknowledged my own positionality and motivations, and explained how I came to examine my particular topic of people's experiences on MMT. In addition, throughout this thesis, I used the first person voice (e.g., "I said," or "They reacted to me by...") which according to Tracy (2010) effectively and appropriately reminds readers of the researcher's presence and influence in participating and interpreting the scene. Moreover, in my field notes I included subjective feelings. I also

dedicated a section in chapter one to describing myself as a researcher and in chapter five I included a section which returns to this reflection after having completed the research study. Lastly, I was transparent with respect to my connection and previous experience at the clinic that served as the study site for this research project. Secondly, transparency refers to being honest about the methods and challenges of research study. To address this criteria in the current study I discussed how I as a researcher got into the context, the level of participation I had, the field notes I made and what those were comprised of, and the level of detail in transcription. The next section concludes this chapter.

### **3.8. Conclusion**

This research was located within a critical theory paradigm and was conducted using a qualitative case study approach. Townsend and Wilcock's (2004) Exploratory Theory of Occupational Justice was used as a framework for this study as it illustrates the relationships between factors impacting occupational justice. A case study approach was best suited to answer my research question because I was concerned with the real-life doings of people in the context of MMT. This study can be considered an intrinsic, single, holistic case study because I studied a unique subject matter where the results have limited transferability and I have a genuine interest in better understanding the daily lives of people on MMT. Participants completed two in-depth semi-structured interviews, occupational maps, and demographic questionnaires. All data were audio taped, transcribed verbatim and analyzed using a three-stage approach. Ethics approval was obtained prior to the start of research. For this specific study, additional ethical considerations were also noted with regards to how I managed my dual role as both a researcher and as an employer. The quality criteria (Tracy, 2010) used to ensure the trustworthiness of this research were rich rigor and sincerity. The next chapter presents the findings of this research.

## **Chapter Four – Findings**

### **4.1. Introduction**

As previously discussed in chapter three, this intrinsic case study involved a total of ten sessions using three different data collection methods including in-depth interviews, occupational mapping, and demographic questionnaires with five MMT patients. This fourth chapter presents the findings from the data analyses. The following section presents the demographic information describing the participant sample. I then introduce the participants and the common threads that they each emphasized throughout their sessions. A description and interpretation of their maps is also included, which highlights their daily routines. Subsequently, the findings are presented according to four themes that highlight key aspects of the participants' experiences. First, findings outline a 'descent into chaos' as participants' addictions began and worsened over time. Second, participants' experiences of 'MMT as a bridge' to recovery from addiction are described. Third, a 'new normal' daily life that is characterized by liminality is shown to be linked to people's experiences of MMT. Finally, participants' hopes for 'moving forward' are outlined.

### **4.2. Introducing the Participants**

According to Baxter and Susan (2008), there is no single correct way to report a case study but one approach is to tell the reader a story as it is important to describe the phenomenon itself as well as the context in which the phenomenon is occurring. Although descriptions of the participants cannot be detailed at length in order to protect their confidentiality, a brief outline is provided to give some background information and context prior to the presentation of the findings. It should also be noted that this description reflects the period of time during which the data were being collected and some of the participants' circumstances have since changed. The

participant descriptions highlight key threads that emerged from each participant's sessions. During the mapping exercise, the participants described their routines in detail, highlighting what they did and where they went on a regular basis. Again, the maps cannot be reproduced in full detail because they may make the participants identifiable. It is also important to note that strict time frames could not be captured by the maps. An example of the maps can be found in Appendix H.

The sample of study participants consisted of three females and two males ranging in age from 27 to 42. All five participants were living in London, Ontario. Three participants lived with family members (one paid rent) and two were renting. Only one participant was married, one was divorced and the other three had never married. Two of the participants had children but neither lived with them. The highest level of education obtained by two participants was a Bachelor's degree. One participant had completed some university. One had a high school diploma and one participant had not completed high school. None of the participants were working at the time of data generation. One participant, however, was a freelance writer. Three of the participants were on Ontario Disability Support Program (ODSP) and two were neither employed, nor receiving social assistance. The main mode of transportation for the participants was public transit. Other main modes included walking and borrowing family members' vehicles.

In terms of their length of time on opiates before MMT, this ranged from three to eleven years. None of the participants were using opiates when the initial interview was conducted. Participants' opiates of choice included hydromorphone, oxycodone, and morphine. Two participants indicated that they used marijuana. One participant indicated that in the past he also used crystal methamphetamine and cocaine. He further specified that alcohol was a drug that he

was currently using. Even though I focused on MMT, which is largely used to treat opiate addiction, it is not a 'drug addiction cure', and most of the participants in the current study had histories of polysubstance use, aspects of which MMT may not be as well suited to. In terms of their length of time on MMT, this ranged from just over a year to seven years. The length of time at their specific clinic ranged from eight months to six years. Three of the participants had only ever been to their current clinic. Two participants had previously been to another clinic. Three of the participants had six carries (maximum legally allowable amount). One participant did not have any carry doses. Another participant was eligible for the full six carries but chose not to use them.

John had been on MMT for two years and was currently living with a family member. He had completed university and had worked as a company manager prior to his addiction. John had struggled with anxiety since he was a teenager. It not only affected his experience of MMT but it had also caused trouble in relationships and at work where he would often have panic attacks. He had tried methadone in the past when he was working but had to stop because he found it too difficult to go to the pharmacy every day and to the clinic every week while holding down a job. He would go in on his lunch hour and have difficulty providing a urine sample, which would cause him to be late getting back to work. He ultimately lost his job as a result of his drug use and spent much of his subsequent time looking for pills on a daily basis. He had also unsuccessfully tried to go to detox. In addition, he started seeing a psychiatrist. A dominant thread in meetings with John was experiencing the comorbidities of addiction with mental illness. Having anxiety made MMT particularly difficult for him:

Methadone has been very, very hard for me with the anxiety levels that I have. Obviously my situation may not be something that applies to a whole lot of people but I do know a lot of people that have mental illness. That's one thing I do know...that have drug addiction. Most people do self-medicate. So, you know...I'm hoping to get back to work

soon, but right now my whole life is going to doctor's appointment. I've been absolutely paranoid of losing my family's help because the longer this process takes, the more I'm at risk of ending up on the street. I don't believe there's any way in hell with the amount of depression and everything else, I don't think I'd be able to make it if I wasn't living at my [family member's]. I know a lot of people that, between everything, just coming in here there's time I've had to hang out here for hours. I'll leave here when you guys close for break and I'll go sit at the Tim Hortons for 45 minutes or half an hour because I can't do a urine sample.

Prior to drawing to his map, he prefaced by saying that he was born outside of London and went to university. He had been working full-time and came to London after he lost his job. He had never owned a vehicle and felt that made a big difference in terms of knowing his way around the city. He indicated that he had a poor sense of direction and was unsure of how to go about drawing his map. First, he outlined his whole daily routine and then he started drawing. When he began to draw, he outlined his routine and indicated the places he regularly visited. The map highlighted that he lived with family and his routine consisted mostly of medical appointments. He drew the clinic as well as the pharmacy and indicated that he went to appointments every week. He had been seeing his psychiatrist twice a week. He also included his family doctor on his map. In addition, he drew a shopping centre, grocery store, a liquor store, and the place where he volunteered. In his initial interview, John stated that he had been clean for five weeks. During the follow-up interview, he indicated that he was no longer at that clinic and that he was using again but was in the process of restarting MMT at a different clinic. He indicated that clinics vary and that his experience has been different based on the location.

Bonnie had been on methadone for three years. She was the only participant who was married and her spouse was also on MMT. Prior to and during her addiction she had worked part-time. On days when she was not working she talked about spending time with her husband and friends. They would mostly 'binge watch' movies. She also talked about spending a lot of time with their dog. Bonnie initially got prescribed opiates after an injury. She described how her



use escalated to the point where she began ‘chewing them, crushing them, snorting them’, and then started using intravenously. Eventually she and her husband ended up homeless. Bonnie talked about how she dosed daily for a while and came to the clinic twice a week. Her dose slowly increased and she gradually began to notice a difference in how she felt. She “started to feel more and more normal and able to do more and more” of her usual things. The recovery process, although it was addressed by all participants, was a particularly dominant theme throughout the meetings with Bonnie:

I didn't do well with the sort of strict, abstinence based programs. I failed every time I tried you know to quit cold turkey. I managed to go you know a week or two but I'd always slip right back into it. I find this gives me really great craving relief. It just helps me maintain a good level. The cravings is a huge thing...just not having that there and wanting to use. I'm able to focus my attention on other things. I feel better. I'm able to function and do what I want. I'm not tied to pills or trying to find money for pills. That was literally all my life was before.

Bonnie's map included only her house, the clinic, the pharmacy, her parent's house, her grandmother's house, and a friend's house. She highlighted her routine of going to the clinic every two weeks to give a urine sample and once a month for appointments. She also talked about her work as a freelance writer and her blog focusing on the topic of addiction and methadone. During her follow-up interview she said she does a lot of writing throughout the day. One thing that differed with this participant in comparison to the other four was that she chose not to have carries. She explained that her preference not to have them helped to keep her in a routine and out of trouble. Other routine activities included visiting her grandmother and volunteering at sporting events. She also said that although she tries to distance herself, there is one friend she sees a couple times a month so she included that on her map as well. Her main mode of transportation was the bus but she said that in the summer she liked to ride her bike to the clinic and the pharmacy to get some physical activity. Her daily occupations were fairly

flexible in that “when it needs to be done, it gets done”. She said that being on methadone made it easier for her to take care of herself in general. For example, during her addiction she would never eat as her appetite varied greatly, whereas she had gotten back to eating regular meals again.

Patrick had been on MMT for almost a year and a half but at the time of the initial interview he was tapering off methadone in order to prepare for a surgical procedure. A key thread in meetings with Patrick was that of comorbid medical issues. After immigrating to Canada, Patrick was diagnosed with a severe and chronic health condition for which he was prescribed opiates. Prior to his diagnosis Patrick worked in the automotive industry. He had difficulty maintaining any of his jobs as he would often be off sick due to his medical issues. Over time, his use increased and when his dose was eventually cut in half he began to ‘smash’ (inject) them. His medical condition consumed his life:

You’re looking at 18 times a month I was being rushed to the hospital for my episodes. Prior to going to the hospital I had to take a certain amount of opiates. If that didn’t work to stop the episode I’d then be rushed to the hospital where they would give me, at one time it was 326 cc of morphine in four hours to stop the episode. That was literally basically my life. I was trying to do that, raise a child, and take care of his mother who had postpartum depression as well. So without literally wanting to be a junkie, without willingly being a junkie, I turned into a junkie, in a sense where I was addicted to it.

He went on to describe how this impacted his routine:

Before, I could at least go out if I wanted. Now I don’t have that option ‘cause I can’t even walk to the bus stop, I can’t walk to the store. If I walk to the back of the house I’m out of breath.

Patrick strongly felt as though MMT was geared towards people who were “junkies”. He felt that there was nothing for people who were given a prescription and wanted to get off of it. He talked about the program being designed and easy to use for drug addicts who are unemployed and

hanging out downtown, but that it is harder for people who have jobs, or who do not have cars, among other challenges.

His medical condition made MMT difficult for him. As a result, he had a fairly limited routine that was reflected in the map he drew. He said that he was essentially a “housewife”. Most of his time was spent taking care of the house, preparing dinner, and doing laundry. Thus, he drew his house and indicated that everyone comes there. In addition to his home, he included a friend’s house, Tim Hortons, and the pharmacy. He was the only participant who mentioned marijuana and included his two dealers on his map. He also included a First Nations’ reservation where he purchased cigarettes. He was the only participant who did not include the clinic on his map. He noted that his lack of occupational engagement was due to his illness. During the follow-up interview he explained that if it were not for his medical issues, MMT would have allowed him to go back to work.

Karen had been on and off MMT for seven years. Before she started methadone she was homeless, in and out of jail, and engaging in sex work. She was using on a daily basis and spent the majority of her time finding pills. Karen had been struggling with Attention Deficit Disorder (ADD), post-traumatic stress disorder (PTSD), and depression. She also ended up getting Hepatitis C. Karen initially went on suboxone, another opiate replacement therapy, while she was at a psychiatric hospital but relapsed multiple times as she “couldn’t stay clean long enough for the suboxone to kick in”. She then switched to methadone. Karen made multiple attempts at trying stay clean on MMT but would relapse as soon as she went off the program. A central theme in meetings with Karen was her life during her addiction as it was an extremely chaotic time:

Because every time I’ve went off and I try to go a bit and blah blah blah, I relapse.  
Because I go out and three months and I come back and I’d be so dope sick. Same thing

all over again. But this time it's different for me. This time it's different for me. I've been to nine treatment centres. This time it's different for me and I don't know why but I'm just doing so well this time and I'm proud of myself and I had a year prior to this relapse but then my life was not like this six years ago. Believe me I was in and out of jail and my life was like just I don't even know. I can't even describe to you how my life really was. I mean, I had like no place to live, I'd shower wherever, I'd pick up guys and I'd be abused all the time. So many scary things have happened to me. But none of that scared me. Like even this guy he left me in the corn field with no clothes on. That didn't scare me at all. All I wanted was that next hit. That's what scared me was not being able to get the next hit. Now I have Hep C and shit from it. A lot of medical problems because of the stuff right.

Karen's routine involved getting up in the morning, going to the fridge, and taking her drink of methadone. This was indicated on her map as she drew her home with her refrigerator full of methadone bottles inside. She went on to draw a grocery bag and a caption explaining that she ate three times a day. She also drew the pharmacy, the methadone clinic, her psychiatrist, and the place where she volunteers on a daily basis. She explained that each week she leaves a urine sample at the clinic. Every Tuesday she goes to the pharmacy to get her six carries. She also sees her psychiatrist weekly. She had been going to therapy for six years. Every other week she sees the methadone doctor. Like Bonnie, she talked about taking her dog for walks. She discussed going to the grocery store every Wednesday and explained that during her addiction she would hardly ever eat. She also noted that her map looked a lot different prior to getting carries. Before she had carries she would wake up, go to the pharmacy, then to volunteer, then home, and then to the pharmacy the next day and then back home. She indicated that every three weeks to a month she would get one carry. Karen had gotten her sixth and final carry just before our initial interview took place. This made her feel very proud of herself. She also felt proud that she was going to be going back to school to get her high school diploma.

