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Counselling Utilization Experiences among Methadone Maintenance Treatment Clients in Rural and Small Urban Communities
Expériences de l'utilisation du counseling parmi les clients subissant un traitement de maintien à la méthadone dans les communautés rurales et les petites communautés urbaines

Nichole D. Pickett
José F. Domene
University of New Brunswick

ABSTRACT

As a result of growing rates of opiate dependence in Atlantic Canada, numerous methadone maintenance treatment (MMT) and associated counselling programs have been implemented. A qualitative study employed semistructured interviews to examine the counselling utilization experiences of 7 participants (4 males, 3 females) who were receiving MMT. Four salient themes were identified using an interpretive thematic analysis strategy, and results suggest that counselling was a beneficial supplement to methadone, but challenges existed with its implementation. Implications on how to improve the efficacy of available counselling are identified and discussed.

RÉSUMÉ

En raison du taux de croissance de la dépendance aux opiacés au Canada atlantique, de nombreux programmes de traitement d'entretien à la méthadone (TEM) et des programmes de counseling associés ont été mis en œuvre. Une étude qualitative a employé des entretiens semi-structurés pour examiner les expériences de l'utilisation du counseling de 7 participants (4 hommes, 3 femmes) qui recevaient un TEM. Quatre thèmes marquants ont été identifiés par une stratégie d'analyse thématique interprétative, et les résultats suggèrent que le counseling est un complément bénéfique à la méthadone, mais il existe des défis dans la mise en œuvre. Les implications et la façon d'améliorer l'efficacité du counseling disponible sont identifiés et discutés.

The association between opiate dependence and methadone maintenance treatment (MMT) has been extensively investigated, and research literature suggests it is an effective means of treatment (Health Canada, 2002; New Brunswick Department of Health, 2005; Ponizovsky & Grinshpoon, 2007). Methadone is a medical synthetic opioid agonist appropriate for maintenance therapy because it is an efficient and long-lasting method of relieving the intense cravings and withdrawal symptoms associated with opiate detoxification. Although the effec-

tiveness of MMT is well documented, little research has been conducted on the utilization of counselling by MMT participants. Furthermore, the majority of existing research has been completed in large urban centres, potentially limiting the transferability of findings into smaller urban and rural settings. Taking into consideration the rising rates of opiate dependence experienced within Atlantic Canada in the past decade, the present study aimed to expand this research to examine the counselling experiences of MMT participants living in small urban and rural communities within Atlantic Canada.

COUNSELLING AND METHADONE MAINTENANCE TREATMENT

A small body of literature suggests there are additional benefits experienced by MMT clients who access counselling services as part of their opiate dependence treatment (Fischer, Chin, Kuo, Kirst, & Vlahov, 2002; Gossop, Stewart, & Marsden, 2003, 2006; New Brunswick Department of Health, 2005; Vigilant, 2008). Furthermore, many studies have found that better treatment outcomes occur when clients include some form of counselling as part of their recovery plan rather than relying solely on methadone to treat their opiate dependence (Gossop et al., 2003, 2006). Addiction and psychiatric focused counselling, including individual, group, couple, or family counselling, may contribute to providing important support, education, coping strategies, and skill development to the methadone maintained clients (Fals-Stewart, O'Farrell, & Birchler, 2001; Gossop et al., 2003; New Brunswick Department of Health, 2005). Furthermore, the behavioural and cognitive changes that occur when MMT is implemented have been found to be strongly associated with increased access to counselling services (Gossop et al., 2006; Sigmon & Stitzer, 2005).

