

The Effectiveness of Methadone Maintenance Provision

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Abstract

Introduction and Aims; A qualitative study was carried out among a number of community drug projects in west Dublin. The projects in the course of their work support individuals that are accessing methadone maintenance treatment (MMT). The study aimed to gain an insight into the experience of service users as they negotiate MMT provision. This research focused in particular, on client's initial goals as they accessed MMT, the important motivation factors driving their treatment decisions and the study considered the opportunities service users had to engage in self-directed change within the context of service provision.

Design and Methods; The case study focused on person centred practice within a number of frontline community drug programmes in west Dublin. Nine participants were interviewed, all of whom in the course of their work engage professionally with MMT service users. Research was conducted using semi-structured interviews which were informal and open-ended and set out to discover some of the embedded elements within drug service delivery which have direct impact on service user progression. Participation in the study was voluntary and anonymous.

Results; The general findings from this research were that MMT service users primarily are seeking to introduce a level of stability into their lives when they first present for treatment. The decision to access treatment is largely motivated by matters relating to their immediate family. In the majority of cases service users state that their long term goal is to be drug free. The clinic environment and difficulties encountered establishing a shared and equal relationship with clinic staff, GPs and pharmacies, were identified as the major barriers to client progression.

Discussion and Conclusions; It was accepted that many elements of MMT provision worked successfully and that both clinic staff and GPs were in many cases willing to engage meaningfully with service users and key workers. However many elements were highlighted within service provision which serve to obstruct the purposeful engagement of service users. The study suggests that in order for MMT to develop into a more effective service, formal measures which promote the service user as a partner to other stakeholders, need to be integrated into provision.

Chapter One

Literature Review

The Effectiveness of Methadone Provision.

The purpose of this research project is to investigate the effectiveness of methadone treatment provision.

The aim of this research is to investigate the effectiveness of methadone maintenance provision in the context of the service users own objectives with regards to their current and future drug use. Whilst acknowledging that these aspirations may change over time and transform as an individual moves through various services, the researcher would like to explore how factors external to the individual effect the service users ability to engage in decision making, goal setting and how such factors affect his or her short and long term progress.

This research, by focusing on the knowledge and experience of frontline staff (the key worker) will offer a unique opportunity to assess the impact of the wider debates, policies and practices that directly and indirectly influence the service user's negotiation of services and ultimately their addiction. The nature of the key working process allows practitioners a level of contact over a prolonged period. This relationship can offer a unique insight into service user's aspirations, motivations, struggles and progress. It is hoped that this research will add to the small but growing field of study which aims to address the gap in knowledge and understanding from the perspective of the service user.

Introduction

Historical Background of Methadone Maintenance Treatment

Methadone has been used as a substitute for illicit opioid dependence internationally for over forty years. It was first synthesised in Germany in 1939 and further developed as a medical intervention in New York in 1964, mainly as a response to the heroin epidemic that developed in that city after World War Two. Central to this pioneering work were Doctors Vincent Dole and Marie Nyswander. Their work was based on the understanding that opiate addiction made permanent changes to the brain's chemistry and that methadone intervention served as a corrective measure rather than a curative one (McGovern, 2010).

Research by Dole and Nyswander demonstrated that methadone provision reduced or eliminated the use of heroin, had a long duration of action and because it could be taken orally avoided the use of needles and therefore helped in preventing the spread of infectious disease. In addition it was generally seen to improve patient's mental, physical and social health (Herman, Stancliff, & Langrod 2000; Seivewright, 2000). In 1966 the first outpatient clinic was established in New York and this clinical model was expanded out across the USA in that same year. The outpatient clinics, rolled out as part of health provision in America were a precursor to those later developed in mainland Europe and eventually in Ireland in the 1990's.

Methadone is a long lasting synthetic opioid analgesic. It acts as an opiate agonist, which essentially means it bonds to the same receptor area in the brain as heroin and morphine. It is usually taken in oral form and has an advantage over heroin and morphine in that it remains active in the body for twenty-five hours. The prolonged effect that methadone offers allows for the provision of a single daily dose in order to deter onset of withdrawal symptoms (Ford, Halliday, Lawson, & Browne, 2011).

Early medical studies on the effectiveness of methadone, particularly those initiated in Rockefeller University in 1964 showed that methadone taken orally with dosages of between 80mg-120mg/d were sufficient to stop cravings and block effects of administered heroin (Herman et al., 2000). Furthermore, subsequent and more recent reviews of substitution treatment have shown that methadone maintenance treatment (MMT) at appropriate doses is more effective at retaining people in treatment (Amato, Davoli, Perucci, Ferri, Faggiano, & Mattick, 2005).

An International Issue

There is much debate and controversy worldwide with regards to MMT. This ongoing discussion continues to generate an enormous amount of research literature. Many commentators believe MMT to be the most effective treatment available in the fight against illicit opioid use. Citing medical research, they emphasise that this treatment approach offers a level of relative safety especially with regard to toxicity and impairment of cognitive and motor functioning. While accepting that patients may remain on treatment for indefinite periods, possibly even for life, those in favour of this form of treatment maintain that patients can enjoy a normal life with family and pursue employment opportunities unimpeded. In

addition treatment minimises harm and therefore increases life expectancy and quality of life (Herman et al., 2000; Haasen and Van den Brink, 2006).

Along with the potential of improved health and social productivity for the individual receiving treatment, it is claimed that MMT has a positive wider social effect as it reduces the economic burden of the community at large through reduction in criminal activity, a reduction in emergency room use and a reduction in the onset of more serious health problems. One particular study carried out in California found that for every one dollar spent on drug and alcohol services seven dollars were saved on future costs (Ettner, Huang, Evans, Ash, Hardy, Jourabchi, & Hser, 2006). More detailed studies such as Masson, Barnett, Sees, Delucchi, Rosen, Wong & Hall (2004) compared the cost effectiveness of methadone maintenance to a 180-day enriched methadone detoxification programme. This study found that methadone maintenance was more cost effective with a cost-effectiveness ratio within the range of most medical practice parameters. The study also found that over the final six months of the research that patients on the 180-day detoxification programme which involved significant psychosocial inputs, had over twice the use of illicit opioid use than those on maintenance.

Influential studies in the 1990's such as the research carried out by Ball and Ross (1991) support the case for MMT. Their observational studies carried out in the United States showed that maintenance at sufficiently high dosage rates had significant influence on heroin use patterns. Their evaluations showed that 28% of patients receiving doses of methadone below 45mg/d were also using heroin compared to 5.4% also using heroin on 46mg/d or above. In addition this report noted that quality of service particularly presence of committed staff was a significant factor in patient outcome. This final point in relation to secondary

supports is emphasised by various professional bodies including the Royal College of General Practitioners (UK) who maintain that the more successful methadone maintenance programmes are those that provide the optimum dose regime to the individual within a broad treatment programme which they stress should include access to a key worker and supports around psychosocial matters (Ford et al, 2011; Ball & Ross, 1991).