Mia had been on MMT for almost four years. Prior to her addiction, she got her Bachelor's degree and was enrolled in a Master's program. She began using cocaine to stay

awake at night after she experienced a traumatic event while attending university. Her use escalated from cocaine to opiates. Mia, like John, struggled with anxiety as well as Obsessive Compulsive Disorder (OCD). She found that opiates relaxed her and helped with her symptoms. During her addiction, she differentiated between days when she had no money and days when she did. On days when she had money, she would use more. She eventually ended up homeless. Like John, Mia tried to detox multiple times but was unsuccessful. After coming to a ‘crossroads’, she finally decided to go on MMT when a new clinic opened that was out of the area where she would buy drugs. The predominant thread in meetings with Mia was family and how having family support influenced her recovery process. She talked about the importance of having her family involved in her recovery and being around people who have a regular routine and help give her structure:

I think sometimes people just don’t want to be alone, especially if you already have some sort of trauma or some sort of like emotional damage because really like at the beginning, boredom was like the biggest issue. Like what am I gonna do? So living with my parents who are like functioning normally and like sort of orbiting around them I think really helped get me back into a regular, real world sort of lifestyle. Like going to bed at a reasonable, waking up before breakfast, you know...before noon. Just those sorts of things...like eating three meals instead of just like when I had money to eat. Eating healthy...and I guess while I was using because I was just always so tired and like so numbed out to everything I had become like a shell of like my former self. I wasn’t like...my personality had changed I guess is what I’m trying to say. So my parents have sort of been like a litmus test or like sort of something I could measure myself against to see how much better I was getting because eventually they were able to say like, “You are your old self again.” Because I’d been such a different person and so like that was a really good point in my recovery because they were just like we have like our old [daughter] back, you know?

This was reflected in the map she drew. Mia’s map was the most detailed out of the five participants. She began by drawing her neighborhood and a compass at the top of the page to show the area of the city where she spent most of her time. She was the only participant to mention geographical location. Unlike the other participants, she talked about staying in one

particular area of the city where she felt safe. She explained that Thursday was the one day when she would ‘venture’ out because that is the day when she had someone to give her a ride. She went on to explain that getting on a bus involved going downtown and she did not like to be reminded of what she used to be. Her routine occupations were represented on her map and included her parent’s house, the clinic, and the pharmacy. She explained that these were the only places that she considered “safe” and that she would go to, or people she would call if she was having a problem. She also included a specialty food shop and explained that she enjoyed cooking and eating different types of food especially since she, like Karen, could now taste food as opposed to when she was using. She also drew a public library and talked about her love for reading, especially when she was using as this was her only escape from reality. Mia did note, however that she did not consider the library or the food shop to be ‘safe spaces’. In addition, like Bonnie and Karen, Mia talked about her dog and how taking care of him kept her company and also allowed her to have some extra responsibility. When Mia was discussing her map, she noted her lack of occupational engagement. At the same time she admitted that she tried not to commit to going a lot of places as she did not want to complicate her life as she continued to recover. During a follow-up interview she made a point of telling me that she had recently joined a gym.

As previously discussed in section 3.3.3 in chapter three, occupational maps were used to assist in describing where the participants routinely went and the types of occupations that occurred in those places. Some participants drew streets and two dimensional objects while others chose not to draw streets but instead drew three dimensional objects in different sections to indicate the various places they go. As highlighted by Patrick and Karen, the maps could change according to factors such as carry level. Participants also noted that their maps would

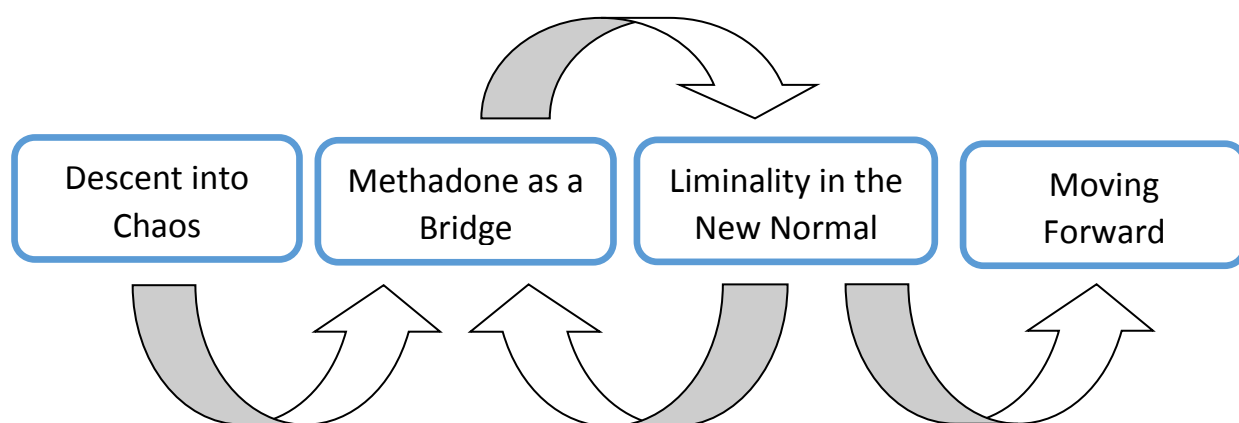
look very different if they were drawn before they were on MMT. Every map included the house where they lived. Everyone except Patrick included the clinic and a grocery store. In addition, everyone except Bonnie included the pharmacy. Two participants drew their pets on their map. Other places that appeared on more than one map were friends' houses, psychiatrists and the place where they volunteered.

The absence of particular places was also important. There were occupations described by participants that were not located on their maps. For instance, participants talked about travelling to other cities and other countries, hanging out with friends, and seeing their parents. None of these, however, were included on their maps. Furthermore, the absence of some occupations within the lives of participants also contributed to the absence of particular types of places on the maps. For example, none of the participants had a job and as a result, none of the maps included workplaces. In addition, the absence of friends on their maps was notable as all of the participants talked about social interaction and engagement in some way. However, Bonnie was the only one included a friend on her map. Only one of the maps included drug dealers, a smoke shop, and a Tim Hortons. Ultimately, the maps helped me to better understand how limited the daily routines of the participants were. Despite participants' discussions of their everyday occupations prior to the mapping sessions, this information was not easily accessible in the interviews due to the tacit nature of daily activities. Participants even noted that these maps made them realize their lack of occupational engagement. The next section presents the themes that emerged from participants' experiences of daily life on MMT.

#### **4.3. Findings**

According to Baxter and Susan (2008) each data source is one piece of a puzzle and different strands are braided together to promote a greater understanding of the case. As

previously discussed in section 3.5, following transcription, whole text analysis, and line-by-line coding, individual codes were organized into categories and themes. In this section, findings are presented according to the four themes that highlight key aspects of the participants' experiences (Figure 4.1). The diagram serves to visually represent the main topics that emerged as people shared their experiences with me. It is not a strictly linear relationship and is not intended to be a model that explains or predicts people's addiction/recovery trajectory. Instead, it is used to capture patterns in data and convey important aspects of participation (Jones & Hocking, 2015).



**Figure 4.1. Participants' Experiences of MMT**

#### **4.3.1. Descent into Chaos**

In this section I will address how participants described their routines before and during their addiction. This will encompass their discussion of their downward trajectory as they became addicted and how their addiction progressed, leading them to a point where they decided to go on MMT. Participants each detailed a 'descent into chaos' as their addictions began and worsened over time. Prior to their addictions, participants briefly discussed that their routine was pretty normal and consisted of going to school or working, and spending time with family and friends. Mia talked about the influence of her mental illness upon her pre-addiction routine:



Before my addiction I was always...I have Obsessive Compulsive Disorder so I would always be making lists of everything that I had to do each day and most of the time it was university classes. Sometimes like part-time jobs or...I would usually be able to get a job at the university for the summers. I was also super into working out so I would go to the gym, I would go for a run and I was really social so I wouldn't go to bars but hanging out with friends or going to pubs...that sort of thing.

Her compulsive behavior pre-dating her drug use significantly impacted her daily routine. She never really considered how this may impact her ongoing health, but stated that it is something that helps her now as she attempts to be more productive during her recovery. Bonnie also described having had a fairly typical routine:

Before I got into all this mess I was working. I had a great job, car, great place. Everything was awesome. I never would have anticipated ending up homeless but it happens.

Bonnie did not anticipate the challenges and adversities she would later experience.

The participants explained that they had relatively stable lives prior to their addictions. As they started using drugs, they noted a shift in their daily occupations and routines. Becoming addicted was a different experience for each of the participants. For some it happened fairly quickly, while for others it was more of a gradual process. The participants became addicted for numerous reasons. Mia started using after experiencing a trauma and admitted that prior to that, she had very limited knowledge about drugs. She detailed her experience of learning how to 'snort' cocaine and then eventually injecting drugs. On the other hand, Bonnie was initially prescribed opiates for an injury. Patrick also detailed his experience of getting prescription medications for his medical issue:

Well I was diagnosed back in [year] with [a medical condition]. Where they started to put me on, by the time I was done and got on the methadone program I was on 294 mg hydromorphone tablets, 21 cc shots of raw morphine IM injection, and 150 microgram patch of Fentanyl every two days. That was my monthly intake. I went down to Montreal to the pain clinic down there to see if there was any kinda help that I could get. Unfortunately there wasn't. And the doctor down there decided that I was on too many pills and cut my pills in half, which is not a smart thing to do when you're on that much.

He went on to say his opiate dependence that developed secondary to his primary illness became his main occupation and required his full-time attention. Some participants indicated that they used drugs as a way to escape from both physical and emotional pain.

Once they were addicted, participants' described their addiction routine as hectic and chaotic. Many participants described a routine that mainly consisted of finding money for drugs, and for some this often entailed engagement in criminal activity. When they had money they would then spend their time finding pills. For Bonnie, pills became a necessity:

The only daily need I really met was just getting drugs, everything else went to shit...everything else was neglected, whether it be food, personal hygiene, everything. Just completely secondary to drugs and that was it. Getting up in the morning, first thing, drugs, finding money for drugs.

Similarly, John had a hard time controlling his use:

I could never get my pay check and just go out and buy pills for the next two weeks. I couldn't do that. If I had them in the house I'd go to bed and get up two hours later and do another one. So I had to be able to look for pills every day. It was the only way to make my money actually last. That's how bad it was. It was very chaotic.

Drugs also consumed Karen's life as she described doing 'anything and everything' to get more pills:

Oh my life was terrible. I was in and out on the streets. I was a prostitute. I couldn't go any longer than...I actually couldn't go any period of time without using anything because the thought and the pain of the...the thought of not having the next hit would just like drive me crazy. I would go like about two hours in between. My life was chaotic, it was horrible. I lived in the streets, I worked in the streets. I lost all my children. I had no place to live, I was homeless, I stole. I've been in jail 50 times. My life was just very chaotic.

Drug use took control and became a powerful influence in their lives with the rest of their everyday occupations being organized around their addiction. By using drugs, participants were getting something that they otherwise were not. They experienced relief from pain, a sense of peace, a sense of control, and a sense of calmness. At the same time however, it impacted their

health, wealth, and relationships. Participants went on to explain how, over time, their addictions progressively got worse. Some evolved to polysubstance use escalating in frequency and altering the route of administration allowing for more rapid uptake of the drug and further building tolerance to the point where they were using more frequently. Bonnie explained how her drug use escalated:

I was in really bad shape. I initially got prescribed opiates after an injury and it just sort of progressively got worse. I started chewing them and then crushing them, snorting them, and injecting them and ended up homeless, on the streets, just a total mess. Probably would have been dead if I hadn't have found methadone.

Participants' narratives outlined how they continued on a downward trajectory as they started engaging in riskier activities such as buying drugs on the streets and using drugs intravenously. While some participants indicated that they used needle exchange programs, some contracted Hepatitis C. The more they used drugs, the more their physical health declined. As noted above, some participants also experienced homelessness and incarceration and some admitted that there were numerous times when they could have overdosed.

A few participants, such as Mia, discussed the painful experience of going through withdrawal:

And then I used that to sort of like get off cocaine, like I weaned off cocaine with opiates and then, you know, it's very short distance from like doing opiates on the weekend to like not being able to stop because the withdrawal is so bad.

Some participants talked about ultimately hitting rock bottom. They lost their homes, jobs, relationships, and families. Bonnie felt as though she could not get any lower:

I had lost absolutely everything. We ended up homeless, me and my husband ended up homeless on the streets. We were a mess. Total mess. Just withered away to nothing.

Similarly, Mia reached a point where she realized she was not ready to give up on her life and on the chance of overcoming everything she had gone through:

I just felt like there was just such a waste of people and such a waste of life and I felt like really guilty for putting everyone in my life, like through so much hell. But at the same time, I like wasn't really ready to like die, you know, on the street. 'Cause I feel like I was just at a crossroads where it could have gone either way. I was just ready to like...I wasn't really ready to give up and like I was really...after a while the sort of excitement of like slumming and...it just becomes like too real and it's like really all I'm gonna do. And also a lot of the times I felt like I had had such a better chance at life than like so many people I've met because, while there are like a lot...like professionals and people from good homes that like get caught in like addictions with opiates, I felt like a lot of the people I had met were from like broken homes, had like some severe trauma, like when they were children. Or had like mental illness and sort of always been on the street or like transient and I sort of felt like I had come from a different place so maybe I had a better chance of getting back out. 'Cause I really like...I say all the time to my parents if I didn't move out and get out of a bad relationship and like get totally out of like the geographical area, like I would...I don't know how good my chances would have been of like getting over it. I can see why it's hard for like a lot of people.

Hitting rock bottom was the motivation for participants to try and turn their lives around. They decided that they did not want to continue living the way they were living and described feeling ready to make changes. At this point participants started seeking treatment as they wanted to end their addiction and stop using substances.

#### **4.3.2. Methadone Maintenance Treatment as a Bridge**

In this section I will address how participants described their overall experience of MMT. This will encompass their discussion of their decision and readiness to seek treatment leading up to how they began the program and their perceived barriers to MMT. As briefly mentioned above, participants indicated that they reached a point where they were ready for treatment. They did not want to keep living on the streets or be sick anymore. Ultimately, they wanted to stop using drugs. Despite their desire to get clean, starting MMT was not an easy decision. While contemplating change, Karen came to realize that substitution therapy, like MMT, might have been her best option as she was clearly not able to manage withdrawal symptoms and maintain stability for any length of time on their own:

I wasn't ready for it I don't think at the time. I wanted to not feel sick but I wasn't actually ready for the program...cause methadone you don't just take methadone and hope things get better. You have to take the methadone and do other things as well. I take the methadone and I would still...I would not be sick but I'd still go smoke crack. I'd still go shoot whatever.