Fischer et al. (2002) and Quigley (2003) found that MMT clients believed that counselling participation was an important element of their recovery efforts. However, attendance in counselling among the MMT population often remains very low. Sigmon and Stitzer (2005) reported only one third of the MMT population they surveyed accessed counselling services regularly. It has been suggested that low attendance may be the result of MMT participants wanting flexibility and active involvement in the decision-making process with regard to the counselling they receive (Fischer et al., 2002; Quigley, 2003). When given a choice in their counselling, opiate-dependent clients reported they felt the process was empowering. In addition, clients favoured counsellors who were flexible in their availability to schedule appointments. MMT participants stated they preferred a counsellor who could be available for them both physically and psychologically, with an understanding of the special needs of their population (Quigley, 2003). These participants felt that methadone gave them the ability to address their concerns therapeutically, examining their addictions in greater detail and offering a chance to rebuild important relationships hurt by their addictions (Vigilant, 2008).

counselling services and rural communities

The literature has repeatedly noted that individuals living in smaller urban and rural communities may face additional challenges to accessing counselling services for their substance abuse. Sexton, Carlson, Leukefeld, and Booth (2008) categorized these barriers into five areas: physical, financial, societal, organizational, and psychological. Physical barriers are often related to the distance clients have to travel to receive treatment (Darke, Hall, & Swift, 1994; Health Canada, 2002; Heil, Sigmon, Jons, & Wagner, 2008; Metsch & McCoy, 1999; Sexton et al., 2008). Economic barriers to treatment in small urban and rural communities are often related to the physical barriers (Leukefeld & Edwards, 1999; Metsch & McCoy, 1999; Sexton et al., 2008). Individuals living in smaller communities may have difficulty traveling to treatment centres. This is especially true for those living in rural areas where affordable public transportation may not be available (Health Canada, 2002; Robertson & Donnermeyer, 1997; Sexton et al., 2008). Furthermore, people living in rural areas are often self-sufficient or self-employed and, as a result, they may lack the income or insurance policies required to take the time off from work necessary to participate in such treatments (Metsch & McCoy, 1999).

Several societal barriers are particularly evident in small urban and rural communities. The stigmatization related to addictions may result in individuals desiring treatment to be negatively stereotyped by their community (Metsch & McCoy, 1999; Sexton et al., 2008; Warner & Leukefeld, 2001). In addition, the lack of anonymity when receiving treatment is a particular problem for clients in smaller communities. Furthermore, several organizational barriers exist in developing addiction treatment programs in these communities. Frequently, smaller communities have difficulty both recruiting and retaining health care professionals (Health Canada, 2002; Metsch & McCoy, 1999; Robertson & Donnermeyer, 1997). As a result, addictions services available to clients in smaller communities are often limited, resulting in problems such as longer wait lists for treatment, restricted accessibility of inpatient treatment and long-term care programs, lack of services for special needs clients, a lack of bilingual staff, and poorly located treatment sites (Metsch & McCoy, 1999; Sexton et al., 2008).

The culture of skepticism and suspicion about mental health services that has been found to be present in many small communities creates additional barriers (Sexton et al., 2008; Warner & Leukefeld, 2001). People living in rural areas have repeatedly been found to believe that mental health services are unlikely to help or meet the needs of substance-dependent people (Brown, Hill, & Grioux, 2004; Fortney & Booth, 2001). Additionally, individuals living in these areas have been found to view increased drug use as nonproblematic or not reflective of an addiction (Warner & Leukefeld, 2001). Thus, drug-dependent individuals in small urban and rural communities are less likely to seek out treatment even if it is available (Sexton et al., 2008; Warner & Leukefeld, 2001). Taking into consideration the economic, physical, social, organizational, and psychological barriers unique

to smaller communities, it is evident that there are extensive challenges for clients living in these areas when trying to access adequate treatment services for their substance abuse and dependence (Falck et al., 2007; Metsch & McCoy, 1999).

THE PRESENT STUDY

Overall, the existing research suggests that counselling can be a beneficial supplement to individuals participating in MMT programs, if it is carefully planned and implemented in coordination with clients to meet their specific needs. However, there is substantial evidence that individuals living in smaller communities and rural areas face additional challenges when trying to access and integrate services to treat their substance dependence. As such, one gap in knowledge is whether counselling programs available to MMT clients in smaller centres are capable of meeting their needs. Addressing this issue, the present study explored the role of the utilization of counselling and related services among MMT participants within a small Atlantic Canadian province by addressing the research question, "What role has counselling services taken on or played in MMT participants' recovery efforts?"