Methadone provision as outlined above has significant professional backing. McGovern (2010) supports the premise that methadone provision offers the most successful and proven intervention in the treatment of opioid dependence. This viewpoint maintains the idea that MMT is effective in reducing the risk of HIV and other blood borne virus and is also effective in improving mental, physical and social health. In addition, McGovern and many of his peers with the backing of much research including Sees, Delucchi & Masson (2000), put forward the argument that the provision of MMT encourages service users to continue engagement in support programmes, whereas they suggest that the detoxification route is associated with high rates of relapse and death.

Critical Evaluation of Methadone Maintenance Treatment

Many commentators believe that there is an over reliance by service providers on MMT in addressing drug misuse. Some commentators such as Quirion (2003) consider this singular response in the context of wider social and political trends. Quirion maintains that where methadone programmes developed in the early '1960's responded to the individual needs of drug users, such as professional and social integration, more recent provision has been motivated not by humanistic issues but by wider social and political pressures. Quirion

believes current provision's primary objective is to eliminate practices that result in harm to the community at large.

As a consequence, some observers suggest that expected outcomes and the effectiveness of Methadone programmes are quite often measured by indicators that occur in or impact on larger society, indicators such as levels of criminality, social functioning and social productivity. Commentators point to the emergence of 'cost effectiveness' based research which has increased in recent years, to demonstrate the over emphasis towards social outcomes rather than indicators that reflect the impact on drug users (Fischer, Rehm, Kim & Kirst. 2005).

In addition, those critical of current provision argue that, whereas it is a normal procedure if not requirement of health care provision in general to actively engage the consumer in service delivery, drug users in the past have not had the opportunity for adequate input in their service provision. Opportunities for consumers to engage in general health services include opportunities for an input on planning and delivery, input on the sharing of information and involvement in problem solving issues. Some suggest that the reason for the lack of engagement with the drug user as customer may be due to how drug users are generally perceived. Because of their illicit drug use they may be viewed as deviant and therefore are assumed to lack the skills required for engagement in the detail of their service (Bryant, Saxton, Madden, Bath & Robinson, 2008). The absence of drug user input means that it is professionals and resource availability generally that determine service development and delivery across all treatment options. Hence, decisions around mode of intervention i.e. detoxification versus stabilisation or residential versus community based interventions are rarely made by service users themselves (McKeganey, Morris, Neale & Robertson, 2004).

Some observers believe the prioritising of harm reduction measures over measures to help achieve abstinence in drug service delivery reflects a gap in thinking between those involved in drug service delivery and the consumer. This apparent variation between the consumer's perspective within drug services and the harm reduction philosophy is reflected in Scottish research. A study carried out over thirty-three drug agencies and involving one thousand and seven drug users as they commenced a new episode of treatment in Scotland identified abstinence as the principle goal or aspiration with 56.6% of those surveyed indicating this to be their 'hoped for' achievement (McKeganey et al., 2004). The study however states that the results should not be interpreted simplistically and emphasise the importance of harm reduction in the recovery process. The report recognises that one success with a harm reduction measure may be of more value to a client than a series of failures at attempted abstinence. This work also suggests that rather than being treated as mutually exclusive, harm reduction and abstinence modalities should be treated as two valid options within a wider range of choices, which are available to the service user at any given time. This is considered within the context of a rehabilitation process which, for many, unfortunately is a prolonged and often complex journey.

The Irish Context

In Ireland, methadone maintenance is now the opioid dependency treatment of choice and has been available since 1992. Methadone was initially used primarily in the abstinence treatment setting to aid the detoxification process. However, the emphasis on provision changed, partly driven by the rapid spread of HIV which was becoming evident in the late 1980's and early 1990's (HPU, 2003). Standardised treatment provision was initiated following the Report of the Expert Group on the Establishment of a Protocol for the

Prescribing of Methadone (1993). This report served to outline guidelines for medical practitioners. These guidelines were brought into legislation through the Misuse of Drugs Regulation, establishing a new methadone protocol in 1998. The protocol not only set out to update drug treatment provision but also address the growing 'black market' in methadone. Recent figures show that in 2009; there were, 8551 patients receiving methadone treatment through clinics, GPs and pharmacists in the Republic of Ireland (Farrell & Barry, 2010).

Two pieces of research, 'Methadone: What's the Story?' (Uisce, 2003) and 'Maintaining or Enabling' (Cox, & Lawless, 2002) represented the first attempt to gauge the performance of the new methadone protocol. Uisce's report in particular attempted to capture service user's opinions on the impact the protocol was having on them. The report highlighted issues of discrimination and inequality in service provision. In some instances, chemists required behavioural contracts to be signed by service users prior to attendance for collection of medication. Cox and Lawless (2002) reported that the method in which methadone was dispensed under supervised conditions further stigmatised an already marginalised group.

This research highlighted practices including the imposition of sanctions which involved dose reduction for minor transgressions as a means of behavioural control (Uisce, 2003). Significantly Uisce's research found that the service users of methadone services felt powerless in all aspects of their drug treatment. Not surprisingly this lack of involvement at any level by the service users in their own treatment resulted in patterns of frustration and demotivation. The picture emerging from these early appraisals of methadone provision 'Irish style' would appear to support Quirion's (2003) assertion that provision ideology was centred on addressing wider social issues and concerns rather than providing a respectful response to

the needs of drug users. In addition both reports highlighted service users' concerns that their desire to move from methadone maintenance to detox were not matched by their prescribing doctor. Participants stated that there seemed to be a lack of interest and motivation on the part of the doctor, in this regard.

Both of the reports outlined above while bringing some balance to the issue of methadone provision by way of giving voice to service user's concerns, offer little in the way of exploration of the overall structure and philosophy of treatment programmes and how restrictive current practice may be in fostering alternative options for service users. There are limitations particularly in the findings of Cox and Lawless, as much of the focus and ultimately the recommendations lie stubbornly within the methadone maintenance paradigm.

Although the medical model undoubtedly improves the lives of many individuals it detracts from and fails to deal with the fundamental institutional mechanisms that may have led to the problem of drug use in the first place. Furthermore as is evident in these two reports, the majority of service users wish to be more influential around decisions with regards to type of service they are receiving and 'wish that all services would recognise the client's self-worth and value in this regard. In fact many commentators maintain that any sustained drug recovery requires at its centre, evidence of the client self-directed change.