Likewise, Mia would rationalize her particular behaviours as part of the addictive process and discussed some of the many myths and misconceptions about methadone that she said were shared 'on the streets':

I didn't really know much about it and what people on the street would say is it makes your teeth fall out or it makes you gain weight. Or my like big excuse for like not going on methadone for so long was, "I don't want to be like handcuffed to a pharmacy for each day". Even though I was like totally handcuffed to my addiction, like to my dealer, you know? But at the time it was...I totally just wasn't ready to stop using drugs.

Karen and Mia were both hesitant and scared to make significant changes and leave their lifestyles behind. Initially, recovery for a lot of the participants was a 'trial and error' of different treatments. Sometimes they tried these treatments multiple times without success. For instance, prior to methadone some participants went to rehab while others tried detox centres. The detox experience for some showed that not all people follow a linear route from addiction to MMT to full recovery. Mia highlighted the key differences between detox and methadone:

But I think the thing that's worked with me for methadone as opposed to detox is like I would detox and you know I'd be in there for like two weeks or three weeks and I'd come out and I would go back to the apartment I was living in and using in, back to the abusive addict boyfriend. So it was just like, it was really hard to maintain...like it was so easy in detox to be clean but you can't live in detox forever, you know? And you sort of felt like all of a sudden you were on your own. Once you've left, you can't like walk back in and say like oh by the way what happens if I'm in this situation? But with methadone it seems like it's much more...it seems like to me, methadone has been much more of a continuous...like it's not just like you're there for two weeks and then you're on your own. I like that you're seeing your doctor, especially in the beginning. I was going two or three times a week. For me it felt more like a long term solution. Also, with methadone it felt more gradual, not such a...get everything out of your system and then you're going from there. I felt like on methadone I had the time to like tackle each problem like slowly.

Mia spoke well to the fact that many of the issues in the lives of MMT patients require time and attention. She also explained the process of gaining stability and that initially, the early part of the MMT program provided people with just enough structure to return to a level of daily function that did not revolve around drug seeking.

The decision to go on MMT was a personal choice that participants made on their own. Participants explained that was important because it would not have worked if they did it for anybody else, including their family. Mia explained how she made the choice to end her addiction:

Because when you're basically...like when you get on methadone, for me, it was like that's when I was ready to like end my like addiction to pills and like stop that lifestyle. I did know like a lot of people that would talk about that they were on methadone because it made them sort of when they didn't have like opiates that they didn't get dope sick. But it sort of felt like a plan B, that they weren't really ready to quit but it was a good safety net so that they didn't have to go through all the sickness. But I sort of like never wanted that for myself. That was like the hard part was being like, "Ok, I'm ready to stop."

She illustrated that people have different motivations and different goals. For some the goal might be just to control dope sickness while others might aim for complete abstinence. Not all people who go on MMT are necessarily seeking abstinence. John also talked about the fact that success for him personally might not mean being completely clean all of the time. Though he expressed a desire to work and contribute to society again, he also acknowledged the potential for his drug use to be limited to the weekend.

Starting MMT involved being educated about what methadone is, how the program works and what is involved. Participants noted that the two major difficulties to getting started on the program were being able to access sufficient information and barriers to accessibility. Once they decided to try MMT, finding information about it was difficult for many participants.

Most said that they learned about MMT through word of mouth, such as Patrick who heard about MMT from a friend of his:

I was going into withdrawals and then by the time I came back to London I was buying pills and just to get me through that two week time frame and I didn't like that shit so when I got out that's why I talked to my buddy and he told me to get on the methadone program.

Barriers to accessibility of treatment also made it difficult to get on the program. The location of the clinic was important to participants as some talked about how they found it difficult to find a clinic that was close to where they lived. Karen said that if she could change anything about MMT she would make it easier to access:

I would make it so it would be easier for the person that was getting it at first. Have an easier access, easier way to get that because I know from lots of people, the reason why they don't choose methadone is because, like I said, it's easier to get the hit and the 30 buck or the 20 buck than it is to get the methadone...

It was also important to the participants that the clinic they went to was discrete and looked like any other medical practice. For instance, Patrick did not want to be made to feel any different than anyone else who might be seeking a medical treatment. He did not want to continually be viewed in a negative way like he felt he was:

Like you don't want to feel different, you want to feel like you're getting...you already feel different enough and segregated enough on all those meds and the way you're living your life. Now to get help that makes you feel like you stand out even more is not nice. That's one of the things I like about say [the doctor's]. You got lawyers, you got dentists, you got doctors, you got everybody that's in a house on [street name]. So when you go in, let's say people driving by aren't like they did with [the other clinic] where you drove by there you knew everybody out there was a drug addict. Where you go drive by [my clinic], Christ almighty it could be a psychiatrist, it could be a doctor, it could be an ultrasound place for all you fucking know. The [clinic], it's a big building, there's a big sign with [the name] on it. Granted it doesn't say what it means but if you type it into your phone...[clinic name]. To me it should be a little more subdued for one.

Patrick went on to say that there are limited options when it comes to MMT. He, along with Bonnie and Karen, explained that MMT should be more open and accessible without the stigma

that many articulated exists at other clinics within the city of London. For instance, they suggested that clinics should be centrally located on bus routes.

In general, the participants described their MMT experience as helpful in terms of reducing or stopping their use of opiates. Several discussed general aspects of the MMT program including the methadone dose, urine testing and carry doses. Participants explained that their methadone dose slowly increased over time. They started to feel better and reported that their physical withdrawal symptoms were alleviated and their cravings lessened once they reached a stable dose.

John highlighted the extent to which urine testing was a central aspect of the MMT experience as it was especially challenging for him for a number of reasons. The first reason was his anxiety issues which caused him to have difficulty providing a specimen within the allotted time frame. The second reason that urine testing was a challenge for John was that he felt as though people on MMT are treated differently. He described feeling no sympathy, and a lack of respect and sensitivity that compromised both his dignity and self-worth:

If some normal professional person and had them go through that and have them get done surgery, tell those women...have some professional woman tell them that somebody is gonna stand there and watch them through a little cut out window, watch them go pee. And then I see all these addicts and they don't even question it. They don't even care. That tells me something about maybe they're part of the condition. They're self-worth, their dignity. I don't know. And so the people that are supposed to be helping them with those problems. This whole issue is about...it's not even real. It's political. It's because society is afraid of it. Society doesn't understand methadone and they're afraid of it. That's why we have to do all this.

John clearly articulated that the structure around urine screening is rigid and in some way traumatizing for him. John went on to explain that with the rigid protocols, people get subjected to humiliation.



Another part of MMT that had a significant impact on the participants' MMT experience was the privilege of take home doses (i.e. carries), which seemed to make a big difference in the daily lives of the participants. For instance, Patrick, Karen, and Mia all had full carries making their daily routine logistically less demanding as they were not required to make the trip to the pharmacy for their methadone on a daily basis. Conversely, as noted above, Bonnie chose not to have carry doses as she recognized them to be a hindrance to her recovery and highlighted the need to have a stable and consistent routine which she maintained by going to the clinic and pharmacy on a regular basis:

When you've had several clean samples or enough clean samples you can have the option to have some take home doses. I personally prefer not to. I mean, I've had a couple here and there and I've had no problem with them. But I guess I just...when I was using I had absolutely no respect for like medications or opiates in general. One thing is I just sort of want to maintain that sort of respectful distance again. It keeps me in a really good routine...just getting me up in the morning, out. Going...I bike there in the summer. It gets me off my ass and exercising. I love the pharmacy I go to and I do still enjoy going down and you know, just seeing fellow patients and everything. I'm not using or anything, but it's just nice to get out. It's a really good routine, as much as I'd like to think I'd be fine with a fridge...carries sitting in the fridge. I know I'm still...you know, there's an addict in me and the temptation to take a little sip out of the next day or whatever. I'd just prefer it not to be there at all.

Bonnie valued the structure that daily dosing provided for her and she recognized that she may relapse should she not have to see a clinician, in this case a pharmacist, daily.

Participants also discussed the rules, regulations, and protocols involved with MMT that govern the administration of the therapeutic program. While some find the structure promotes their recovery, others find the guidelines to be punitive in nature. For instance, Patrick mentioned that a barrier to MMT was the rigidity of the program. He felt that there were a lot of ways that one could lose privileges but not a lot of ways to gain them. He went on to say that:

The group, for lack of a better word, but the people, the grouping of people that I've met since I've been on the methadone program are not the likes of people that I would've normally would have hung out and met and been associated with. I can fully understand

because of them people and what I've seen, why these protocols are in place. But on the other end of it though, not everybody who has an addiction to opiates was a homeless street bum who sells themselves to get the money to get their next fix.

Throughout his interviews Patrick placed a lot of emphasis on differentiating himself from what he perceived as a stereotypical MMT patient. In his interviews he often referred to such patients in a negative manner. On the other hand, Mia said she considered the rigidity to be a positive thing:

I needed that. I feel like if this clinic...like if methadone clinics were really laid back and stuff and if you didn't feel like coming then you didn't have to then I wouldn't be clean. This is the first place that I needed to be accountable to and that's why it was hard but I needed that, you know? Like, I don't know. People are...if you're an addict you're obviously not very good at structuring your life. You aren't really good with priorities. You need...and it's like hard. It's like tough love sort of thing where like these people are telling me they're not gonna give me my methadone or my prescription unless I show up at this time, before I close. Like yeah, that sucks and makes you really cranky when you have to walk here in the summer and you don't have a bus pass or a bus ticket but like if I wasn't willing to do those things like I don't think I would have deserved to be clean because it's like methadone has to be hard. Quitting drugs is hard. You know?

Mia went on to explain that the responsibility of having to go the clinic and the pharmacy while on MMT gives her structure and it is a good way to prepare her for the transition back to the real world where there are deadlines and times where she would have to be at work or be at appointments.

Linked to their discussion of the program's degree of rigidity, some participants perceived the program to have a lot of grey areas while others felt as though there should be more 'grey'. The rules of the program were not always clear to them and they felt as though they had no choice in the matter. Returning to his discussion of providing a urine sample, John went on to describe the lack of self-advocacy for what he perceived as typical MMT patients and noted that they are content with getting their prescription and leaving:

And a lot of them to be honest, I'm not saying it's black or white it's just my opinion, a lot of them don't even know what...they're just happy to get in and out of the door as fast as they can.

On the other hand, Patrick explained that he wanted more grey areas.

There should be the availability to be not so black and white. There should be some grey areas within the program for people who are not 'drug addicts' as the typical word states but more for the pain clinic where doctor prescribed addicts.

It was evident that participants had various opinions of how they experienced different aspects of the program. They also differentiated their experience at various clinics and pharmacies. Some of them said that certain clinics and pharmacies were better than others. One of the participant's experiences in another clinic involved appointments that were not conducted face-to-face but where the doctor connected with patients via Skype. He found that this was a bit uncomfortable, less intimate, and thus making it harder to open up to physician. He explained that he preferred to see the doctor in person. This person also discussed differences in the number of physicians at the clinic as well differences in the collection of urine samples.

Comparably, Karen had switched pharmacies since she had gotten full carries. She described how she had a number of issues at the previous one she had been using:

My drugstore where I'm at now I'm so grateful. I couldn't be at that drugstore unless I had full carries 'cause they are not open on weekends. So every time I relapsed I'd have to go to one of the other drugstores. But they're terrible because they treat you differently. Except for [pharmacy] it's not so bad because they actually 'cause they have a separate part where you go in, you get your own juice, you go up and they know who you are and you get your drink really fast. But like at [pharmacy] and all...like I don't know all the others I can only say for which ones I've went to but like for instance, the one at [pharmacy] it's terrible. They treat you badly.

She discussed the impact that the pharmacy team could have on the experience, whether by making one feel supported or further ashamed. Conversely, Patrick felt as though having a separate part in the pharmacy could be additionally stigmatizing.

MMT was an important commitment and participants emphasized that it was a gradual process. Once participants were on MMT, they explained that it took time for them to adjust and feel better. John explained that MMT is a slow process as opposed to a rapid treatment where change is incremental and patients move at their own prescribed pace:

When you go on methadone, for a person with mental illness that the difference is when you go cold turkey off using, you're hit with everything all at once. Where methadone I don't know how much it actually helps, how much self-medicating it does compared to. I don't know how much it helps with anxiety compared to other opiates. That's what I was hoping for originally. At least everything doesn't hit you at once. It's very gradual. You get to adjust very gradually. Whether you feel better or worse than you did when you were using, it happens gradually.

Similarly, Mia initially hoped to get clean right away and was disappointed when she found out that it would take both time and effort to reduce her drug use and for her to start to feel better. Patrick talked about how the program was different for each person based on what they did prior to it and what they are hoping to do after it. He felt that the program was designed and easy to use for drug addicts who are unemployed and hanging out downtown, but that it is harder for people who have jobs or who do not have cars:

For someone who's not a drug addict, the methadone system has a lot of problems, a lot of flaws. So for the drug addict who is living on the street the program's fucking easy as pie and it caters to your ass so bad it's not funny. But for a person who's trying move on with your life and not be part of that it may not be easy for you to do. So I guess it all depends on what side of the fence you're on.

Overall, participants' experiences highlighted 'MMT as a bridge' to recovery from addiction. Being on MMT allowed them to gain stability in their lives and focus on other issues rather than drug seeking. The next section outlines how their experiences of MMT have lead them to a new stage in their lives.

### 4.3.3. Liminality in the New Normal

In this section I address how participants described their lack of occupational engagement while on MMT, which resulted in much free time and a sense of boredom. This will encompass their discussion of their shift in routine once they got on MMT as well as their change in self-concept and identity in this new stage of their lives. A ‘new normal’ daily life that is characterized by liminality<sup>1</sup> was shown to be linked to people’s experiences on MMT. The participants described being in a liminal stage in their life as they were no longer regularly using drugs but were not back to where they were prior to their addictions beginning, or had not yet achieved the new goals they had set for themselves. This was particularly evident in Mia's interviews as she talked about how she was not able to move forward quite yet:

So now like my...when I was a few months being on methadone like I feel like my schedule, things I do are not at the point that they were before I started using, like I’m not there yet. Where like, you know, I’m not full-time back in school. I don’t structure my day like that because I still like...now that I’m weaning off methadone, some days are better than others.

She went on to explain that she had to find her own ways to fill her time and seek community supports to further structure her life as MMT did not specifically address this need during this phase of treatment. Participants explained that since they started MMT they had a lot of free time as they were no longer spending their time looking for money or drugs. As a result, they experienced boredom due to an expressed lack of meaningful occupations in which to engage. John admitted that he had to adjust to a different lifestyle:

So for me, I think I made that transition and for me, it was much more difficult because I had a lot of money, for me, relatively speaking to where I am today I made a lot of money. I was very busy. I used to go out to eat all the time. I used to do things. I had a nice car. I had to, for the sake of recovery, I had to get used to doing nothing. I had to be

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<sup>1</sup> The concept of liminality refers to a phase where a person is generally in a state of limbo after being separated from everyday life during an event then returns to mundane life having been transformed in some way (Peralta-Catipon, 2009).

able to be a homebody. I think in a way that might be kind of a contradiction, I have to get used to getting bored and being at home and watching TV.