METHOD

Participants

Participants were recruited from a population of approximately 400 MMT patients attending clinics that provided MMT services to individuals living in small urban and rural communities in an Atlantic Canadian province. The study was open to individuals who were taking part in an MMT program during the time of data collection and had been MMT program patients for a minimum of one year. Additional inclusion criteria were fluency in English, the ability to complete a paper-and-pen interview interest form, and being 18 years of age or older. Seven participants (4 males and 3 females) volunteered to take part. Their mean age was 42, they had participated in MMT for a mean of 30.57 months, all participants were Caucasian, and their first language was English.

Materials and Instruments

The researchers developed a semistructured interview protocol for this study designed to assess participants' involvement in counselling and peer support programs since starting MMT (see Appendix for a copy of the interview protocol). For each topic area, a smaller list of follow-up questions were also developed as a way to gain more detailed information from clients who hesitated in responding to the initial main questions. In particular, follow-up questions focused on participants' reasons for choosing to access counselling-related services or not, and any benefits they experienced from participating in counselling-related services.

Procedures

Participants were recruited through the use of poster advertising and postcards placed in methadone clinic wait areas and by asking gatekeepers (MMT staff) to inform potential participants about how to take part in the study. Participants were able to access copies of the research package in methadone clinic wait areas. This package included a detailed description of the study, an invitation to participate, a demographic information sheet, and a request for contact information if they wished to participate. Participants who completed the materials in the research package were then contacted to arrange interviews.

Data were collected using audio-recorded interviews conducted by the first author at the local addiction treatment services centre or on campus at a local university, based on participants' preference. Interviews ranged in length from 45 minutes to 1 hour and 50 minutes. Immediately before the start of the interview, clients were given another detailed informed-consent letter that included information about the structure of the interview, anticipated time, and measures to ensure confidentiality. Written consent was then obtained from the participant. The interviews were transcribed verbatim by the interviewer, and all identifiers were removed to ensure anonymity.

Interview transcripts were analyzed using Thorne's (1999) interpretative descriptive method, a form of thematic analysis. The researchers read the transcripts to identify explicit statements related to the research questions. They also identified the role counselling services played in participants' recoveries. These statements were collected for each interview, organized based on conceptual similarity, assigned labels, and further defined by creating a written description for each individual's experience of MMT. In the final stage of analysis, these labels were examined among the data set and grouped together using patterns of similarity of content to identify the kinds of themes that emerged most frequently in MMT clients' experience of their utilization of counselling and other related services. Researchers noted that divergent themes were not present across the data set. If similar content was present among two or more participants, it was noted as a common theme.

The researchers employed a second coder to examine a selection of the transcripts and associated thematic descriptions. This credibility check was implemented as a validation procedure, and was designed to reduce the likelihood that the emergent themes reflected the idiosyncratic interpretations of the primary analyst. The researchers chose the interviews by considering and examining each interview, looking for those that produced the greatest variation in themes. The second coder reviewed the selected transcripts and associated descriptions and agreed with all themes that the primary researcher identified in the selected interviews. The second coder did not identify any additional themes. Given the transient nature of the population and their mistrust of institutional structures, it was not possible to conduct participant validation interviews.

FINDINGS

The MMT participants discussed a wide range of themes when they spoke about the role counselling and other related services had taken in their addiction recovery efforts thus far. We begin by taking a look at barriers and challenges.