Most progressive treatment models put much emphasis on self-efficacy as a means to arrest destructive behavioural patterns. Bandura (1990) discussing this concept in relation to the exercise of self-control, identifies four required components to ensure effective self-directed change. They are a source of information highlighting health risks, development of social and self-regulatory skills which can be applied into preventative action, skill

enhancement including an element of feedback and identification of social supports to enhance effective change (Bandura, 1990).

Research into drug use patterns and behaviour has demonstrated repeatedly the strong negative correlation between high levels of self-efficacy and reduced drug use. Furthermore, while patient progress is quite often measured by sample analysis, attendance at sessions and level of engagement with counsellors, some recent studies have concentrated on the cognitive component of 'patient expectation'. This focus on treatment relating to patient expectations with regards to their future drug use has shown to be highly predictive of drug use behaviour (Joe, Flynn, Broome, & Simpson, 2007). Programmes which include patient expectation measures allow for timely interventions before drug use or relapse becomes more severe. Research such as this gives us some indication of the resource requirement which is perhaps necessary to begin addressing drug use in a sustained manner.

As observed earlier much research to date has concentrated on factors such as retention rates and optimum dosage rates when assessing methadone treatment. However many studies have indicated the importance of secondary supports such as counselling and key working inputs (Ford et al, 2011; Ball and Ross, 1991). One area which has tended to be overlooked is the social process involved in treatment provision, more specifically the relationship between those delivering service and those receiving support. As remarked on earlier this relationship can be problematic as it is rife with issues of regulation and perceptions of or actual power imbalance. Lilly, Quirk, Rhodes and Stimson (2000) highlight in their study of 'Sociality and Methadone Treatment' the importance of broadening our investigation so that we can measure how and why the dynamics of client- staff relations can act as a deterrent to progress in some situations and are central to driving success in

others. This exploration illustrates how important it is to increase our understanding of how factors such as the nature of client involvement in decision making or the issue of time as a resource are factors in enabling positive working relations to develop within and throughout this process.

In Ireland there is a small but growing field of research that is increasingly looking at MMT from the perspective of the client. Issues being highlighted include concerns around the absence of informed decision making between service users and their doctors, particularly in relation to possible treatment pathways, concerns over polydrug use and concerns in relation to the continued and long term use of methadone (Hout & Bingham, 2011). Harris and McElrath in their study 'Methadone as Social Control' (2011) echoes many of the difficulties first voiced by service users a decade earlier in both 'Methadone: What's The Story?' (Uisce, 2003) and 'Maintaining or Enabling' (Cox, & Lawless, 2002). Harris and McElrath concentrate their inquiry on the impact that social control and institutional stigma have on the drug users' sense of self, the reinforcing of 'addict' identities and examine how these factors can inhibit positive treatment outcomes.

What is contained within much of this current research and something that presents a challenge for many stakeholders is the challenge to reframe the ideology of MMT and its subsequent provision. As McKeganey, Bloor, Robertson, & Neale, (2006) suggest, whilst the theoretical debates between harm reduction and abstinence have far from gone away, there is perhaps a hint that they can converge to a degree. Central to the challenge of reframing ideology or repositioning of the dominant approaches, is the redefining of the service user from a passive recipient to one more reflective of a consumer. Of course this shift must have

at its core a much greater understanding of the key stakeholder and their experience. It is within this context that this research project is undertaken.

This study hopes to add to and act as an accompanying piece to the research outlined above and other recent Irish studies such as, King (2011) which broadly serve to understand the experience of addiction and rehabilitation from the perspective of the client. This study will focus on the knowledge and experience of frontline workers, who in their day-to-day interaction with service users are in a unique position to assess the impact that service provision has on service user's ability to motivate, negotiate problems and achieve their personnel goals.

The research question posed for this qualitative study is;

How effective is methadone treatment provision in addressing the needs and aspirations of service users?

Chapter Two

Research Methodology

This study was carried out using a qualitative research method. The research adopted an exploratory case study approach. This approach was chosen as it offered a measure of flexibility with regards to the manner in which data was collected. This process as Yin (2009) suggests, allows “investigators to retain the holistic and meaningful characteristics of real life events” (p. 4). The choice of a qualitative design was based on a number of factors mainly the contemporary nature of the phenomena being investigated ‘methadone provision’ and the nature and level of data required to adequately address the research question.

The researcher believes this approach offered a degree of breadth and depth to the investigation as it examined multiple cases and then drew a single set of cross case conclusions, linked to the initial question of study. Individual semi-structured interviews allowed for one-to-one interaction in a less formal environment, this as Mason (2003) proposes contributes to a discussion based format rather than a formal question and answer session. The approach sought to bring forward peoples knowledge, experience and understanding of the topic at hand.

The Procedure

The case study focused on person centred practice within a number of frontline community drug programmes in West Dublin. The sample was purposively selected from three separate drug programmes which currently operate in three different West Dublin communities. The researcher believed that the broad sample obtained would offer an

opportunity for a wider spectrum of views to be considered, including any variation of approach within the individual services and also highlight any difference in experience from within the respective geographical areas.

Recruitment commenced with the relevant programme managers being contacted, at which point a brief overview of the proposed research was outlined. Subsequently a letter was forwarded requesting permission to carry out the study with three members of staff at each of the targeted organisations (appendix 1), along with a copy of the interview consent form for their consideration (appendix 2).

The programme managers selected suitable participants using the following inclusion criteria as a guide.

Inclusion Criteria

- Frontline staff that interact with MMT service users on a professional basis in the course of their work.
- Frontline staff who have been employed in their role for at least two years.
- Frontline staff who are aware of the nature of the study and who freely consent to participation.

Each interview was framed around ten related questions (appendix 3). Topics included treatment goals, service user motivation and motivational patterns and service user involvement in care plans.

The Participants

The research project relied wholly on the testimony of frontline staff who, in the course of their work engage professionally with people accessing MMT. Nine participants were interviewed in the study, six women and three men. The researcher, while noting the gender disparity, was not overly concerned with this issue. Of the three male participants interviewed each represented one of each of the three projects in the study. The researcher however viewed this fact as simply coincidental and insignificant, as the study sought to focus solely on the participant's professional observations and experience in the context of the topic of inquiry.

Research was conducted using semi-structured interviews which were informal and open-ended and set out to discover some of the embedded elements within drug service delivery which have direct impact on service user progression. The interviews were scheduled so as to cater for the availability and convenience of the responder. As such all interviews took place in a private room at the participants place of work. Interviewees were identified only by their job title and although individual cases were discussed client names were omitted. In line with good practice, a strict confidentiality policy was adhered to. For the purpose of data analysis interviewees were assigned pseudonyms.