Participants, including John, expressed grief at their loss of former occupations. They experienced a transition from an 'active' and exciting lifestyle to a life that is boring and mundane. Boredom was a recovery issue for these individuals, who had been used to doing things to get drugs, whereas they now had to put in a lot of effort (e.g. taking the bus) every day just to be able to function. The MMT routine was otherwise described as being very limited. This was evident in the occupational maps that the participants drew. Their new routines consisted mainly of eating, sleeping, going to the clinic and the pharmacy, going to a psychiatrist or counselor, volunteering, and spending time with family and friends. Other daily activities included grocery shopping, doing laundry, cleaning, and exercising. Participants also had hobbies that they enjoyed doing. These included watching television, writing, reading, playing video games, and bike riding. The daily lives of the participants were described as fairly simple. In John's interview, he emphasized that most of his daily life was dominated by medical appointments:

I think you have to set yourself up for success but you have to live near it. I mean you really do. You have to build your life around it. You do. You have to build your life around your medical stuff. I hate the idea of that 'cause I don't like my life being dominated by all medical stuff but I think you have to because you gotta go to the pharmacy every day, you gotta go to your doctor every week. You gotta set it up so that way it's very, very simple.

Social engagement was also limited for the participants. Patrick found that it was difficult to make friends because they all worked. He went on to say that if people on MMT want to make friends who are not other people on MMT or people from their past lives of addiction, it is difficult to meet these people or find time to hang out with them. On the other hand, John, having

lost his job and his main social network and support system, felt the need to engage with people in whatever way he could, even if it was just at the pharmacy:

It's funny just the mind of an addict, I remember I literally wanted to be at [pharmacy], even when I was getting clean, it was like I had this feeling that I was going to lose my friends or lose my connections or people were going to forget about me and you know it was my life right, even though I came from having a much more serious lifestyle, but I actually was worried about that and so I liked going to [pharmacy] because I wanted to run into people.

John expressed a desire and a need to be socially connected and supported by some sort of network of people. He went on to say that MMT had become his new social network and it was difficult for him to re-establish himself outside of a non-using, non-MMT group.

Yet, John and Patrick both talked about ensuring they did not get to know too many people. Avoiding certain occupations was a recovery strategy that was also described as having to be appropriately managed. Engagement in occupations was mediated with respect to potential exposure. Participants avoided going certain places, seeing certain people, or doing certain things that may lead to triggers that could harm their recovery. This was evident in Mia's discussion of places where she felt safe and others that she avoided:

Also, just in terms of like sort of interest in like social activities because I'm like so sort of like nervous about being around people that are using or like being in social situations like partly because I'm worried about being exposed to like drugs and alcohol but also because of like I'm socially awkward and like a little bit ashamed of everything I've gone through still. Like I sort of isolate myself up here at my parents, but my mom and dad have been like really encouraging about even going to Chapter's for a few hours or going to the [YMCA]...just trying to get me out there and doing things.

Similarly, Bonnie discussed purposefully avoiding certain occupations such as socializing with friends. She did include a friend on her map but drew it at the bottom of the page and explained that she tries to distance herself. John also discussed how he did not want to get to know too many people in the city of London in order to keep out of trouble.

While some participants chose not to do certain things or go certain places, others felt that, even if they wanted to, their options for occupation were limited in what they did as a result of the restrictive nature of MMT. Patrick mentioned that it would be hard to, for example, travel between provinces or go to destination weddings. He explained that being in the program means that you are essentially stuck because of needing access to the clinic and pharmacy on a regular basis. Conversely, Mia found that her clinic and the MMT program in general were accommodating and helpful. She took a trip to Europe and got the doctor and nurse at the methadone clinic to write her a letter stating that she would be travelling with methadone and described having no issues at the airport.

Self-concept and identity also changed as participants continued to live in this new phase of their life. For instance, many participants said that they were embarrassed about being on MMT. Mia evidently struggled with this embarrassment:

I feel like I always have to preface everything by like telling my story so that people don't think I'm just like a junkie because I have nothing better to do. Like, I always feel like I have to justify why I'm on methadone. But at the same time, like I don't hide it like I used to. Like, I never used to tell anyone. So I sort of like I want to be honest and not be ashamed to be on methadone but it's sort of like the fact that I'm ashamed that I'm an addict at all is what bothers me now.

Despite her progress on the MMT program, Mia appeared to perceive that recovery with MMT is less commendable as opposed to other forms of treatment. One way that participants discussed managing their identity was by deciding whether or not they would disclose that they were on MMT. John mentioned how when he worked, even though he was an addict, he could tell people he was a manager. Now, even though he was trying to get clean, his lack of position did not give him a good answer to types of questions about what he did, making it harder for him to 'get away with things'. This transition in terms of self-concept and identity was a struggle for him both mentally and emotionally. John explained:



When you already got that transition, do not plan on sitting on a bus for every day. I think that's one thing the experts don't get. A lot of the experts think "Hey come on other people can work eight hours a day. If I can work eight hours a day, than they can spend an hour walking to get their methadone." Yeah well no, you can't actually because we live in Canada, this is not a third world country. People today are not gonna feel very fulfilled to just deal with health stuff all day long.

John felt that his MMT situation was unique, thus he differentiated himself from other people on MMT. He expressed feeling as though he had the experience, skills, previous knowledge from when he was a manager to deal with different situations. As previously mentioned, Patrick, like John, separated himself from what he perceived as a stereotypical MMT patient:

I've never been an addict. I've never been a junkie on the street. Robbing or stealing or busting to try to get my next fix. I never lived like that. So I have no comprehension of how that could be.

Similarly, Mia's positive upbringing and family life was noted by her as a positive recovery tool and a distinct difference between several of the other MMT patients she had previously met. Participants' experiences were all different despite the fact that they were all transitioning. It was difficult for participants to transition into a more mainstream lifestyle when they were not yet back to normal. Instead, participants' were in a 'new normal' that appeared stuck in a middle stage, somewhere between where they used to be and where they ultimately want to be.

#### **4.3.4. Moving Forward**

In this section I address how participants described the various possibilities for their future. This will encompass their discussion of their upward trajectory as well as the potential for relapse and overall uncertainty when it comes to moving forward into their futures. While each participant's hopes for 'moving forward' differed from others, for many the future nonetheless seemed to be very unclear and ambiguous. Patrick discussed how there were multiple possible futures for people on MMT, including the future they hoped for and the future that might happen if they struggled in their recovery and relapse:

Wishfully, I'd like to see myself back at work at the automotive...and with my son...'cause that's what I fought for and that's what I've always wanted. Realistically, I see myself going back to jail a couple times...but I do see myself off methadone.

Mia also discussed her possible futures, leaving the experience behind her but remembering what happened:

I know that like London has been great for me and I think that I'll be in London for a few more years, but I really envision like, I see myself not being in London. I look forward to being able ten years from now look back from a different city, maybe in Europe or maybe somewhere in Toronto or Ottawa or Montreal and remembering London as a place where a lot of bad things happened but I also got better. Just like finish that chapter. Move on.

Mia knew she had potential and described feeling like she was not where she wanted to be yet.

She talked about not wanting other people to think that her current state was the 'final product'.

She also stated that she had the capacity to change and reach her desired goals.

An upward trajectory was evident as participants considered MMT to be lifesaving.

Participants were volunteering, earning carry doses, getting counseling, and looking into going back to school. Karen talked about how she went from being addicted to being proud about being able to go back to get her high school diploma:

I'm just trying to get my grade 12. So I'm really excited. I'm really proud of myself. It's amazing that I'm at that part in my life where I'm actually able to go back to school. It's just amazing. I can't even believe it. Like I'm going back to school? The junkie off the street. You know, I must have done something right somewhere along the line because I was a terrible person but I pulled myself up and I worked so hard. I worked so hard like I mean I've been in therapy for six years. I had PTSD, I have dissociation disorder. I've been abused. I have like just a lot of things...depression, ADD severe. You know, it's just all those things...everything if you look back at it now, everything had a reason for my drug...the reason why I chose the drug that I chose...the actual drug that I chose because it calmed me down. It made me feel like calm inside. But what I needed to do was get rid of all that stuff that was in there and I did that with therapy and I'm still doin' it right now with therapy so...

Karen addressed that addiction is a complex, multi-faceted disease process. Her progress took a lot of hard work, especially given her comorbid mental health issues. This upward trajectory,

however, was not necessarily stable for all participants, even Karen as she discussed multiple relapses.

Some participants talked about tapering off methadone and eventually getting off the program altogether. Patrick said that when he gets off MMT he will feel safer, proud, and more confident in himself. He thought he would feel gratified completing the program and would celebrate his success in no longer requiring methadone as a recovery tool. For others, like John, MMT was considered to be a lifelong treatment:

I mean, and for a lot of people methadone is not something that you're on and off in three months, six months. Most people know going into it that they're gonna be on it for a long time.

Other participants explained that they would have to continue to overcome stigma and misconceptions about methadone treatment at both the clinic and the pharmacy. There was a significant relationship between being in the MMT program and people's experiences with other systems and services. For example, participants addressed how the methadone label would get used against people in hospitals and in the court system. Karen discussed a previous hospital experience:

Well the hospital is different. They give you your methadone there right? And if you're in there for any other reasons than your drug related...then they give you, if you need pain meds, they'll give you pain meds. But they don't treat you the same. They don't.

Patrick also detailed his hospital experience having had a lot of previous visits given his medical issue. He described the change in the way people at the hospital would treat him when they found out he was on methadone and explained how he dreaded it. In addition, Patrick found that being on MMT was a hindrance in court where he was trying to get custody of his son.

Thus, the MMT program was not independent of other aspects of the participants' lives and the stigma of being on MMT was not specific to the clinic or pharmacy settings, but was

described as following people elsewhere. The stigma of MMT also affected participants' confidence or self-esteem as they felt they could not get rid of the reputation that label created for them. Patrick felt this stigma impacted the treatment he received:

But the pharmacy that, for instance the [pharmacy] down there, you go in, you get your prescription as anybody else does. But if you're on methadone, oh no you gotta put your hand on the special scanner. Get scanned and finger print scanner and then the machine pumps it out. You don't get any choices. It's warm, it's shitty Tang kinda thing. And you're literally made to feel special, but not in a good way.

In terms of giving advice to people who were considering going on MMT, participants emphasized that it was worth the effort. Karen stated:

Take the chance and just go for the methadone before you think about that next hit because the next hit is easier to get, but what about after that? You know what I mean? And you can't tell them all at once like I mean I wouldn't have understood if somebody told me you take the methadone and then you gotta work on yourself, I wouldn't have understood that at the time. You just gotta gradually like get them on the methadone and getting them feeling better, getting a person feeling better and then make them understand what addiction really is.

Although participants mostly thought MMT was a great program, some of the recommended changes to it included easier access to clinics, more information on the program, more respect at pharmacies, and more time to talk to the doctor at the clinic. Bonnie described her experience of getting kicked out of the pharmacy to highlight why changes are needed:

I broke my foot. I was on crutches at the time and they're just around the corner so it was easy for me to get there every day and I had asked them to fill my thyroid med as well and every time I was in there this one pharmacy tech, "Yeah it'll be ready. You can come back in a couple hours." So I come back in a couple hours that day and, "Oh, it's not ready." You know, whatever. Just didn't bother doing it. Like, I'm on crutches. I walked there. I went back like three times then finally I was like ok. Like this isn't ok. I realized you guys don't treat your methadone patients well in general, but like I'm on crutches. I haven't done anything disrespectful. I just want to be treated equally, get my meds and be able to go. I was basically told if I don't like it, I'm done there. And then the next morning when my husband showed up to get his drink he was told he wasn't allowed to dose there either.

Despite how far they had come, participants admitted that it would not be hard for them to relapse and end up back where they were during their addictions. Some of them had been on MMT in the past, gone off and restarted again. For instance, John, from the time of his initial interview to the time of his follow-up interview had left the MMT program:

I was really sick but I wasn't expecting to be in the position even to have to buy pills and all that like when the relationship ended with [doctor]. I literally was...sorry...I did decide to try to detox and I had a friend offer me methadone and I know that sounds terrible but they did. I was really sick and they said I could maybe give you some of my drink and I said, "No I can't do that." I might break down here and go back on methadone and then when I do I want to be able to get on it.

He went on to explain how he has since started using again:

I didn't have to do it all the time. I had for years, for years. I don't know how many years but years. I had done it every day, multiple...somewhere between three and ten times a day. I had at least three pills I would do plus I had the washes that I would do and you get addicted to the pills and everything. And so I was out of that. But guess what? Because of getting kicked off methadone, I have been off it. I've been shooting up every day now for a while now.

Despite the challenges they faced, the participants were proud of the goals they had already achieved. Mia, for instance, detailed all of the hard work she had put into her recovery and how proud she was of her accomplishments:

It's taken like a whole team of like professionals and it's like such...it's been such a daunting battle. Like, it's literally been a battle and I feel like I've aged...like it's hardened me a bit and like jaded me a bit because I was so sheltered before and like really naïve about things. But at the same time I feel like I appreciate things so much more and I feel like this was like the first thing in my life I've like actually worked super hard on. Like, I got through school like having to work really hard. My parents paid for school. So I've like never really had to work like hard for something. I sort of feel like this is like the first thing in my life that like was so important to me and that like I've done. Like, I know I've had a lot of help, but it's like been up to me. It's success or failure so...I just feel like I could do anything now. And I know I'm not out of the woods yet. I'm still weaning down. I don't know. In the real world, people would be like, "What the hell is she talking about? She's happy because she's not a drug addict anymore?" But it's like really hard! And when you're clean for one day...like your first day of being clean, like 24 hours, you think they should have like a parade for you. Like, that was hard. You know? I feel like I'm getting really confident about like doing something and now that I'm back from France, I'm like ready for another goal.

Mia continued to detail her journey and progress, admitting that she was still in the process of recovering. She further described driving through her old “drug hunting grounds” with her parents as a reminder that it would only take one mistake and she could end up right back where she used to be.