Barriers and Challenges

Every participant identified some difficulties they encountered when attempting to incorporate individual and/or group counselling into their recovery planning. These barriers and challenges fell into three distinct categories: (a) personal, (b) policy and organizational, and (c) practical. Personal barriers experienced when seeking counselling included a lack of interest, discomfort with the procedures or formats of counselling, and a lack of a connection with their counsellor or other members of their therapy group. To illustrate, one female participant who was uncomfortable with disclosure in the therapeutic setting stated, "I'm not a person to open up and tell my private … I think that's why I have such a hard time with counselling because I don't know where to begin." Furthermore, a smaller number of participants stated they were particularly uncomfortable with counselling based in a group setting because they felt other members lied about their continued drug use, they were offered drugs while attending, and they feared the lack of anonymity of the group, given the context of the small community in which they resided. One male participant described his irritation with other group members' inauthentic behaviours within a peer support framework:

> Sitting there listening to people tell stories about being sober and knowing that you seen [them] at the pill dealer last week. So, I don't … I'm not going to sit and listen to people lie and try to tell you that they're sober when they're not. 'Cause that's bull, I can stay home and be sober on my own. I'm not going to sit and listen to a bunch of people tell BS, just because it looks good or just because they have to for court or something.

One participant mentioned his current health status made it difficult to concentrate in a group setting, stating "I've found that it's harder for me to participate because the pain is up and stuff like that, and my concentration is not that good. So I … but I find it relaxing and stuff like that."

Policy and organizational struggles were primarily composed of challenges with peer support programs that restricted the language that could be used at meetings (e.g., "they don't want you to use the word dilaudid, cocaine, or whatever. Well, if you're an addict and you can't use the word, why are you even here?"), lacked a specific focus on the participant's particular concerns (e.g., an opiate-dependent participant having to attend an Alcoholics Anonymous group because Narcotics Anonymous was not available), and being uncomfortable with the religious undertones of some of the groups. One male participant described this latter problem as "the NA and AA thing I'm not really down with that. I had the church shoved down my throat all my life; I don't want it anymore, not for a minute."

Beyond this, participants spoke of a lack of available MMT and associated care services. Participants also reported that there were long wait-lists to gain access to MMT programs. In particular, participants felt there was limited follow-up care, poor facilities, and poor programming associated with the detoxification services available. Furthermore, they were often returned to their previous environment, which was problematic because "I was right back in the area that I was using in, so I ended up falling back in old ways." A number of the participants attributed these deficits to the programming being at the early stages of development or the lack of government funding for the program. As one participant stated, "The detox here is a sham, and it's not their fault, there is no money for programs." Finally, one female participant indicated she felt there was poor communication between the clients and their assigned individual counsellors, stating, "nobody ever called and said, you know, I'm your counsellor, would you like to make an appointment, or the doctor didn't say this person's been assigned your case … so at first, it was just because of a lack of communication."

To a lesser degree, participants described the practical barriers they faced when trying to access services, including the time of day services were offered, personal time constraints, long travel distances, and associated costs of travel due to rural living arrangements. For example, one male participant stated his desire to attend counselling, but also his inability due to scheduling conflicts:

> It's just basically with work. Like I have to already take off a day a month for [the] doctor's appointment. It's kind of hard to explain to have to take another day off for this. If there were some night sessions … I would definitely be up for that.

Types of Engagement

A second theme that arose from the participants' conversations revealed how they came to participate in and how they engaged throughout counselling. Many participants stated that counselling participation was a mandatory requirement of their MMT program or was necessary to access the program privilege of "carries" (i.e., taking home doses of methadone). There were mixed feelings about this policy. Two participants, who had engaged in counselling because it was mandatory, believed it was a good policy, especially for individuals who had the time to participate. Furthermore, one participant stated he would not have entered counselling otherwise:

> Yeah, 'cause there's a lot of people like me that would never. Jeeze, do you think I would have ever gone to counselling if [they] hadn't made me? No. No, I would have stuck with the program because I planned on taking it seriously, but it did help.