Apparatus

Interviews, which were approximately thirty minutes in duration, were carried out over a two week period. Interviews were recorded using a standard digital dictaphone. Access to recordings was strictly limited to the researcher and after transcription, recordings were destroyed.

Ethical Issues

The type of data collection carried out allowed for a degree of elaboration and disclosure by participants which may not occur in other data collection methods. The researcher acknowledged that the area of drug treatment and rehabilitation can be at times a traumatic and upsetting environment for workers and that sensitivity must be employed by the researcher at all times. Though not all conversational issues could be anticipated, every effort was made to ensure that participants experienced no anxiety. In order to protect participants from any distress, the researcher made available all relevant information pertaining to the research exercise prior to the interview commencing. This included the rationale for the research, the issues to be covered in the interview and the manner in which the interview was to be conducted.

Once the necessary information had been imparted, informed consent was obtained from those participating in the study. The researcher ensured that all individuals participating were qualified professionals and principles of anonymity and confidentiality were rigorously observed. These standards were of utmost importance especially where the individual's views or philosophical approach may have been at odds with that of their organisation.

Finally, the researcher endeavored to manage the dialogue so as to limit any stress. Participants were made fully aware that the interview process could be terminated at any stage at their own request.

Data Analysis

Once interviews were completed the data collected was transcribed and a thematic approach was applied to analyze the transcripts. This method of analysis required full immersion by the researcher in the data collected. Initially this involved reading and rereading of transcripts to gain familiarity with data and to identify any prominent patterns. The information was then entered onto NVivo 9 (QSR Software) for further analysis and reporting. This software facilitated coding of key words and phrases and the gathering of the data into meaningful groups and themes. By adhering to this system the researcher feels it was possible to maximize their capacity to draw valued analysis from the data.

Chapter Three

Results

Initial Goals and Motivation

By and large there was a high level of consistency across the three agencies, in relation to the enquiry about client goals; both as the client commenced treatment on methadone and in relation to the key motivational factors that brought about their decision to access treatment in the first place. The respondents to this study reported that in the case of those individuals who had, in particular, prolonged periods of heroin use, in many cases ten years plus, the individual had arrived at a point in their life which was characterized by a general sense of fatigue brought about by the ongoing chaos associated with an opiate addiction lifestyle.

When their young they think they [service user] can go on for years and years and years until something causes a change, maybe it's very often just about being exhausted and fed up and a desire to have a different life.

Reference 4 - 0.69% Coverage

Anna

Yeah, yeah just to give them a little more kind of quality of life, do you know what I mean that they can actually do something with their day, that they're not kind of focusing on where they're going to get the next, you know, fix from, do you know.

Reference 2 - 1.04% Coverage

Katy

The decision to access MMT, as understood by the respondents, is primarily an attempt by the client to gain some stability in their lives. There was no evidence that respondents would try to steer service users down a particular treatment path. All respondents made it clear that their approach was led by the goals expressed by the service user. Whilst most service users sought stability first and foremost it was suggested that as many as eight out of ten service users stated on assessment with the individual projects, that the goal of being drug free was their ultimate ambition.

Well a lot of them [service user] would want to come off their methadone. So you'd always kind of in the first year start reducing and their main goal is kind of to come off their methadone and be drug free.

Reference 2 - 0.80% Coverage

Tricia

Respondents however did state that whilst many service users may have expressed a preference for a drug free lifestyle as a final outcome of treatment, the respondents suggested that this expression may sometimes be driven by the service user's belief or perception, that this is just what the key worker wants to hear.

There were a whole range of factors identified as to what the main aspects that drive service users motivation towards accessing MMT. Issues related to family were central to motivation, in many cases, it was stated, that individuals arrive at a reflective phase. A phase that is undoubtedly age related, where the impact drug use is having, not just on the drug user, but on their immediate family is more pronounced. In particular the impact the drug user's lifestyle is having on their children. It was suggested that as their children begin to

grow up and start to become more aware of their parent's behaviour this can initiate a great deal of introspection by the drug user which quite often brings to the surface feelings of shame, embarrassment and guilt.

I think that's the main, main thing that really motivates them to and you know obviously as well that affects your whole family life having to because the minute you wake up in the morning it's like where am I going to get, where am I going to find my heroin? And that affects everything that day.

Reference 6 - 1.46% Coverage

Katy

Well they'd get a lot of structure, more stability in their life. The likes of being around their children and stuff that they're not, having to go out and score to feed, have to go to their clinic at a set time and they take their set amount of methadone.

Reference 1 - 0.38% Coverage

Tricia

Other related motivating factors included deteriorating health. This might perhaps be a diagnoses such as having contracted hepatitis C or HIV. Of course for some the pressure to change their lifestyle does not so much come from a process of personal reflection as much as external pressures such as ultimatums from parents and partners or pressure from the courts and probation.

Yeah well they're coming in with ideas kind of first of all around kind of if me ma wasn't on me case or if me girlfriend wasn't saying this or if, you know, the police hadn't arrested me.

Reference 4 - 0.83% Coverage

Andy

Barriers to Recovery

One of the key elements identified by respondents with regards to recovery pathways was the importance of sound information. Some respondents made the comparison between the amount of information available in their own projects and the level of information available at the dispensing clinics and pharmacies.

There's nowhere in a clinic setting that says do you know what you can get off methadone and you can have a drug free life. You know if you're on methadone or if you're on up in the clinic you're not going to be given any other information. I think it's only when linked into other services do you realise that there is other options available.

Reference 4 - 0.54% Coverage

Amy

Many of the respondents did however make it clear that this was not necessarily a reflection on clinic staff or the attention they paid to their roles but rather a reflection on the whole dispensary environment which did not lend itself to the efficient distribution of information. It was acknowledged that the clinic environment, including public access routes to it, can be chaotic places and many service users want to get in, get their methadone and get

out, as quick as possible, so the opportunity for good communication with clinic staff was limited.

Well for some people if they go onto maybe a certain clinic where there might be a lot of dealing outside and stuff like that. And even though they're on methadone they, you know, meet these people outside who are offering them other stuff and it might not necessarily be heroin. It could be cocaine, it could be tablets, and do you know what I mean?

Reference 1 - 0.63% Coverage

Katy

Not all clinics were viewed in the same way, with considerably different experiences at different locations. However it was felt, that the lack of sound information generally created the opportunity for 'street myths' to thrive.

There's also a lot of negative gossip goes around as part of the subculture. You don't want to go there, they shake your head. They've all heard rumours, don't send me here, don't send me there or I'm not going to that place, they make you pray, they take all your money off you and there's all these little stories that go around and they're scary. It must be very fearful.