Goals that participants had for the future included going back to school, getting a job, being more physically active, travelling, dating, and moving to a different city. John was hoping that he could get back on MMT and stop using drugs. Despite having an idea of some of the goals they would want to achieve, participants expressed a great deal of uncertainty in terms of where they would end up. John was concerned about the fact that he had not worked for a while “And you can’t get jobs after. I can’t find a job. Do you know how hard it would be for me to find a job in anything else with a big gap on my resume like this?” When discussing the possibility of returning to work he struggled to find an answer. He seemed uncertain as to what the future would bring. Mia explained that she saw herself moving but was not at the point yet where she was ready to do that:

I feel like I'm not ready to go anywhere. I'm not ready to move out of the city. I'm not ready to go to another clinic. And also like when I was using, I never stuck with anything. Like, I never completed anything. It was hard enough to finish reading like a novel.

She discussed her determination to finish what she started, where she started it, and who she started it with. She did not want to go to another clinic despite her desire to get out of the city. She described her positive relationship with the clinic staff and how they complemented her family's support. She felt as though she had a whole team of people supporting her and went on to say that she was focused on one goal at a time. Karen was also focused on the immediate present and the fact that she would be going back to school, but did not know what would

happen after that. The future for the participants was unpredictable. With a lack of control over their addiction they had no way of really planning for the future.

#### **4.4. Conclusion**

This chapter presented the findings from data generation and analysis. Sessions with the participants included two in-depth semi-structured interviews, the creation of an occupational map, and a demographic questionnaire. Introductions and descriptions of each participant provided background and context. These descriptions also highlighted key threads that emerged during data collection. Maps highlighted participants' routines that consisted mainly of going to the clinic, to the pharmacy, and to other medical appointments, volunteering, grocery shopping, and visiting friends. Four themes emerged from the data that highlight participants' experiences of living and being on MMT. The findings indicate that a 'descent into chaos' occurred as participants' addictions began and worsened over time. Prior to their addictions their daily routines involved going to work, school, and hanging out with family and friends. Participants started using recreationally or because drugs were prescribed to them. During their addiction, their daily lives were chaotic and drugs became a priority. Participants were on a downward trajectory as their addictions evolved to polysubstance use that escalated in frequency and varied in route of administration. Participants' experiences of 'MMT as a bridge' to recovery from addiction were then described. Participants reached a point where they felt ready for treatment. After failed attempts at other types of treatments, participants made the decision to begin MMT based largely on what other people told them about the program. Starting MMT was a commitment that involved obtaining information about the program, a task that participants found particularly difficult. Once they were in MMT, participants were able to gradually recover from their addictions. They discussed various aspects of the program including the methadone

dose, urine testing, cravings, and carry doses. While the participants were able to reduce and stop their drug use on MMT, they also felt that MMT had a lot of 'grey areas' or that aspects of the program were unclear. A 'new normal' daily life that was characterized by liminality was subsequently shown to be linked to their experiences on MMT. Since they started treatment, participants had a lot of free time that was characterized by boredom. Their MMT routine was fairly limited and was dominated by medical appointments. Participants were often embarrassed or ashamed about being on MMT. Self-concept and identity was managed by their decision of whether or not to disclose that they were on MMT. Finally, participants' hopes for 'moving forward' in the future were unclear. Their lives were on a hopeful but precarious upward trajectory as they were volunteering, earning carry doses, receiving counseling, repairing relationships and looking into going back to school or work. Despite this progress, participants were very cautious and aware that it would only take one mistake for them to relapse and end up back where they were prior to beginning MMT. Overall, participants were fairly uncertain about where they would end up.

In the following chapter, I discuss how the findings presented in this chapter can be further understood using a conceptual frame of occupational justice. In addition, I address the implications of these findings and how they may inform occupational science as well as treatment providers, service organizations, families, policy makers, and broader society to support these individuals in the recovery process. The limitations of the current study as well as future research directions will also be outlined prior to presenting the study conclusion.



## **Chapter Five – Discussion and Conclusion**

### **5.1. Introduction**

The aim of this study was to deepen the understanding of the experiences and daily routines of people on MMT through in-depth exploration of their everyday occupations and the ongoing challenges and barriers they face to accessing treatment. This thesis began by introducing MMT and how the program works. I outlined how this topic is situated within the field of occupational science and how the occupational justice framework was used to guide this study. In addition, I presented my research objectives, which were to: i) describe the challenges and disparities faced in the everyday occupational lives of methadone patients, ii) map the daily lives of MMT patients and examine the ways in which these individuals orchestrate the use of their time, and iii) examine the time, routines, spaces, and interactions characterizing the everyday occupational lives of individuals on MMT. A description of myself as the researcher, as well as an outline of my thesis were also provided. The second chapter presented a scoping review of the qualitative literature on the daily lives of people on MMT. Key themes found in the literature included stigma, self-concept and identity, and personal relationships. The third chapter detailed the study's ontological and epistemological positioning, methodology, and data collection methods including semi-structured interviews, occupational mapping, and a demographic questionnaire. I also described data management and analysis methods, ethical considerations, and quality criteria. The fourth chapter presented the findings from the analysis of the data collected from the study. I introduced the participants and the common threads from their interview sessions. I also provided a description of their maps. The fourth chapter ended with the presentation of the four themes that highlight key aspects of the participants' experiences, including a 'descent into chaos', 'MMT as a bridge' to recovery from addiction, a

liminal ‘new normal’ daily life, and hopes for ‘moving forward’. In this final chapter, the key findings are linked to the concept of occupational justice and their implications for further research, policy development and service provision are considered. In addition, the strengths and limitations of this study are addressed and future research directions are noted. I end with the final conclusions of this research study.

## **5.2. Discussion**

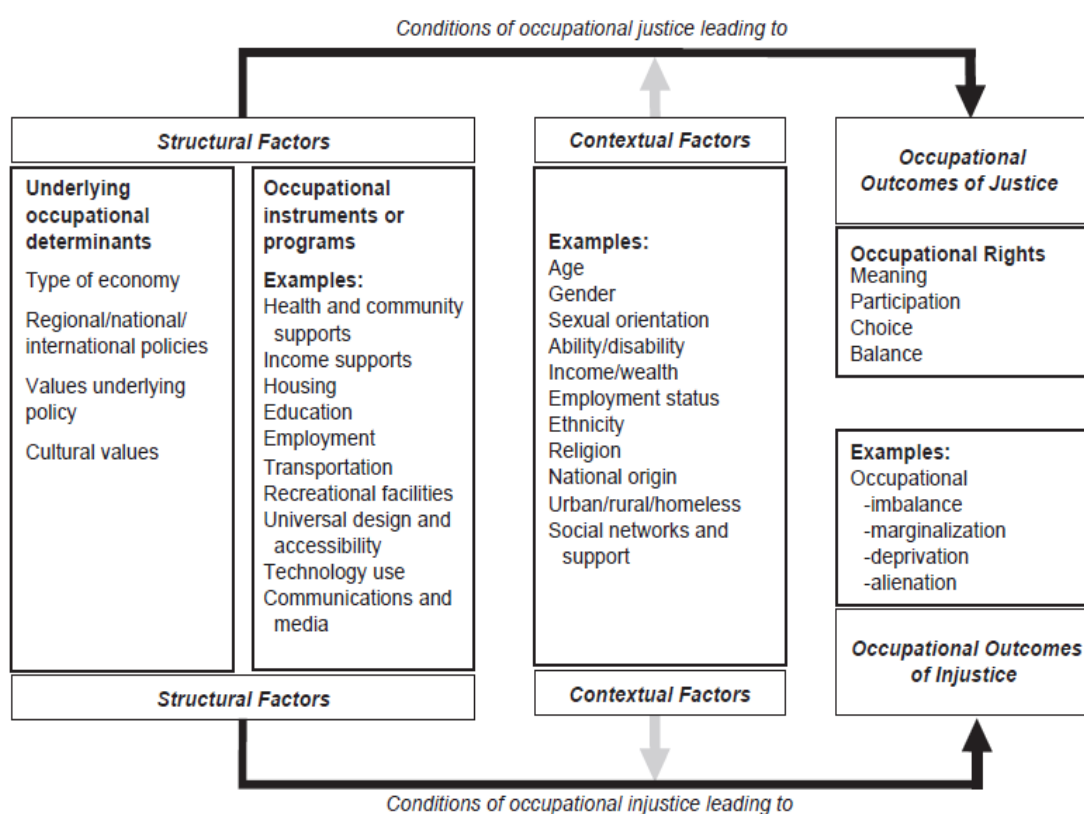
This section serves to further interpret the findings of my research. I will discuss the current study’s findings in relation to the framework of occupational justice (Townsend, 2012). This framework stems from Stadnyk et al.’s (2010) original article and according to Townsend (2012), the framework offers a critical occupational perspective of justice and injustice. Below, I will consider the structural factors, contextual factors, and occupational outcomes from the framework that are most relevant to the participants’ experiences of daily living on MMT.

As discussed in chapter four, the findings reveal a ‘descent into chaos’ as participants’ addictions began and worsened over time. Second, participants’ experiences of ‘MMT as a bridge’ to recovery from addiction was described. Third, a ‘new normal’ daily life that was characterized by liminality was shown to be linked to people’s experiences on MMT. Finally, participants’ hopes for ‘moving forward’ remained ambiguous. These themes in the data suggest that participants did not follow a strictly linear route to recovery but generally shifted from chaos to boredom with the ever present possibility of relapse. This transitional experience conveys important aspects regarding individual issues of occupational engagement shaped by broader conditions of occupational injustice (Townsend, 2012). In order to further examine this issue Stadnyk et al.’s (2010) occupational justice framework can be used. In the following sub-section

I begin by exploring the structural factors that are most relevant to the participants' experiences of daily living on MMT.

### 5.2.1 Structural factors

As previously discussed in section 3.2.2, Stadnyk et al.'s (2010) evolving theory of occupational justice outlines how structural factors, including underlying occupational determinants, as well as occupational programs and instruments, combine with contextual factors to contribute to occupational justice or injustice (refer to Figure 5.1).



**Figure 5.1. Framework for Occupational Justice (Townsend, 2012, p. 13)**

As discussed in chapter three, the examples listed in the columns are not exhaustive and there are many other possible structural and contextual factors. According to Stadnyk et al. (2010), structural factors influence whether certain occupations are available or unavailable. For example, there may or may not be employment, affordable housing, or programs such as ODSP

or Ontario Works available within a particular region. In terms of underlying occupational determinants, elements such as the type of economy, policies, and values have an influence on occupation. These occupational determinants are operationalized in occupational forms (i.e. occupational instruments or programs). The availability of occupational forms such as housing, education, recreational facilities, and technology use, when combined with the underlying determinants may create conditions for occupational justice or injustice.

Some of the occupational forms that were most discussed by participants in this study included health and community supports, income supports, housing, education, employment, transportation, and universal design and accessibility. These reflected issues that participants had with more general aspects of the social system. According to the participants, health and community supports were lacking in the city of London as participants struggled to find information on MMT prior to starting treatment and to find information on accessing additional support programs or resources once they were on MMT. Participants also discussed how they felt as though they were not supported by external agencies in their attempts to manage their recovery. For example, John explained the relationship he had previously had with his psychiatrist and how he lost this support when he needed it most. He also detailed his experience of trying to find another psychiatrist and expressed concern at the length of time it took for him to do so. In Smye et al.'s (2011) study many of the participants also expressed mistrust with the healthcare system due to everyday experiences both within and outside the system that further marginalize them.

However, income supports were available and used by three of the participants who described them as essential to their recovery as they covered the daily cost of methadone. Despite this financial support, these participants were unable to afford housing. Three

participants were staying with family members, two of whom discussed the challenges they would have to face if they did not have that additional support. For example, Mia explained that if it were not for her parents she would not be in the same place with respect to her recovery. Although she expressed a desire to move on with her life, she admitted that she would not be able to live on her own and stay clean. Being on ODSP she had a limited income and even though she wanted to go back to school, she was not at the place where she was able to do that yet.

Education was also an occupational form that was relevant to participants' experiences as some were going back to school while others talked about doing so in the near future. An example of this can be found in Karen's situation where she had the opportunity to earn her high school equivalency. Employment challenges related to being on MMT were also addressed, as participants talked about the program being easier if unemployed, but that it is harder for people who have jobs or who do not have cars. Participants were thus, also restricted in terms of transportation as most of them relied on a family member or a family member's vehicle to go places. Similarly, universal design and accessibility are considered barriers to the MMT program. The specific universal design principle that best applies to the participants in my study is equal access. Equal access means that everyone is provided with the same opportunities and full participation in programs and activities as other members of society (Stadnyk, Townsend, & Wilcock, 2010). An example of the violation of this principle highlighted in my study was the practice in some pharmacies where individuals have to enter through a separate door in the pharmacy to get their methadone. Another example of how participants in this study were restricted in terms of accessibility is the fact that MMT clinics have to be located in specific parts

of the city. These practices violate this principle and changes should be made to enable equal access.

While some participants explained that the structure of MMT promotes patients' recovery, others found the guidelines to be punitive in nature. Urine sampling, for example, was a recovery issue for John in particular. In some cases, illicit drug use has been known to impair the individual's ability to eliminate and provide a urine sample (Benyamin, et al., 2008). With clinical stability, urine sample decreases in frequency and is often perceived as a reward for good behavior. In addition, participants explained that MMT should be more open and accessible without the stigma that many articulated exists at other clinics within the city of London. For instance, some suggested that clinics should be centrally located on bus routes. In Anstice et al.'s (2009) study, respondents explained that longer opening hours provided clients with flexibility to arrange transportation. They went on to conclude that people on MMT may need to disclose their MMT status to friends and family members in order to explain daily visits to the pharmacy to get assistance with transportation.

Thus, the current study adds to what is already known about people's experiences of MMT. Structural factors such as the ones described above were experienced differently for each participant depending on their varying contextual factors. In the next sub-section I will discuss the contextual factors that were most relevant to the participants' experiences of daily living on MMT.

### **5.2.2 Contextual factors**

Contextual factors are described by Stadnyk et al. (2010) as creating conditions where there is equal or unequal access to resources, programs, and services. As previously mentioned in chapter three, these factors are experienced differently by people depending on their personal

circumstances or situation. Some of the notable contextual factors for the participants in this study were income and wealth, employment status, homelessness, family and friend support, and health status. These factors referred to the unique experiences that each participant had. Firstly, with regards to income and wealth, participants were not financially stable to be living on their own. As noted above, three of the five participants were on ODSP, which also covered the cost of their methadone. Their levels of income were shaped by their employment status; all of the participants were unemployed at the time of data collection. This finding differs from to the population in the study by De Maeyer et al. (2011) who found that methadone supported opiate-dependent individuals' integration, because they were able to function normally (e.g. being able to have a job) and operate in society.