Participants who expressed that mandatory counselling was a good policy also went as far as saying that they felt this policy should be enforced more strictly, as it helped them engage in counselling. However, two more participants who were participating in mandatory counselling stated they were hesitant to do so

and often distanced themselves from truly engaging in the counselling process. One female participant described how she continued to distance herself from completely engaging in counselling: "I see [counsellor] once in a while. I don't talk about my past. I never talk about my past. I talk about the future." Finally, one participant exercised her personal autonomy even within the constraints of mandatory counselling by choosing to see a private counsellor offered outside the program.

Two participants had voluntarily engaged in counselling. These individuals noted they chose to freely and actively participate in counselling because they wanted to obtain recovery planning abilities to achieve the most out of their recovery. One female participant described how she now truly engages in the counselling process:

> I've actually given them a shot at it. I'm not playing them anymore, and I'm not playing the game anymore. I'm not going in there and telling them what they want to hear. I'm working it, basically, I'm just working it … and I'm not working against it.

Finally, individuals who entered counselling in a self-directed way appeared to see their counsellors and other mental health support staff regularly and remain truly engaged in the counselling processes.

Counselling Benefits

All seven participants openly discussed the benefits they experienced from the counselling services they received in conjunction with their MMT program. All participants had taken part in counselling at some point during their MMT participation and some chose to disengage when they achieved a sense of stability or felt it was no longer benefitting them. Six participants spoke of the additional support counselling offered them, providing an outlet to speak about their experiences, which allowed them to feel heard, understood, encouraged, and believed in. One male participant who struggled significantly since his entrance to MMT stated, "I don't know if … I don't think I could have went through all the things that I've been through since getting on the program if I didn't have somebody there to talk to."

Participants also used their time in counselling as an educational tool to learn about their addiction, to gain additional skills related to goal setting, coping, recovery planning (including overcoming cravings), and finally to gain self-awareness about their drug use patterns. A male participant described the need to learn new ways to work toward recovery because he

> knew the things that I were trying on my own weren't working. So I needed to do something. I needed to learn skills. Yes, and I did that too, skill building or something for relapse prevention. I did relapse prevention.

To a lesser degree, participants stated that counselling helped them with their mental health concerns, allowed them to experience an elevated mood, enjoyment of life, improvements in self-esteem, relaxation, and a sense of belonging. A female

participant explained that, although she continued to struggle with sharing her past with her counsellor, she has gained the ability to think about past difficult experiences, "I'm actually letting these thoughts come into my mind instead of trying to block them out and I'm trying to deal with them every day … Sometimes I will be able to tell [counsellor], it's just not time yet."

Consistent with the extensive literature highlighting the importance of the therapeutic relationship, participants also noted that the qualities of their counsellors contributed to their overall counselling experiences. Participants expressed that they appreciated counsellors who were genuine, caring, and trustworthy. Some participants noted that their counsellors went as far as to advocate for them when they needed additional support. As one female participant noted when seeking assistance in choosing a physician to oversee her methadone treatment, "I was seeing [Dr. A] and she bumped me to [Dr. B], and I had to fight to get back to [Dr. A]. I asked [counsellor] to [help] put me back." Finally, some participants discussed how group counselling acted as a therapeutic community. A male participant described how one of the counsellors he encountered made him feel:

> [Counsellor] made you feel intelligent, made you feel accepted. A lot of things that you don't have there when you go in there because you're pretty beat up, you're pretty physically and mentally beat up…. so self-esteem levels and [counsellor] made them go up like that.

Overall, participants felt it was important that they were comfortable with and supported by their counsellors.

Perceived Disclosure Discrepancies

Highlighting the importance of confidentiality to the counselling process, two participants expressed dissatisfaction with what they perceived as their counsellors sharing information with other MMT caregivers. As a result, they were apprehensive of the counselling available at the MMT clinic and felt uncomfortable with disclosing information to their counsellors. These incidents led participants to self-censor and limit their engagement in the counselling process. As one female participant explained,

> if I go into a counsellor, I don't want to be having to watch what I say. You know, if you're going to go in there and tippy toe around what you say, what's the sense in seeing one anyway.