Reference 6 - 0.56% Coverage

Anna

I know for instance there was one rumour of course went around that if you're on a hundred ml or more you're going to have a heart attack

Reference 1 - 0.54% Coverage.

Anna

The level of interaction and communication between MMT service users and prescribing doctors as understood and expressed by the respondents would appear to present further barriers to the ongoing recovery process. Service users struggle trying to get clear communication with their GP as they attempt to get them on board with their own treatment goals. This appears to create an enormous level of frustration for service users especially where, hoped for moves toward reducing methadone intake are ignored or dismissed. The problems surrounding a proper engagement between GPs and methadone service users undoubtedly are rooted in the issues of power relations. As methadone is highly regulated with a penalty system in place for non-compliance, service users are reluctant to engage in full disclosure to doctors or to their clinics. This conflict can lead to disillusionment and a lack of belief on the client's part.

I've heard from people is usually kind of well, you know, I went in and sat with the doctor and I said "I wanted to go off the methadone and I was thinking of moving on", you know, and usually the first sentence in the reply is "well I don't think you're ready", you know. And I find that sometimes it just knocks people's belief that they can actually come off it.

Reference 1 - 1.18% Coverage

Andy

Opportunities for Self-directed Change

The majority of respondents expressed quite negative views in relation to enquiries about how much or to what degree service users were seen to have ownership of the treatment provision they were receiving. Compliance with the different rules and regulations was seen to be the only requirement expected from staff. One respondent summarised the situation as follows:

It's like I [service user] can't leave the country unless the doctor gives me permission to leave the country. I can't leave the country until he gives me a letter to say that I can take my methadone out of the country.

Reference 1 - 0.87% Coverage

Amy

Respondents indicated that there were small elements directly within MMT provision or elements that occur as a consequence of provision which go some way towards supporting the acquisition of social and self regulatory skills. The fact that service users are committing to a daily and weekly schedule around a methadone service is itself a positive progression, compared to the anti-social and disruptive schedule associated with heroin addiction. Also service users who are judged to be compliant with clinic or GP policies maybe allowed a measure of self regulation.

Where part of the, I suppose their own power or their own control of like they're going down to a GP, they're getting a prescription, they're bringing it to a pharmacy, they're handing it in, you know.

Reference 1-0.87% Coverage

Andy

You can kind of, you know, you attend every day. You [service user] give clean urines, you know, what I mean, you know, you probably will see the results. You might get weekend takeaways, instead you might get takeaways from the clinic and then you could possibly request from your doctor in a clinic that you go onto your GP.

Reference 4 - 1.30% Coverage

Katy

It was also suggested that service users can develop a level of dependency, not entirely or necessarily a negative one after prolonged attachment to a clinic.

So there's nearly an ownership. It's my clinic and maybe that's all they have. Maybe that's the only human contact that they would have in that day.

Reference 1 - 0.87% Coverage

Anna

However the general consensus in relation to questions regarding 'opportunities for self-directed change', suggest that, methadone provision offers very little in the way of client skill enhancement or ownership. The clinic, but probably more so the GPs and pharmacists were broadly speaking run in a manner that reinforced traditional power based relations. Strict regulations which include urine sample analysis and pharmacy contracts were seen to be overly punitive and served to reinforce addict identities. The pharmacy experience for many service users reflected this matter.

[Service users] have to go in and they have to sign a contract and they're not allowed to shop at the time, buy anything. They have to wait until other customers are finished and then they're to go and drink in a corner and you know.

Reference 1 - 0.51% Coverage

Tina

The relationship between the MMT client and the clinic/GP of course is central to successful treatment progression and outcomes. All respondents felt that there was a general reluctance on the part of GPs and clinic's to pursue treatment options that involved detox. Establishing service users on a methadone maintenance programme seemed to be, from a providers perspective an adequate response in itself. Whilst methadone detox was certainly available most respondents believed it was not readily available and that as an option within provision detox availability was very often dependent on the individual GPs approach or dependent on the individual client's ability to insist on a detox option.

The only thing in my own experience through the whole thing like, you know, I think doctors once you're on a maintenance course they'd rather see you on it for the rest of your life.

Reference 3 - 1.90% Coverage

Tom

There's little or no encouragement or motivating factors. For instance there's no care plans as such. There's no psychosocial approach to treatment provision. It is a medical intervention and as such a pharmaceutical intervention.

Reference 2 – 0.94% Coverage

Anna

I think there is, like some service users would say like when I was on heroin, heroin controlled me, now doctors control me.

Reference 3 - 0.52% Coverage

Amy

As a means of addressing the frustrations borne out of the apparent unwillingness shown by, clinics/GPs to pursue detox treatment, a great number of service users make the decision to manage their own detox.

On their own, just completely coming off it and having medical conditions after it but also people then going back to their doctor and their doctor asking them “well maybe you should go back on your methadone”. Now to me that's just crazy.

Reference 5 - 0.92% Coverage

Kevin

As they can keep them on the methadone but service users that wouldn't, that I'd say I'm[service user] on sixty ml and in two months time I want to go to fifty ml, they do it themselves slowly but surely, like they'd gradually bring themselves down and then inform probably their GP or their clinics.

Reference 3 - 1.97% Coverage

Tricia

The decision to 'self detox' is obviously a risky choice as it is done without and possibly in direct opposition to medical advice. Some respondents commented that service users would generally manage this option with the help of their mothers or partners who took on a supervisory role, holding methadone stock and doling it out as required. Whilst this pattern is cause for concern, it also highlights the conflict that quite often exists between client aspirations on the one hand and service provision on the other.

Key Working and Interagency Work

A number of key areas have been identified by the respondents in this study where the MMT operational systems are effective in responding to client needs. However, there are numerous accounts that suggest that there are also high levels of variations and gaps running throughout service provision. In particular respondents expressed opinions that suggested treatment systems can because of their structures; instil levels of fear and frustration due in part it must be said, to poor communication arrangements. These obstacles it was stated combine to impede the recovery progress. One important aspect of provision which can determine the success or otherwise of MMT is how MMT operational systems work in conjunction with local community drug projects

It is clear, from the data collected, that the keyworking process is viewed to be a critical aspect of community drug team work and crucial to the overall success of the methadone maintenance treatment system. Many of the gaps and inconsistencies identified within methadone provision are successfully addressed through these services. Respondents outlined the varieties of ways in which their services tackle service user issues and how their services are and can complement the work of the clinics and GPs.

I think with key working you're a multitude of things like. You're playing all types of roles. Like you're a facilitator, you're an educator, you're a supporter, you're a negotiator, and you're a carer.