Moreover, three of the participants had experienced homelessness at some point and many emphasized that social networks and support were very influential in their recovery. John discussed living with his brother but recognizing that this was not a long term solution. His uncertainty regarding his housing situation influenced his experience of MMT because he was worried that he would be unable to make it to his appointments at the clinic and the pharmacy once he was no longer living with, and having access to transportation from his family. This led him to make the decision to start to taper off methadone. His aim in tapering was to be 'clean' but he ended up relapsing even though that was not his intent. Mia particularly emphasized the importance of having her family involved in her recovery because it helped her to be around people who had regular routines that helped give her structure. She noted that having this guidance and stability would help her to transition back into the 'real world'. Higgs et al. (2010) suggest that family can play an important role in maintaining and facilitating treatment. Mia also discussed how much she valued her relationship with the physician and nurse at the clinic.

Conversely, John talked about his desire to have more of a relationship with both the clinic staff and health professionals in general, citing one of his biggest concerns as not having enough time to talk to anyone about his co-morbid health issues.

On the other hand, the significance of friend support regarding treatment varied for the participants and was largely limited. As mentioned in chapter four, there were only two participants who included friends on their occupational map. However, in both their interview sessions and description of their maps, those two participants indicated that seeing the few friends that they did have was a rarity. This finding also contrasts those from De Maeyer et al. (2011) as the participants in their study frequently cited that the presence of a good friend was characteristic of the time during which their quality of life was the highest. In the current study, most of the participants seemed to be particularly cautious about the friends that they would associate with. Others found that it was difficult to make friends because if they wanted to meet with people outside of MMT programs, they were employed, which made it difficult to find a time and place to socialize.

Two participants also discussed going to the clinic and the pharmacy to address their lack of social interaction. They were unable to engage in occupations that fostered connections as they lost their social context and the potential to strengthen social roles (Whalley Hammell, 2014). John, for instance, was used to socializing at work on a daily basis. When he lost his job he not only lost his source of income but he also lost his social connections over time as he struggled with ongoing health issues. Their perceived or real lack of social support is a potential issue that could impact on the quality of their recovery as well as their transition to their 'new normal'. It was evident that it was difficult to transition into a more mainstream lifestyle while they were still in treatment.



Lastly, health status for the participants involved severe medical conditions, chronic pain as a result of past injury, and HIV. Opiate dependence that developed secondary to participants' primary illness or injury became their main occupation and required their full-time attention. For instance, Patrick's health conditions impacted his everyday occupations as well as his experiences of MMT. He spent most of his time at home. This resulted in limited social engagement as the friends he did have had to come to his house to see him and to socialize. In the following sub-section I will discuss the occupational outcomes from the framework that are most relevant to the participants' experiences of daily living on MMT.

### **5.2.3 Occupational outcomes**

As outlined by the framework, when structural and contextual factors combine 'positively' (e.g. jobs are available and the individual is employed) the occupational outcome is justice characterized by the rights of choice, participation, meaning and balance. When they combine 'negatively' (e.g. there are adequate financial resources but they are not distributed equally) people experience the outcomes of injustice, which are imbalance, marginalization, deprivation and alienation. Participants' experiences did not often lead to them enjoying particular rights such as choice and balance. Choice refers to the right to exert individual autonomy through choice in occupations (Christiansen & Townsend, 2010). Despite experiencing the forms of injustice that will be described below, the participants were not completely without occupational rights. In contrast to Smye et al's (2009) study that found that individual agency was affected in several ways and limits were placed on the freedom of some people to move from one area to another and choices were limited by power inequities, participants in the current study still experienced some choice. They would organize their day in a certain way and used occupational strategies to engage in some occupations strategically and/or purposefully avoid certain

occupations to help their recovery. For instance, some participants would go to the pharmacy or clinic first thing in the morning. Others would make lists for each day so that they would feel like they accomplished something.

Another occupational and recovery strategy was avoidance of certain occupations. Engagement in occupations was mediated with respect to potential 'exposure'. Participants avoided going to certain places, seeing certain people, or doing certain things that may lead to 'triggers' that could harm their recovery. Despite facing challenges, they were not simply victims with no agency, they were taking some control by being on MMT and trying to be successful on the program. While this avoidance could be seen as contributing to imbalance, it was also a choice people were making to not do these things. This finding is in line with Smith and Rosen (2009) who, as discussed in chapter two, explored barriers to the use, maintenance, and expansion of social supports in older adult methadone clients. Some participants in their study articulated a desire to keep to themselves to avoid "people, places, and things" (p. 660) related to their past drug use.

Occupational balance refers to people's right to benefit from fair privileges for diverse participation in occupations (Christiansen & Townsend, 2010). Participants lacked balance as their lives revolved around their recovery and were dominated by medical appointments structured in relation to their MMT schedule. Participants often felt they lost the rights of choice and balance as a result of stigma from being on MMT, which prevented them from moving forward and forced them to stay in a liminal state of limbo. Participants in De Maeyer et al.'s (2011) study explained that being able to continue working also prevented participants from falling into the sort of limbo described by the participants in my study who were unemployed.

Participants without a job had an abundance of free time that they sometimes had trouble deciding how to fill. Their routines consisted mainly of occupations related to MMT.

At the same time, it pushed them to advocate for methadone, break down myths, and justify their situations in order to challenge other people's prejudices toward MMT. Mia in particular talked about her hesitation when it came to starting MMT and the myths that she often heard from people on the streets about the program. This is similar to Neale's (2008) finding that some clients had a preconceived notion that methadone would present similar or worse problems than the drugs that they were using. Participants described being made to feel different at the pharmacy, for example, where they would have to wait in a separate line and have their hand scanned prior to getting their methadone drink. This was similar to Anstice et al. (2009) who found that clients' accounts of supervised methadone consumption were interwoven with their experiences of feeling stigmatized as an MMT client. However, in contrast to Anstice et al.'s (2009) study, the current study found that there was less stigma related to relationships with staff members and that those relationships helped participants to overcome obstacles and progress in their recovery.

The occupational justice framework (Stadnyk et al., 2010; Townsend, 2012) outlines four outcomes of occupational injustice: occupational imbalance, occupational marginalization, occupational deprivation and occupational alienation. The findings most clearly illustrated participants' experiences of occupational imbalance and occupational marginalization. With respect to occupational imbalance, which is defined as "an individual or group experience in which health and quality of life are compromised because of being overoccupied or underoccupied" (Christiansen & Townsend, 2010, p. 420), the participants on MMT were restricted as they were 'underoccupied' that in some cases, further compromised their health and

quality of life. They were unable to engage in a range of fulfilling activities that could promote well-being and experienced a shift in occupational imbalance from chaos to boredom. As an occupational being, someone's lived experiences of imbalance would make them feel segregated and bored. For example, in Patrick's life, as a man who had previously been in the military, he now took on chores around the house and referred to himself as a "house wife" in order to occupy his time. Participants had a limited routine before starting MMT. They described their time before MMT as being comprised mainly of seeking drugs (and seeking money to buy drugs). They also described having a limited routine now that they are on MMT, which consisted mainly of going to the clinic and pharmacy, going to other appointments, volunteering, and grocery shopping. While on MMT they described being bored because of a lack of meaningful occupations in which to engage. Boredom was also noted by Helbig and McKay (2003) to contribute to the cycle of addiction. They examined the occupation-based literature in order to gain a better understanding of addictive behaviors from an occupational perspective and explained that boredom was related to restricted access to occupation due to costs, individual and societal values about the occupation, time restraints, or lack of awareness.

In addition to simply being bored, the participants appeared to be experiencing a sense of being stuck as they expressed uncertainty about their futures, therefore making it difficult for them to move forward. This echoes findings from Aldrich and Laliberte Rudman's (2015) study of long-term unemployment. Using situational analysis, they found that unemployed workers described themselves, and were described by service providers, as being stuck in their situations. Difficulty moving forward was also an issue discussed by participants in Radcliffe and Stevens' (2008) study where they conducted interviews with former MMT patients. They found that supervised methadone consumption was seen as hindering progress to the desired 'normal' life

of conventional employment. As discussed in chapter one, Heuchemer and Josephsson (2006) argue that occupational imbalance is related to the narrowing repertoire of daily occupations that typifies addiction-related behavior. They explain that "an unhealthy balance of daily occupations may lead to an internal conflict between what people should do and what they want to do" (Heuchemer & Josephsson, 2006, p. 161). This conflict was something that participants in this study struggled with, however it was often expressed in terms of what they would want to do versus what they thought they might actually end up doing. For example, Patrick discussed his wishes to get off methadone and get his son back, but admitted he felt it was more likely that he would go first go back to prison.

The study participants also discussed some of the spatial implications related to MMT such as it being hard to travel both due to lack of vehicle ownership but also because of the responsibility they had to go to clinic appointments and to go to the pharmacy to get their methadone. Participants went on to discuss how being in the program meant they were essentially 'stuck in place' and described a paradox of needing the program to move forward, but not being able to move forward while in the program. They experienced a different kind of imbalance where they were unable to develop skills for work or leisure. Most of their daily lives were dominated by medical appointments and this finding is consistent with Järvinen and Miller's study (2010) that found MMT increases participants' sense of stability by providing them with methadone which allows them to better address their economic, housing and other daily needs but the program also represents a context of physical, emotional, and social dependence.

Occupational marginalization occurs when people are not able to participate in occupations as they are restricted from experiencing autonomy through lack of choice in

meaningful and health promoting occupations (Stadnyk et al., 2010). People who are occupationally imbalanced may also experience occupational marginalization. Marginalization often occurs because individuals or groups, such as MMT patients, are discriminated against explicitly or implicitly because of the contextual factors such as homelessness and employment that were described above. While the participants discussed their desire to do something, they were unable to as Western society largely prioritizes paid productive occupations, leaving important occupations across the lifespan, such as recovery, to be under recognized (Christiansen & Townsend, 2010). As occupational beings, individuals' lived experiences of marginalization would make them feel lonely, excluded, and sad. For example, in Karen's life she was treated differently at the hospital she disclosed that she was on methadone. Participants in this study did not have full time employment and were not contributing to society in the traditional sense. Instead, their main occupation was MMT and in contrast to the perception that people on MMT are unproductive and 'lazy', participants were proud of themselves for having come so far in their recovery journey. Despite the fact that participants had a limited routine prior to and during MMT, they had progressed from the homeless, drug-seeking lifestyle they once had. Being on methadone is so negatively valued by society that it is not recognized as a legitimate and life sustaining occupation and is outside the dominant or mainstream discourse. For example, Bonnie told the story of an interaction she had with a man downtown who disclosed to her that he felt unsafe downtown being around lazy methadone patients. Baffled at his comments to her, Bonnie went on to tell the man that she herself was on methadone.

In both the current study and in Ning's (2005) study, gossip permeates everyday routines for MMT clients. Being on methadone helped participants in this study get more back to normal, but that normal still did not reflect mainstream lifestyles. Furthermore, depending on when they

started using, not all of the participants experienced that type of lifestyle prior to their addiction. One's experience of the program was different based on what they did prior to it, and what they were hoping to do afterwards. Participants described working hard at getting clean, but that did not imply that they would return to their pre-addiction lifestyles. They were working hard at getting to a new point in their life where they were healthy and feeling positively about themselves.

Overall, MMT is not strictly an 'individual' experience, rather it is shaped by the broader factors that adopting the occupational justice framework helped me to identify. These broader structural and contextual factors such as health and community supports, transportation, and employment status, lead the participants to experience particular occupational injustices such as occupational imbalance and occupational marginalization. In the following section, I return to my personal reflection after having completed this research study.

### **5.3. Return to Reflection**

In section 1.5 I briefly introduced who I was in relation to this research when I first started. Now that I have completed my research study, this section provides further reflection with regards to having engaged in the research process. As I mentioned in section 1.5 working at the MMT clinic made me wonder how clients not only access MMT but also carry out their daily routines when they have to go to the pharmacy on a daily basis and to the clinic once a week. I oftentimes tried to put myself in their shoes and thought about how I would be able to engage in other occupations if I was on MMT. The experience of conducting a study of people's experiences while on MMT strongly contributed to my role at the clinic. Having worked at an MMT clinic as a laboratory technician I was familiar with some of the struggles that patients had in terms of being able to make it to their appointments. Initially, I was excited to be starting my

research study, however at the same time I was nervous, not only about being able to recruit participants and how participants would react to the questions but also about how they would react to me being the researcher given that I worked at the clinic. The welcoming reception I received from each participant encouraged me to become increasingly engaged and passionate about this group of people.

Personally, I learned that as an academic and as a researcher I can help people on MMT just by treating them with dignity and respect. I also learned that I can help them by shedding light on their everyday experiences just as I have done in this study. Each person on MMT has unique circumstances yet they are categorized into a group of people who are thought of and treated negatively. Conducting this study has made me increasingly aware of the ongoing challenges faced by people on MMT. I was surprised at how limited the routines of these individuals are as well as the lack of occupational and social engagement. Now that the study is complete, I remain committed to supporting these people as they take this positive step in their lives and to treating them with dignity and respect. Recommendations for service provision are provided in the next section.

#### **5.4. Recommendations**

As an outsider to the experience of MMT the findings presented in chapter four are important since MMT was highlighted as one of the few main occupations in the daily lives of the participants around which most of their routines were built. My findings show that even though the participants chose to engage in certain occupations such as volunteering and to avoid other occupations such as social interaction with former friends, they were subjected to both occupational imbalance and occupational marginalization as a result of the combination of structural and contextual factors. It is important for MMT practitioners, researchers, and



occupational scientists to understand the occupational nature of MMT. It is vital to consider how the structure of MMT promotes patients' recovery but also how the guidelines can be punitive in nature. This study indicates that program rigidity such as carry dosing shaped people's individual experiences of MMT. MMT programming should consider the structural and contextual factors shaping the occupational aspects of patients' experiences described in this thesis in order to better attend to the centrality of MMT in the recovery process and concomitantly to people's lives. The next section addresses the limitations of this study and related directions for future research.

### **5.5. Study Strengths/Limitations and Future Research Directions**

In this section I outline the strengths of the current study. I also present possible directions for future research that address the study limitations. A key strength of this study was that I applied occupational justice related concepts to a population that has not yet been studied within the occupational science literature. Thus, the current study was novel as the occupational science literature has yet to examine the daily lives and routines of people on MMT and has only marginally addressed addiction. By using an occupational perspective to study MMT, I also contributed to the literature on addiction and MMT. This was another strength as occupation-based literature has marginally addressed addiction. Finally, the use of occupational mapping is also a strength of the current study as it added to the richness of the data and helped to further our understanding of the routines of people on MMT. In the following sub-section I will discuss the four directions for future research and the limitations that each of them address.