Furthermore, one participant indicated that she allowed this practice to continue because she was unsure of the policies that guided sharing of information between physicians and counsellors, stating, "I don't know what the counsellor and doctor stipulation is?" Therefore, this particular participant was unclear of her rights and perceives a power differential in her relationship with her counsellor. Overall, perceived discrepancies with disclosures led to unsatisfactory counselling experiences for those that experienced these incidents.

DISCUSSION

Many of the findings from this study examining counselling for MMT clients in rural and smaller city settings are similar to past studies conducted in larger cities, but there were a number of findings about the specific programs that were evaluated (e.g., sharing information between members of a treatment team, the mandatory nature of the counselling component of the program). Nonetheless, these themes reflect practices that may be found in other methadone programs and are thus important to consider. Participants were able to openly speak about both the benefits they received from attending counselling and the barriers they faced when attempting to access counselling and related services as part of their treatment for opiate dependence.

Consistent with existing literature (Darke et al., 1994; Health Canada, 2002; Heil et al., 2008; Maddux, Desmond, & Vogtsberger, 1995; Metsch & McCoy, 1999; Nyamathi et al., 2008; Robertson & Donnermeyer, 1997; Sexton et al., 2008; Warner & Leukefeld, 2001), some of the barriers that emerged in this study were long travel distances, time, costs, conflicts with work schedules, lack of adequate and appropriate follow-up treatment, and loss of anonymity at treatment sites. Beyond these practical barriers, participants frequently dealt with difficult personal concerns and were often uncomfortable opening up and sharing their personal struggles with a counsellor. Finally, participants also experienced difficulties with the policies and procedures of some of the counselling services offered, especially surrounding the peer support framework. Participants struggled with the religious undertones of some programs, restrictive mandates, and lack of specific programs for individual needs.

All participants indicated that they had participated in some form of counselling and most found it beneficial. Specifically, they reported that counselling acted as a form of support and education, and led to mental health improvements through the creation of cognitive and behavioural changes. Furthermore, as past literature suggests (Joe, Simpson, Dansereau, & Rowan-Szal, 2001; Lilly, Quirk, Rhodes, & Stimson, 2000), participants indicated that the relationships they formed with their counsellor was of the utmost importance to the benefits they experienced. Indeed, the development of strong trusting relationships is a difficult but essential component of counselling drug-dependent clients, as long-term drug use has been noted to severely deteriorate the ability to form and maintain trusting relationships by many drug-dependent individuals (Hien & Levin, 1994).

Two unexpected findings related to MMT participants' experiences with counselling and other support-related services also emerged. Participants spoke openly about how they came to engage in counselling. Some self-referred to the service, some attended to receive special privileges, and some came because it was a mandatory component of their MMT participation. Mixed feelings were expressed with regards to making counselling mandatory; some participants supported the policy while other participants were strongly opposed to its implementation. Existing literature suggests that self-directed counselling often yields better outcomes than

mandatory counselling (Maddux et al., 1995; Mattick, Ward, & Hall, 1998). Therefore, given the dissatisfaction of some of the participants of this study, it appears that self-directed counselling entry would be preferable. However, some participants stated that they would not have attended counselling unless they were mandated to, and did respond positively to mandatory counselling. It has been suggested that there is the potential for positive outcomes for those clients willing to forgo their personal autonomy for the structure provided by counselling (Hunt & Rosenbaum, 1998; Maddux et al., 1995). Evidently, additional research is needed to gain a more complete understanding of the complexities of the issue.