Reference 2 - 0.60% Coverage

Amy

We work on their addiction and their behaviours and you know help them to build confidence because people can't come off drugs unless they feel confident enough to do that so we try to build their confidence so they feel like, well I can do something else with my life.

Reference 1 - 1.38% Coverage

Tina

It was suggested that many of the barriers to recovery outlined earlier could be overcome with the aid of an effective key worker process in place.

So that's the way but we certainly motivate all the time and encourage, you know, we'll emphasis that this is where you've come and you're saying that you can't move from here to there but this is what you've already done, so we'll

look at any particular blocks and we'll work through each obstacle but it's totally up to the client ultimately

Reference 4 - 1.43% Coverage

Tracey

In addition to the 'one to one' work carried out by key workers, one of the more important roles is that of mediator and of advocate. Respondents advised that this role was crucial but had to be carried out in a manner that enhanced rather than impeded client's ability to acquire their own skills. Respondents noted that working at this level with a client requires time in order to build a relationship of mutual trust and understanding.

And it takes a long time, I would say three months would be a good time working with somebody where you really get to know them and they really get to know you. And it gets very clear what's motivating them and how you can engage them in something meaningful.

Reference 2 - 0.61% Coverage

Anna

When you get service users that are motivated you try and tap in. I try and tap into that you know, it's like for me to work with a client the respect and trust is kind of the two things that we kind of work on and build on which is central to what the relationship is

Reference 16 - 0.72% Coverage

Kevin

One of the major elements contained within the key worker role is the ongoing links that are cultivated with other relevant agencies around client care plans. For those key workers involved with service users accessing MMT, this link is primarily with GPs and the dispensing clinics. Many respondents stated that this relationship can be a very positive one with good information flow where there is a shared recognition by all stakeholders of the value that such arrangements can build. As one key worker said:

Yeah I think the ideal situation is where the person is linked with medical services and then they're linked with the psychosocial services as well that there a dual approach. That seems to work. The people that do well and even the people that are very, very long time methadone users and have no intentions of stopping they can keep very well within that system.

Reference 1 - 1.35% Coverage

Anna

It was acknowledged by respondents from all three projects involved in the study, that the level of constructive engagement between agencies was determined by the GPs and/or clinics and that GPs for the most part were the stakeholder that were often unwilling to engage. In the vast majority of cases respondents suggested that they themselves or the client would be responsible for initiating such a joint approach with GPs. The resistance was understood by respondents to be due primarily to the more traditional way of thinking held by some GPs.

I've had meeting with GPs. Yeah I've spoken to them on the phone. They've been brilliant. However, some GPs just won't engage with you at all. Their attitude is it's a medical issue and as such a key worker has nothing to do with it.

Reference 2 - 0.92% Coverage

Tracey

However there were some encouraging and progressive interagency initiatives discussed by respondents. One of the community drugs programmes in the study had been approached by a local medical clinic to collaborate on a pilot programme. The programme was setup to deal with the issue of methadone maintenance waiting lists. This particular project helped develop a pre MMT assessment programme with the aid of a designated doctor, councillor and support worker.

Discussion and Conclusions

The principle finding of this research study was that there were significant shortfalls in methadone maintenance provision in addressing the needs of service users. While many of the organisational systems in place were understood to operate effectively there was evidence of high levels of inconsistency running throughout MMT provision.

Initial Goals and Motivation

The study set out initially to establish what the aspirations opiate users were presenting with when they first made contact with the various community drugs teams involved in this research project. The general consensus was that service users first and foremost were looking to introduce a level of stability into their lives and that in most cases service users' stated that their long term goal was to be drug free. These observations would appear to correspond with the extensive studies carried out in Scotland (McKeganey et al., 2004) which while emphasising the importance of harm reduction, identified abstinence as the principle goal or hoped for achievement for the majority of service users as they commenced new treatment episodes.

The motivating factors driving opiate users towards MMT were recognised by the study respondents, to be borne out of a general realisation on their part of opiate users, as to the extent to which the addiction lifestyle was having on their lives. Much of this motivation was driven primarily by issues relating to their immediate family, in particular, their children but also by significant personal health matters. Whilst these motivating factors would appear to offer a very sound foundation from which a recovery process might evolve, respondents in

the study, felt that this was not always the case. It was suggested that for many service users, subsequent progress can be sporadic at best as service provision tends to focus on the efficiency of the operational systems more so than the individual needs of service users. This observation is very much in line with much of the international research reviewed, such as Quirion (2003), which suggests that the impetus for MMT provision is driven by wider social and political pressures rather than any humanistic concerns. This opinion is in line with much established research which highlight in particular, the high degree of regulation involved in MMT provision as evidence of its main focus, where service attention is on client surveillance, compliance and sanction (Harris & McElrath, 2011; Cox & Lawless, 2002).

Barriers to Recovery

A number of barriers were identified which serve to challenge MMT provision. Good communication whether through information dissemination or through professional interaction with service users was limited by the dispensing clinic environment which was viewed in some cases as unsafe. Communication was also restricted between the client and prescribing doctor as this relationship, in many cases, reflected the more traditional power difference associated with doctor/patient relations. These conditions were seen to reinforce the idea of the client as a passive recipient of service and tend to correspond with other research literature (Bryant et al., 2008, McKeganey et al., 2004), which suggest that drug users are not recognised by those involved in MMT provision, to be equipped with the skills required to engage, as partners, in the detail of their own treatment. These two studies concluded that decisions around mode of intervention such as detoxification or stabilisation are rarely made by service users themselves.

The findings outlined in this study draw attention to the effect a lack of engagement in their own treatment has on service users and highlights the frustrations experienced which can lead to a gradual waning of initial motivation and in many cases can lead to decision making which runs contrary to medical advice.

Self-directed Change

One of the more significant themes to emerge in this study was the matter of client ownership of their treatment and the question as to whether service users had the opportunity to engage in any level of self-directed change. Bandura (1990) discussing this concept in relation to the exercise of self-control, identified four components which are necessary to ensure effective self-directed change. They are a source of information highlighting health risks, development of social and self-regulatory skills which can be applied into preventative action, skill enhancement including an element of feedback and identification of social supports to enhance effective change.