This study was conducted as part of the requirements for a Master's in the occupational science field of the Health and Rehabilitation Sciences Program at The University of Western Ontario. As a result, the study was subjected to time and resource constraints. I suggest four

directions for future research that address the limitations of the current study. These include conducting additional comparative research, such as recruiting employed and unemployed participants; recruiting additional participants from the same clinic; recruiting participants from different clinics; and conducting similar studies in other cities as well as rural areas.

Firstly, the participants in this study were all unemployed and felt that it would be difficult for people who are working to access MMT due to the rigidity of the program. I recommend that a comparison be done between these participants and other MMT patients who are employed. I argue that this could identify similarities and differences in the occupational outcomes related to occupational justice and injustice. This might add new perspective and insight on how different contextual factors (e.g. employment status) can influence people's occupational outcomes. The second recommendation I have is recruiting additional participants from the same clinic in order to both highlight the diversity at the MMT clinic and further examine the injustices experienced by other people on MMT. Thirdly, since my research focussed on recruiting from one clinic and some of the participants noted different experiences in various clinics it would be useful to do research at other clinics to determine how people's experiences elsewhere were similar or different. For instance, future research could determine if other people on MMT choose certain occupations over others in order to reduce the risk of relapse. Lastly, my study recruited participants that lived in London. I recommend that additional studies be conducted to compare the city of London to different areas within the province. For instance, other cities within Southwestern Ontario could be explored. Moreover, conducting similar studies in rural areas would allow for the exploration of other contextual factors such as urban/rural location.

## 5.4. Conclusion

In this thesis I aimed to examine the relationship between MMT and other occupations that form part of the participants' daily routines as there is limited qualitative research regarding the daily lives and experiences of people on MMT. The purpose of this study was to generate knowledge and raise insight with regards to the disparities, challenges of, and barriers to accessing MMT and carrying out daily routines experienced by individuals while on MMT. The objectives of this study were to: i) describe the challenges and disparities experienced in the everyday occupational lives of methadone patients, ii) map the daily lives of MMT patients and examine the ways in which these individuals orchestrate the use of their time, and iii) examine the routines, spaces, and interactions characterizing the everyday occupational lives of individuals on MMT. Overall, this research addressed the three objectives I had as the challenges and disparities described by the participants on a daily basis included difficulty accessing MMT, occupational avoidance, and being treated with a lack of dignity, respect, and sympathy, among others. The occupational maps showed the lack of occupational engagement that participants had and helped me to understand how limited the daily routines of the participants were. These maps were however, specific to the particular time at which they were drawn. Interview sessions served to highlight that MMT is a gradual process with a slow progression. Lastly, routines were for the most part fairly limited, unstructured and built around the central occupation of MMT. In addition, spaces and interactions were carefully managed and oftentimes avoided in the everyday occupational lives of individuals on MMT.

I conducted an intrinsic case study using semi-structured interviews, occupational mapping sessions, and demographic questionnaires with five participants. Overall, findings were presented according to four themes. Participants outlined a 'descent into chaos' as participants'

addictions began and worsened over time. Prior to their addictions their daily routines involved going to work, school, and hanging out with family and friends. Participants started using for different reasons. During their addiction, their daily lives were chaotic and drugs were prioritized. Participants were on a downward trajectory as their addictions evolved. Second, participants' outlined their experiences of 'MMT as a bridge' to recovery from addiction as they reached a point where they felt ready for treatment and made the decision to begin MMT. Once they were in MMT, participants were able to gradually recover from their addictions. They discussed various aspects of the program, including what they felt were its 'grey areas'. Third, a liminal 'new normal' daily life was shown to be linked to people's experiences on MMT. Finally, participants' hopes for 'moving forward' remained largely uncertain.

As discussed within this chapter, these findings illustrate how structural factors such as health and community supports, income supports, transportation, and universal design and accessibility, as well as contextual factors such as income/wealth, employment status, homelessness, and family/friend support interact to create negative occupational outcomes that subjected the participants to both occupational imbalance and occupational marginalization. Despite experiencing these forms of injustice described above, the participants were not completely without occupational rights. They used occupational strategies which included strategically engaging in certain occupations and purposefully avoiding other occupations to help their recovery. They chose not to do certain things and thus took some control by being on MMT and trying to be successful on the program.

In conclusion, my research adds a novel contribution to the occupational science literature, which has yet to examine the daily lives and routines of people on MMT. By using an occupational perspective to study MMT and specifically applying occupational justice related

concepts, this work also makes an important contribution to the literature on addiction and MMT. The occupation-based literature has marginally addressed addiction (Helbig & McKay, 2003; Kiepek & Magalhães, 2011) but has not specifically examined recovery or opiate addiction. Likewise, the literature on MMT has not adopted an explicitly occupational perspective. Previous literature does consider identity as discussed in chapter two, but it does not sufficiently attend to 'doing'. It was clear from the sessions with participants that there is a difference between what people were doing while addicted and what they are doing in recovery, but the MMT label creates an ongoing stigma that shapes their occupations. The stigma of being on MMT is not specific to the clinic and pharmacy settings but follows people elsewhere. MMT is not strictly an individual experience, rather it is shaped by the broader factors that the framework helped me to identify, which lead the participants to experience particular occupational injustices. With that being said, people on MMT must be better supported while taking this positive step in their lives and should be treated with dignity and respect.

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### Appendix A: Articles Included in the Scoping Review

Title, Author, Year			Journal Title	Purpose	Methodology and Methods	Whose Perspective?	Findings
Supervised Methadone Consumption: Client Issues and Stigma	Susan Anstice, Carol J. Strike, & Bruna Brands	2009	Substance Use & Misuse	To examine MMT clients' experiences of supervised methadone consumption	Unspecified Interviews	MMT clients	Three themes dominated clients' accounts of supervised consumption: convenient access to service, relationship with pharmacists and staff, and attributes of the dispensing space Clients experience stigmatization in all three of these area Some dispensing contexts help clients manage a stigmatized identity, others make this identity visible
Games of Truth: Rethinking Conformity and Resistance in Narratives of Heroin Recovery	Ana M. Ning	2005	Medical Anthropology	To illuminate complex and shifting relations between and among staff and clients in a methadone clinic	Ethnography Interviews	MMT staff and clients	The staff and clients' multifaceted interpretation of recovery which questions whether or not MMT is really a "successful" treatment
"You're Nothing But a Junkie": Multiple Experiences of Stigma in an Aging Methadone Maintenance Population	Kyaien O. Conner & Daniel Rosen	2008	Journal of Social Work Practice	To examine the existence and experiences of stigma in a sample of older adult MMT clients	Narrative inquiry Interviews	Older adult MMT clients	8 distinct stigmas The more stigmas experienced, he more likely to identify stigma as a barrier
Vietnamese-Australian heroin users' perspectives on the role of the family in treatment	Peter Higgs, Jay Jordens, Lisa Maher, & Adrian Dunlop	2009	Drugs: education, prevention and policy	To explore the experiences of Vietnamese heroin users To examine the role of families in treatment from the perspective of the person going through treatment	Grounded Theory Interviews	Ethnic Vietnamese heroin users on MMT	MMT clients struggled to engage in treatment in an environment where heroin was easily accessible. Family appeared to be a key mediator, a source of motivation, grounding, and connectedness. Family can also be alienating and fragmenting.

Mistrust and Self-Isolation: Barriers to Social Support for Older Adult Methadone Clients	Mary Lindsey Smith & Daniel Rosen	2009	Journal of Gerontological Social Work	To explore barriers to the use, maintenance, and expansion of social supports in older adults MMT clients	Grounded Theory Interviews	MMT clients over the age of 50	Lack of trust is a principal barrier to the use, maintenance, and expansion of the social supports of older adult methadone clients
Users' Experiences of Heroin and Methadone Treatment	Jane Gourlay, Lina Ricciardelli, & Dam	2005	Substance Use & Misuse	To further develop an understanding of the experience of methadone treatment in relation to issues concerning identity To examine and compare how different personal and social resources relate to participants' use of both heroin and methadone as well as their experiences of stigma program regulation, and their evaluation of MMT	Grounded Theory Interviews	MMT patients	Users with "non-addict" or "functional" self-concepts had more resources, supportive social relationships "Conflicted" users with limited resources, few social connections, and negative self-concept saw methadone as an addiction
Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatised identities	Polly Radcliffe & Alex Stevens	2008	Social Science & Medicine	To explore how MMT clients describe the stigmatisation of drug users and drugs	Interviews	Drug users previously on MMT	Some drug users carefully manage information about their discreditable identities by excluding themselves from this category, while acknowledging its validity for other drug users.
Drug users' views of prescribed methadone	Joanne Neale	1998	Drugs: education, prevention and policy	To examine the views and experiences of service users	Unspecified Interviews	MMT patients	Clients valued the ability of methadone to reduce illicit drug use, to decrease drug-related harm and to prevent crime
Methadone Maintenance as a Last Resort: A Social	Mararetha Järvinen & Gale	2010	Sociological Forum	To analyze the programs	Interpretive Phenomenology	MMT patients	The program increases participants' sense of stability by



Phenomenology of a Drug Policy	Miller			implications for participants' sense of agency and constraint and for their orientation toward past, present, and future	Interviews		providing them with methadone and by allowing them to better address their economic, housing and other daily needs. It also represents a context of physical, emotional, and social dependence
Harm reduction, methadone maintenance treatment and the root causes of health and social inequities: An intersectional lens in the Canadian context	Victoria Smye, Annette J Browne, Colleen Varcoe & Viviane Josewski	2011	Harm Reduction Journal	To elucidate how an intersectional lens can provide a more complex understanding of harm reduction and MMT and how harm reduction and MMT are experienced differently by people dependent on how they are differently located	Ethnography In-depth individual interviews, focus group interviews, and naturalistic observation	Aboriginal MMT clients and healthcare providers	Profound history of abuse and violence connected to colonialism Co-occurring illness (HIV, AIDS, depression, substance use, etc.) Most lived in poverty Mistrust with healthcare system due to everyday experiences both within and outside the system that further marginalize them.  There are three intersecting issues that impact access to MMT: <ul style="list-style-type: none"> <li>- Stigma and prejudice</li> <li>- Social and structural constraints influencing enactment of peoples' agency</li> <li>- Homelessness</li> </ul>
A good quality of life under the influence of methadone: A qualitative study among opiate-dependent individuals	Jessica De Maeyer, Wouter Vanderplasschen, Laura Camfield, Stijn Vanheule, Bernard Sabbe, & Eric Broekaert	2011	International Journal of Nursing Studies	To expand the knowledge concerning opiate dependent individuals' perceptions of a good Quality of Life (QoL) and the impact of methadone on components of a	Unspecified In-depth interviews	MMT clients	Five key themes contribute to a good QoL for opiate dependent individuals: (1) having social relationships (2) holding an occupation (3) feeling good about one's self (4) being independent (5) having a meaningful life  Participants valued methadone's ability to help them function

				good QoL			<p>normally, overcome psychological problems and dependence on illicit opiates, and support them in achieving certain life goals</p> <p>Negative consequences included stigmatisation, discrimination, dependence on methadone and the drug's paralysing effects on their emotions</p>
Drug Addiction Stigma in the Context of Methadone Maintenance Therapy: An Investigation into Understudied Sources of Stigma	Valerie Earnshaw, Laramie Smith, Michael Copenhaver	2013	International Journal of Mental Health Addiction	To advance understandings of how drug addiction stigma is experienced among methadone maintenance therapy patients and from whom	Unspecified Cognitive interviews	MMT patients	MMT patients experience prejudice, stereotypes, and discrimination from friends and family, coworkers and employers, healthcare workers, and others. As a result, participants experienced distress including feelings of frustration, anger, and anxiety which could threaten their emotional well-being and mental health.

## Appendix B: Advertisement

### Exploring the Daily Lives of People on Methadone Maintenance Treatment

I am interested in your experience of Methadone Maintenance Treatment.

The study is being conducted by Katrina Warren from the Health and Rehabilitation Sciences Program at the University of Western Ontario. The purpose of the study is to better understand the everyday lives and experiences of people on MMT.

**Who?** Volunteers who are:

- English-speaking and able to participate in an interview in English
- Have been on Methadone Maintenance Treatment for at least 1 year
- 18 years of age or older

**What?** Take part in one or two meetings with a researcher that involve:

- The first session will involve:
  - An interview – I will ask you to tell me your stories of daily living, in as much or as little detail as you would like, to emphasize the issues that are important to you.
  - Mapping session – I will ask you to draw a mental map of the city to assist describing where you routinely go and the types of occupations that occur in those places (e.g. grocery store, workplace). You can choose to draw whatever you would like. You will then be asked to explain your map.
  - Demographic questionnaire – I will ask you to fill out a questionnaire. This will be used to gather information relevant to describing the sample of study participants.
- A second follow-up meeting may be schedule to ask additional clarification questions

**How Long?** 1 to 2 ½ hours for the first meeting, and 30 minutes to 1 hour for a subsequent meeting if needed

**Where?** At a time and place of your choosing

**Why?** Your views can help influence the services, programs, and policies that are put in place for people on Methadone Maintenance Treatment.

**Interested? For more information please contact:**

**Study Researcher:**

Katrina Warren, Masters Student  
Health and Rehabilitation Sciences  
University of Western Ontario  
[REDACTED]

**Thesis supervisor:**

Dr. Suzanne Huot, PhD  
School of Occupational Therapy  
University of Western Ontario  
[REDACTED]

## **Appendix C: Letter of Information and Consent Form**

**Study Title:** Exploring the Daily Lives of People on Methadone Maintenance Treatment

### **Student Researcher**

Katrina Warren, MSc Student  
Health and Rehabilitation Sciences  
University of Western Ontario  
Email: [REDACTED]

### **Thesis Supervisor**

Suzanne Huot, PhD  
Assistant Professor - School of Occupational Therapy  
Faculty of Health Sciences  
University of Western Ontario  
Email: [REDACTED]

As a patient on methadone you are being invited to participate in a research study examining how people on Methadone Maintenance Treatment spend their time each day and how methadone treatment impacts peoples' daily routines. This letter contains information to help you decide whether or not to participate in this research study. It is important for you to understand why the study is being conducted and what it will involve. Please take the time to read this carefully and feel free to ask questions if anything is unclear or there are words or phrases you do not understand. I am a master's student in the Occupational Science field of the Health and Rehabilitation Sciences program at the University of Western Ontario and the information I am collecting will be used in my thesis.

### **What exactly is this research about?**

The purpose of this study is to identify the challenges you face in accessing treatment and in engaging in everyday activities. This research aims to understand how you go about your daily life and how you spend your time. This includes the places you routinely go, the kinds of things you do there, and the people you see and interact with.