The other unanticipated finding was related to perceived discrepancies with disclosure between MMT counsellors and other MMT caregivers. Some participants were concerned that the information they were sharing with their assigned counsellors was being passed on to other members of their treatment team without their express consent. MMT counsellors take on a unique and powerful position within the MMT care team. When these counsellors report to other MMT care providers about clients' treatment, it creates the potential that counsellors will take on the role of gatekeepers to additional resources and monitors of client behaviour. Therefore, these instances of sharing client information can create a power differential in the counselling relationships and may contribute to relationship breakdown (Hunt & Rosenbaum, 1998). These findings suggest a need to inform and remind clients on an ongoing basis of their rights, standardize procedures regarding the sharing of client information, and explicitly describe to the client what will and will not be shared with other members of the client's treatment team. Participants' expressed concern and possible confusion about this issue suggests a need for ongoing discussion about confidentiality, information-sharing practices, and team-based approaches to treatment rather than treating it as a single event to be addressed at the beginning of treatment. MMT is an interdisciplinary field, and the sharing of client information is important for client care, welfare, and overall well-being. However, this has to be done in a cooperative manner, ultimately respecting the clients' wishes surrounding their care. This is particularly important in light of participants' reports that their engagement in the counselling process depends, in part, on their own perceptions of whether confidentiality is being maintained.

Implications for Counselling

The participants of this study indicated that they substantially benefitted from the counselling offered, confirming the important role that ongoing individual or group psychotherapy can have in the treatment of opioid dependency. However, most participants also described challenges they faced when trying to incorporate counselling into their recovery planning. They felt that there were inconsistent rules regarding who did and who did not have to attend mandatory counselling. Participants also stated they would prefer consistent rules that allowed for individual differences regarding the policies and procedures of the counselling available to MMT participants. Given past research suggesting that mandatory counselling is not always helpful (Maddux et al., 1995; Mattick et al., 1998) and

the resentment expressed by some participants in this study, it may be beneficial to discontinue the practice of mandating counselling.

Instead, to enhance the counselling relationship and potential counselling outcomes, counsellors should strive to develop collaborative relationships with their clients. This is also relevant with regards to information sharing with providers of other services. It may be beneficial to have ongoing conversations with clients about their rights as clients and how MMT staff working as a team may benefit the care they receive. However, it is important to allow clients to choose what types of information can be shared and with whom. Furthermore, it may also be important for counsellors on treatment teams to remind their colleagues why it is important to allow clients to control what information is passed on to the team, in terms of professional ethics and promoting successful counselling.

Opiate-dependent clients who receive MMT are unique in addictions treatment; the primary intervention is pharmacological, and counselling and psychosocial supports are seen as optional, secondary interventions. Consequently, care providers should be aware of the potential for numerous continued concerns regarding all areas of well-being. Counsellors should be aware of these potential complex concerns and have the training to be able to work with them or the knowledge to make appropriate referrals. When possible, self-directed counselling entry should be encouraged, and counselling relationships should be based on open communication that fosters trust and mutual decision making. As a final point, each client is unique and should be treated and respected as an individual, in regard to concerns that they present.

Limitations and Future Directions

One potential limitation of this study was the relatively low number of individuals who participated. Although 7 participants is not outside the appropriate number for a qualitative study of this nature (Thorne, 1999), a larger sample may have represented a wider range of experiences and, consequently, generated more themes. Therefore, these findings were not exhaustive of the realm of MMT clients' experiences with counselling services. Also, as with most forms of qualitative research, the study was not designed to generate generalizable results. Nonetheless, the emergent themes do provide transferable insights into some of the counselling experiences of MMT participants living within small urban and rural communities within Atlantic Canada. Future research should attempt to attract a larger sample, to better ensure the efficacy of the findings and attain exhaustiveness or saturation.

A second potential limitation of this study is that only MMT clients were interviewed. This decision was made because the aim of this study was to investigate MMT clients' experiences with counselling utilization. However, incorporating the perspectives of the service providers in a future study may expand understanding of counselling in the context of MMT, particularly the policies, procedures, and additional challenges that MMT participants themselves may not be aware of.