Methadone maintenance programmes whether they are managed by clinics or by GPs/pharmacists were understood by respondents, to operate in a manner that generally did not encourage any significant level of participation by the client. There was clear evidence that some clinics were favoured over others by respondents as these clinics were understood to operate in a manner which was more supportive of client's individual needs. This study indicates that the operational systems in place in methadone provision do not, for the most part, offer the type of environment required for service users to develop a sense of ownership of, or input into, choices in relation to the direction and pace of their recovery path. Perhaps the most fundamental issue, which is seen to contribute to the lack of status service users

possess, is the disciplinary policies and sanctions employed by services which, as argued by King (2011), serve to create client/service relations which are characterised by fear rather than in terms of equality and mutuality. A number of respondents expressed dissatisfaction with how service users are treated in pharmacies where they have to sign contracts, consume their methadone in public and are generally cared for in a less respectful way than other customers. Questionable pharmacy policies such as these, which were first highlighted nearly ten years ago, in 'Methadone: What's the Story?' (Uisce, 2003) tend to reinforce the negative self-image and reduce service user confidence which can feed into a general sense of disempowerment.

Of course several respondents expressed the view that many staff including doctors working within treatment provision were very willing to engage with service users on more equal terms and that this willingness has a positive effect on service users outlook with regard to their future treatment choices. However the lack of any consistency in this matter highlights, as Lily et al. (2000) suggests in their study of 'Sociality and Methadone Treatment', the need to further investigate the dynamics of the relationships between all stakeholders involved in treatment provision, so as to determine why these relationships can act as a deterrent to progress in some situations and are central to driving success in others.

The absence, articulated by the respondents of any meaningful, constructive or equal partnership between service user and methadone services providers, demonstrated by the difficulties in establishing purposeful communication can create a space where informal exchanges of information take place. This space, in turn invites an increase in the incidence of 'street myths' which can be extremely destructive to the individuals and to the welfare of service users as a whole. Poor communication coupled with the subculture that is associated

with the dispensing clinic environment can obstruct an individual's ability to develop skills to promote self-efficacy. This, as outlined by Joe et al. (2007) can have the effect of lowering the service user's expectations with regards to more positive outcomes in terms of their future drug use.

It is evident from the data collected in this research that the issues outlined have contributed to a concerning trend which challenges the assumption that methadone provision is sufficient in addressing the needs of service users. Many service users are choosing to manage methadone dose levels themselves with the help of family and friends. These decisions are made without informing GPs. The reluctance to reduce methadone dose by GPs was understood by respondents, to stem partly from GPs belief that service users would inevitably relapse. The GPs hesitation on this matter is strongly supported by international research such as Sees et al. (2000) and Ball & Ross (1991) which clearly states that there is a high rate of relapse associated with detoxification. It would appear from the interviews carried out that this practice of 'self detox' is common and while on the one hand it highlights the extent to which the goals of service users and those involved in MMT provision can be at odds with one another, it also demonstrates the lengths to which service users are willing to go in order to assume some ownership of their treatment.

Key Worker and Interagency Work

Effective methadone provision is not solely dependent on the successful interaction between MMT provider and client. When we consider some of difficulties experienced by service users as they negotiate the different elements within MMT provision, what clearly emerges from this study is the important role the key worker has in supporting the client

through the treatment process. Much like the experience of service users, respondents also commented on the variety of responses they themselves encounter from clinicians and GPs to requests for dialogue in relation to service users care plans. It is apparent from this study that the level of interaction between community drug programmes and clinic staff and GPs is determined by the latter and in many cases this relationship is unsatisfactorily. The different reactions towards the notion of a shared approach to case work runs contrary to the first external review of the Methadone Maintenance Protocol in Ireland ‘The Introduction to the Opioid Treatment Protocol’ (Farrell, M. & Barry, J., 2010). This review recommended that there should be a widening of involvement across all professions including community workers and key workers into service delivery. The ability of key workers to build trusting relationships with service users over time, as outlined by a number of respondents, is evidently an asset to the overall effectiveness of service delivery and should be viewed by all stakeholders as such.

Conclusion

The research undertaken was limited by a number of factors, in particular the restriction in relation to scope, due to the small number of individuals participating in the study. As the study was concentrated in three similar projects in west Dublin, the findings may not be representative of Dublin or Ireland as a whole. A more comprehensive study may have included a comparative piece, which perhaps could have included the views of the other stakeholders involved i.e. the service user, the statutory agencies, GPs and pharmacy personnel.

Whilst there was a wide range of perspectives articulated in this study, the data collected demonstrates that there is a general consensus among key workers which suggests, there are a number of limitations within MMT provision. It is accepted that motivation to address drug dependency and the challenges of recovery will ebb and flow over time and that community services providing psychosocial supports and statutory services delivering medical supports need to be collaborative and flexible in their approach so as to maximise effectiveness at the appropriate time.

The choice that many service users take to 'self detox' from methadone is an issue which raises questions on a number of levels. This issue deserves further research, perhaps a quantitative study which could establish the prevalence of the 'self detox' option amongst individuals accessing methadone maintenance and also further enquiry into the reasons why some individuals feel it necessary to make such a choice. A commitment by all stakeholders to the recommendation of the methadone protocol review (Farrell, M. & Barry, J., 2010) which includes a recommendation that all requests by service users for detoxification should have a defined timeframe for response, would go some way towards addressing the issue outlined above.

Finally to enhance MMT provision and as a means to address the reluctance by some stakeholders to engage in meaningful and constructive dialogue, a model of practice which recognises the value of a multidisciplinary approach should be formally integrated into MMT provision.

Reference List

Amato, L., Davoli, M., Perucci, C.A., Ferri, M., Faggiano, F. & Mattick, R.P. (2005). An overview of systematic reviews of the effectiveness of opiate maintenance therapies: Available evidence to inform clinical practice and research. *Journal of Substance Abuse Treatment*, 289(4), 321–329.

Ball, J.C. & Ross, A. (1991). *The effectiveness of methadone maintenance treatment*. New York: Springer-Verlag Inc.

Bandura, A. (1990). Perceived self-efficacy in the exercise of control over AIDS infection. *Evaluation and Program Planning*, 13(1), 9-17.

Bryant, J., Saxton, M., Madden, A., Bath, N. & Robinson, S. (2008). Consumers' and providers' perspectives about consumer participation in drug treatment services: Is there support to do more? What are the obstacles?. *Drug & Alcohol Review*, 27(2), 138-144.

Comiskey, C.M., Crispino, G. & Cassidy, T. (2003). *ROSIE, research outcome study in Ireland: Evaluating drug treatment effectiveness*. Project Objectives Document (Protocol and Study Design). Dublin: NACD.

Cox, G. & Lawless, M. (2004). *Maintaining or enabling? Evaluation of a methadone prescribing service in Dublin City*. Dublin: Merchants Quay Ireland.

Department of Health (1993). *Report of the expert group on the establishment of a protocol for the prescribing of methadone*. Department of Health. Dublin.