### **Who are we asking to participate in this study?**

We are looking to recruit 10 methadone patients. To be able to participate in this study, we ask that you have been in Methadone Maintenance Treatment in London, Ontario for at least 12 months. You need to be able to speak and understand English, you must be over the age of 18 and you must have an interest in sharing your experiences of daily living as an individual on methadone

### **What will your role be in this research?**

You will be asked to take part in one or two meetings with the researcher.

The first meeting with you and the researcher will last between 1 to 2.5 hours. At the beginning of the first meeting you will be asked to fill out a questionnaire. This is to help us understand the context in which you carry out your daily life.

You will then be asked to participate in a one-on-one interview. This will allow us to find out a little more about your experiences and your daily life. The meetings with the researcher will be audio-recorded in order to accurately analyze what was said. What you say will be typed out by the study researcher. The only people who will listen to the recording will be the researcher, and her thesis supervisor. You are free to request that the recorder be turned off or that parts of the recording be erased. The meetings will be conducted at a location convenient to you. An example of a question we would ask at this interview is: What has your life been like since you have started Methadone Maintenance Treatment?

After the interview is complete we will ask you to draw a map of the places you go in the city and to describe what a typical day looks like for you. We will discuss what you would normally do each day, the places you have to go, and the things you have to do. We will also discuss how this has changed since you started Methadone Maintenance Treatment.

After the first meeting, it is possible that we may need a bit more information, in which case we may request a second meeting for an additional interview with you. This potential follow up interview will last between 30 minutes and 1 hour and can be conducted in person or by telephone depending upon your preference. Before we finalize any of this research, we will go over the study findings with you, to see if we have interpreted what you have told us correctly. Eventually, we hope to come to a set of core themes that describe what was said during the interviews.

### **Where will this research take place?**

The interviews will take place at a secure public location convenient to you.

### **Are there any risks or harms with participating in this research?**

During the interviews, you will be asked a variety of questions that may be sensitive in nature, and you may feel uncomfortable addressing them. You are free to choose what will and will not be discussed. The meetings will be scheduled at your convenience, and you can request to reschedule or shorten meetings if you experience discomfort or fatigue.

### **Are there any benefits in participating in this research?**

Information you share will be presented to others through publications and at conferences and meetings. As a result, your views can help influence the services, programs, and policies that are put in place for people on methadone. Your identity will never be released in any publication or presentation. If you want, a copy of the study results can be forwarded to you at the completion of the study.

**What happens to the information that I tell you?**

The meetings with the researcher will be audio-recorded. What you say will be typed out by the study researcher and all identifying information (e.g. names) will be removed. The only people who will listen to the recording will be the researcher, and her thesis supervisor Dr. Suzanne Huot.

**Will my information be kept confidential and anonymous?**

Yes. Recorded data will be destroyed after transcription to avoid potential voice identification. The transcript will be coded using unique numeric identifiers, and the master list will be held in a separate secure cabinet from the data. All sheets that are filled out by hand from participants will be re-typed to avoid hand-writing recognition, and IDs will be assigned to each form. Only the researcher and her thesis supervisor will have access to the information. If we find information we are required by law to disclose, we cannot guarantee confidentiality. Participants' confidentiality will be fully protected through specific measures to prevent any loss of anonymity. Electronic data storage and transfer will be encrypted. However, despite these measures in place to protect the privacy and confidentiality of the individual, this cannot be guaranteed for certain. There is the potential for someone to identify the individual even without identifiers contained. No loss of confidentiality is anticipated.

**Can I withdraw from this study?**

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your future care at your MMT clinic. Please note that information collected prior to withdrawal will be kept, unless you ask to have it removed from the study.

**Will I be compensated (financially) for participating in this study?**

You will not be compensated for participating in this study, however, a substantial time commitment will not be required and the interviews will be conducted at a location convenient for you.

**What happens if this research gets published?**

If the results of the study are published, your name will not be used. If you would like to receive a copy of the overall results of this study you may request them.

**Who should I contact if I have any questions?**

Any questions about study participation may be directed to Suzanne Huot at [REDACTED]. You can also contact her if you have any questions about your rights as a research participant or the conduct of this study.

If you have any questions about the conduct of this study or your rights as a research participant, you may contact: the Office of Research Ethics at the University of Western Ontario: [REDACTED].

You do not waive any legal rights by signing this consent form.

**This letter is for you to keep.**

**Consent Form**

I have reviewed the contents of the letter of information, I have had the nature of the study explained to me and I agree to participate. All of my questions have been answered to my satisfaction.

---

Signature of Research Participant

---

Date

---

Printed Name

---

Signature of Person

---

Date

Obtaining Informed Consent

---

Printed Name



**Appendix D: Interview Guide**

1. How did you go about planning your daily activities before you started Methadone Maintenance Treatment?
  - a. How did you go about meeting your daily living needs?
2. How are you going about planning your daily activities now that you are on Methadone Maintenance Treatment?
  - a. What has changed?
  - b. Are there any needs you are no longer able to meet?
    - i. Can you describe these?
  - c. Are there any needs that are more challenging to meet?
    - i. Can you describe these?
3. What has your experience been like while on Methadone Maintenance Treatment?
4. What is a typical day like for you?
5. What advice would you give to people starting Methadone Maintenance Treatment?
6. What are some things that would help you succeed?
7. What changes would you make to improve Methadone Maintenance Treatment?
8. What are some of the barriers to receiving Methadone Maintenance Treatment?
9. Is there anything that enables you to receive Methadone Maintenance Treatment?

***Thank you for sharing your experiences.***

## **Appendix E: Mapping Facilitation Questions**

### **Instructions:**

Please draw your map of London to illustrate the types of places you routinely visit.

The map does not have to be to scale and you can including as much or as little detail as you like.

### **Facilitation questions:**

- 1) What places do you go on a daily basis? What is your routine like?
- 2) Is there anything else you do on a weekly or monthly basis?
- 3) What places are within walking distance? What modes of transportation do you use?
- 4) How has your routine changed since you started Methadone Maintenance Treatment?

## Appendix F: Demographic Questionnaire

Thank you for taking the time to fill out this questionnaire. If you do not feel comfortable answering some of the questions, feel free to leave them blank. For each question, please circle the answer that best applies, or fill in the blank space given.

*First we would like to find out more about you:*

1) What is your age? \_\_\_\_\_

2) What is your gender?

Male          Female          Other

3) What is your current marital status?

Married

Never Married

Separated

Divorced

Widowed

Other (please specify): \_\_\_\_\_

4) Do you have any children?

Yes    No

5) If so, how many? \_\_\_\_\_ Do they live with you?    Yes    No

6) What is the highest level of education you have?

Less than high school

High School Diploma

Community College

Technical Degree

University Bachelor's Degree

Other (please specify): \_\_\_\_\_

7) What is your current employment status?

Full Time

Part Time

Not Currently Employed

Other (OW, CPP, ODSP): \_\_\_\_\_

8) What city/town do you currently live in?

\_\_\_\_\_

9) What is your current housing situation?

\_\_\_\_\_

10) What is your main mode of transportation?

\_\_\_\_\_

9) How long did you use opiates before you were on Methadone Maintenance Treatment?

\_\_\_\_\_

10) Are you currently using opiates?

\_\_\_\_\_

10) What is your opiate of choice?

\_\_\_\_\_

11) Do you use any other drugs? If so, which ones?

\_\_\_\_\_

12) How long have you been on Methadone Maintenance Treatment?

\_\_\_\_\_

13) How long have you been a patient at this clinic?

\_\_\_\_\_

14) What carry level are you at?

\_\_\_\_\_

Thank you for filling out this questionnaire. Your answers will be kept anonymous and confidential. If you have any questions about this questionnaire, or any aspect of the research project, please contact Suzanne Huot at [REDACTED]

## Appendix G: Ethics Approval from the University of Western Ontario



**Western  
Research**

Research Ethics

### Western University Health Science Research Ethics Board HSREB Delegated Initial Approval Notice

**Principal Investigator:** Dr. Suzanne Huot

**Department & Institution:** Health Sciences\Occupational Therapy, Western University

**HSREB File Number:** 105819

**Study Title:** Exploring the Daily Lives of People on Methadone Maintenance Treatment: Disparities, Challenges, and Barriers to Access  
**Sponsor:**

**HSREB Initial Approval Date:** November 11, 2014

**HSREB Expiry Date:** April 30, 2015

**Documents Approved and/or Received for Information:**

Document Name	Comments	Version Date
Western University Protocol		2014/10/29
Instruments	Appendix A-Interview Guide	2014/10/18
Instruments	Appendix B-Mapping Facilitation Questions	2014/10/18
Instruments	Appendix C-Demographic Questionnaire	2014/10/18
Letter of Information & Consent		2014/10/29
Recruitment Items	Appendix E-Advertisement	2014/10/20
Other	Appendix F-Services	2014/10/29

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above named study, as of the HSREB Initial Approval Date noted above.

HSREB approval for this study remains valid until the HSREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB Continuing Ethics Review. If an Updated Approval Notice is required prior to the HSREB Expiry Date, the Principal Investigator is responsible for completing and submitting an HSREB Updated Approval Form in a timely fashion.

The Western University HSREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use Guideline for Good Clinical Practice Practices (ICH E6 R1), the Ontario Personal Health Information Protection Act (PHIPA, 2004), Part 4 of the Natural Health Product Regulations, Health Canada Medical Device Regulations and Part C, Division 5, of the Food and Drug Regulations of Health Canada.

Members of the HSREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

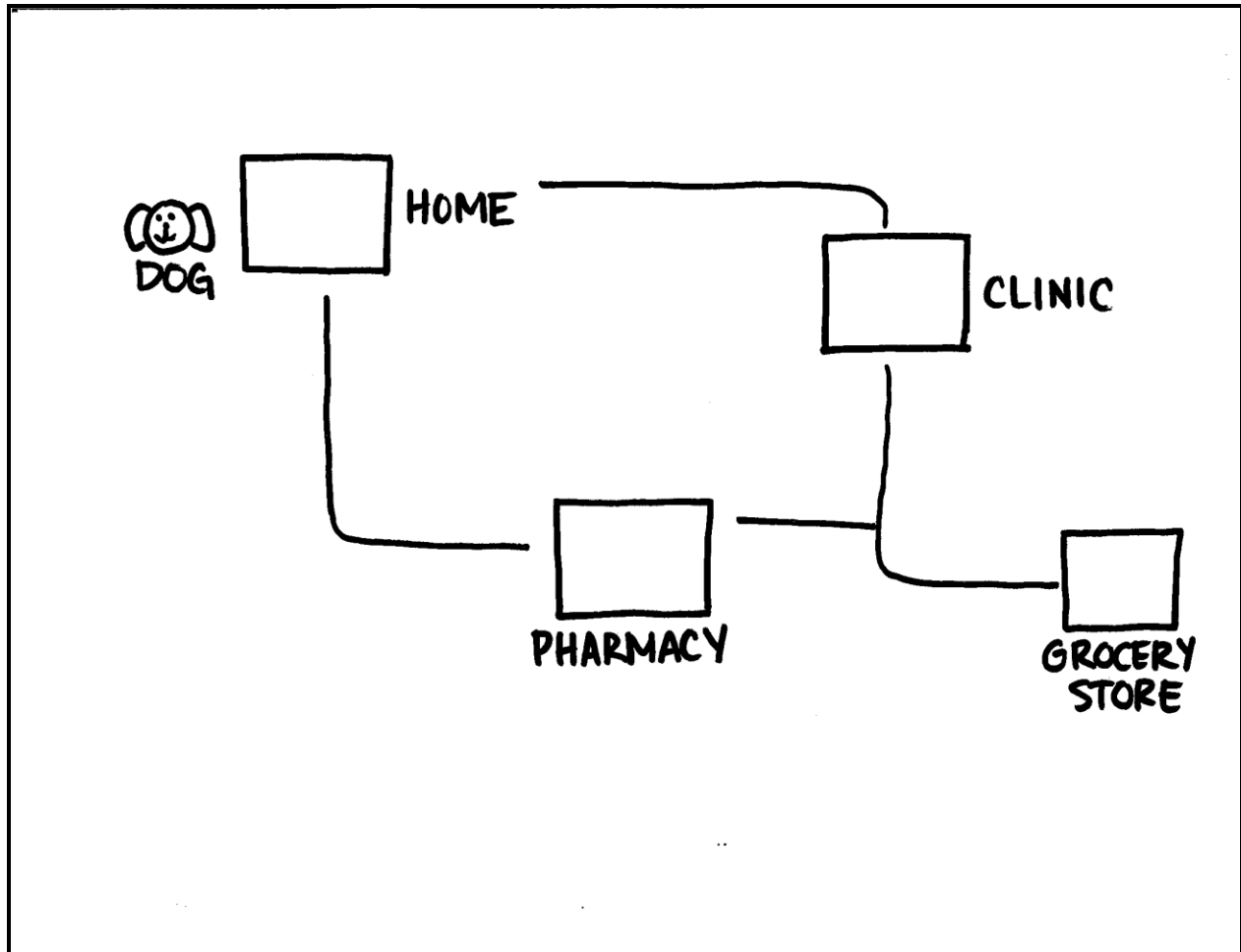
The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Ethics Officer on behalf of Dr. Joseph Gilbert, HSREB Chair

**Ethics Officer to Contact for Further Information**

Erika Basile ebasile@uwo.ca	Grace Kelly grace.kelly@uwo.ca	Mina Mekhal mmekhal@uwo.ca	Vikki Tran vikki.tran@uwo.ca
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*This is an official document. Please retain the original in your files.*

**Appendix H: Example of an Occupational Map**

## VITA

<b>Name:</b>	Katrina M. Warren
<b>Date of Birth:</b>	February 12, 1990
<b>Post-Secondary Education and Degrees:</b>	<p>Brock University St. Catharines, Ontario, Canada 2008-2012 B.A. Honours Child and Youth Studies</p> <p>McMaster University Hamilton, Ontario, Canada 2012-present Addiction Certificate Program</p> <p>The University of Western Ontario London, Ontario, Canada 2013-2015 MSc Health and Rehabilitation Sciences</p>
<b>Honours and Awards:</b>	<p>Brock University Entrance Scholarship (2009-2010)</p> <p>Western Graduate Research Scholarship (2013-2015)</p>
<b>Related Work Experience:</b>	<p>Graduate Teaching Assistant School of Occupational Therapy The University of Western Ontario (February 2014 – April 2014)</p> <p>Graduate Teaching Assistant School of Physical Therapy The University of Western Ontario (September 2014 – December 2014)</p>