Ettner, S.L., Huang, D., Evans, E., Ash, D.R., Hardy, M., Jourabchi, M. & Hser, Y.I. (2006). California treatment outcome project: Does substance abuse treatment 'pay for itself?' *Health Services Research*, 41(1), 192- 213.

Farrell, M. & Barry, J. (2010). *The introduction of the opioid treatment protocol*. Health Service Executive, Dublin.

Fischer, B., Rehm, J., Kim, G. & Kirst, M. (2005). Eyes wide shut? A conceptual and empirical critique of methadone maintenance treatment. *European Addiction Research*, 11, 1-14.

Ford, C., Halliday, K., Lawson, E. & Browne, E. (2011). Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care. Retrieved from <http://www.smmgp.org.uk/download/guidance/guidance004.pdf>

Haasen, C. & Van den Brink, W. (2006). Innovations in agonist maintenance treatment of opioid dependent patients. *Current Opinions in Psychiatry*, 19, 631-636.

Health Promotion Unit (2003). *Facts about drug misuse in Ireland*. Health Service Executive, Dublin.

Herman, J., Stancliff, S. & Langrod, J. (2000). Methadone maintenance treatment (MMT): A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, 67(5), 347-364.

Joe, G.W., Flynn, P.M., Broome, K.M. & Simpson, D. (2007). Patterns of drug use and expectations in methadone patients. *Addictive Behaviours*, 32(8), 1640-1656.

King, A. (2011). Service user involvement in methadone maintenance programmes: The 'philosophy, the ideal and the reality'. *Drugs: Education, Prevention and Policy*, 18(4), 270-275.

Lilly, R., Quirk, A., Rhodes, T. & Stimson, G.V. (2000). Sociality in methadone treatment: Understanding methadone treatment and service delivery as a social process. *Drugs: Education, Prevention and Policy*, 7(2), 163-178.

Mason, J. (2003). *Qualitative researching*. London: Sage Publications.

Masson, C.L., Barnett, P.G., Sees, K.L., Delucchi, K.L., Rosen, A., Wong, W. & Hall, S.M. (2004). Cost and cost-effectiveness of standard methadone maintenance treatment compared to enriched 180-day methadone detoxification. *Addiction*, 99(6), 718-726.

McGovern, G. (2011). Making the case for methadone. *The Medical Times*. Retrieved on the 11/11/2011 from <http://www.imt.ie/clinical/2010/10/making-the-case-for-methadone.html>

McKeganey, N.P., Bloor, M., Robertson, M. & Neale, J. (2006). Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland study. *Drugs: Education, Prevention and Policy*, 13(6), 537-550.

McKeganey, N., Morris, Z., Neale, J. & Robertson, M. (2004). What are drug users looking for when they contact drug services: Abstinence or harm reduction?. *Drugs: Education, Prevention and Policy*, 11(5), 423-435.

Quirion, B. (2003). From rehabilitation to risk management: The goals of methadone programmes in Canada. *International Journal of Drug Policy*, 14(3), 247.

Sees, K.L., Delucchi, K.L., Masson, C. et al. (2000). Methadone maintenance vs. 180-day psychosocially enriched detoxification for treatment of opioid dependence: A randomized controlled trial. *JAMA*, 283(10), 1303–1310.

Seivewright, N. (2000). *Community treatment of drug misuse: More than methadone*. Cambridge: Cambridge University Press.

Uisce (2003). *Methadone: What's The Story?* Dublin: Uisce.

Van Hout, M.C. & Bingham, T. (2011). *Holding pattern: An exploratory study of the lived experiences of those on methadone maintenance in Dublin North East*. Dublin North East Task Force, Dublin.

Appendix 1 - Sample Letter of Permission to Conduct Research

Dr. Bernadette Quinn,
Research Coordinator,
Social Science Programme,
Dublin Business School.

21st November 2011

Dear Sir/ Madam,

Re: Permission to conduct a research study with members of your organisation.

Mark Kavanagh is enrolled as a final year social science student at Dublin Business School. DBS social science students are required to complete an independent research project during their final year of study. Mark's final year research project aims to examine the effectiveness of Methadone treatment in relation to harm reduction or abstinence.

All research conducted by final year students is done for the purpose of meeting course requirements. All results obtained are strictly confidential, and to be used for assessment of the researching student's qualifications for receipt of a BA in Social Science. Mark is requesting written permission, as soon as possible, to collect research data.

Please feel free to address any questions regarding this research to Dr. Bernadette Quinn, Research Coordinator, Social Science Programme, Dublin Business School. Mark (mkavana66@gmail.com) can also provide further details about how he will conduct his research study. Thank you for your time.

Yours Sincerely,

Dr. Bernadette Quinn
Tel: 01 4178737
Email: bernadette.quinn@dbs.ie

Appendix 2 - Invitation to Participate in Research



Effectiveness of methadone

My name is Mark Kavanagh and I am conducting research that explores the effectiveness of methadone provision in addressing the stated aspirations of service users.

You are invited to take part in this study and participation involves an interview that will take roughly 40 minutes.

Participation is completely voluntary and so you are not obliged to take part. If you do take part and any of the questions do raise difficult feelings, you do not have to answer that question, and/or continue with the interview.

Participation is confidential. If, after the interview has been completed, you wish to have your interview removed from the study this can be accommodated up until the research study is published.

The interview, and all associated documentation, will be securely stored and stored on a password protected computer.

It is important that you understand that by completing and submitting the interview that you are consenting to participate in the study.

Should you require any further information about the research, please contact:

Mark Kavanagh (mkavana66@gmail.com) or Paul (paul.halligan@dbs.ie)

Thank you for participating in this study.

Participant Signature: _____ Date: _____

Appendix 3 - List of Interview Questions

Interview questions addressing client experience of methadone provision.

1. If we could begin with you telling me a little bit about your own role in this organisation perhaps starting with your name and how long you have been working here.
2. What outcomes are MMT client's generally hoping for, when they first present to your service/project?
3. How do clients engage in dialogue around initial decision making in relation to their treatment care plan?
4. How do you feel current methadone provision encourages or facilitates clients towards self directed change?
5. How aware are clients about their addiction and treatment options? Are clients aware of the different aspects of the treatment process?
6. How much influence do clients have over the type of service they receive?
7. What in your view are the key elements present in MMT provision which drive client motivation?

8. Motivational levels will naturally fluctuate over the course of MMT provision, what in your opinion are the key factors that affect client motivation during the life of their care plan?

9. Once clients have established themselves on your programme what in your experience are the main factors that obstruct client progress or enhance clients continued progress?

10. Are there differences in expectations between client and key worker with regards to the extent and pace of change being followed in client care plans?