It may also be beneficial to attend to what types of counselling were perceived to be more beneficial in assisting clients. The current study did not differentiate

between distinct models of counselling services available to the MMT participants, or between participants' stages of treatment. By expanding the current design to include quantitative methodology it may be possible to examine the interactions between types of counselling and stage of treatment. Incorporating these measures into future research may assist in adapting treatment plans to meet clients' needs at different stages of MMT.

Furthermore, in light of the persistent concerns that participants described, it is clear that counsellors need more information to guide them toward evidence-based practices, particularly guidelines that focus on how to engage, retain, and meet MMT clients' needs. Consequently, in order to improve the efficacy of the counselling available to MMT clients, there is a need to conduct additional research to develop an overreaching best practices guideline to support the field of counselling within the MMT community. This need has been demonstrated in past literature focusing on MMT-based counselling, which concluded:

> The fact that there is no clear definition of the role and the goals of counselling in methadone maintenance programs makes this task even more difficult. There is clear need to define the task of counselling … There is also a need to ensure that counsellors implement their interventions faithfully, and evidence that the content of treatment does not always match the label it is given. (Mattick et al., 1998, p. 275)

Presently, there exist no nationally accepted best practice counselling guidelines for MMT clients. Thus, a series of nationwide studies that not only attends to type of setting (large urban, small urban, rural) but also includes the perspectives of clients, service providers, and experts in the field of MMT treatment may contribute to the development of such a guideline that is able to suggest generalized practical evidence-based interventions across the Canadian context. Ultimately, this guideline will help inform the practices of MMT counselling service providers, which in turn will benefit clients receiving MMT with the counselling they need and deserve.

CONCLUSION

In rural and smaller urban settings, such as the communities that characterize most of Atlantic Canada, counselling has been made available to help with MMT clients' continued needs. The results of this exploratory study provide a preliminary understanding of Atlantic Canadian MMT participants' current experiences and conceptualization of the counselling services available to them. The findings suggest that, although counselling has significant benefits in addressing some basic unmet needs, changes in the nature of the programming are still required. There is also a need to provide highly trained counsellors skilled at addressing the range of presenting issues MMT clients may have. This is not surprising, given that the implementation of MMT services in Atlantic Canada is in its infancy (New Brunswick Department of Health, 2005). Although many of the themes reflect the

findings of previous research on MMT programs in rural settings, there remains an imperative need for additional research to be conducted that that will enable MMT counsellors working in these kinds of settings to address barriers to access, incorporate evidence-based interventions, and develop policies and procedures that protects clients' rights and best interests.

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APPENDIX

Interview Protocol

1. Can you describe to me what your life was like before beginning methadone?
2. Can you describe what led you to decide on entering the methadone maintenance treatment program?
3. Can you describe to me what kind of differences methadone has made in your life? To your quality of life?
    a. How are your experiences currently different from before starting methadone?
    b. How long have you experienced these changes?

4. Have you participated in counselling or any peer support since beginning methadone?
    a. If you have chosen to seek additional support, what are your reasons for doing so?
5. Do you feel counselling was beneficial for you? How has counselling benefitted you? If you have not chosen to seek additional support, what are your reasons for doing so? Based on what we have talked about today, do you have any final thoughts you would like to share?

About the Authors

Nichole D. Pickett is now a student counsellor with the Department of Student Affairs at the College of the North Atlantic – Qatar. Her research interests broadly include addiction, development and evaluation of counselling-based interventions for individuals with addictions concerns, and the impact of stigma on treatment participation.

José F. Domene is an associate professor and Canada Research Chair in School to Work Transition in the Faculty of Education at the University of New Brunswick. His research interests include the social and relational contexts of career development and professional issues in counselling and counselling psychology.

Address correspondence to Nichole Pickett, c/o College of the North Atlantic – Qatar, P.O. Box 24449, 68 Al Tarafa, Duhail North, Doha, Qatar; e-mail: nichole.pickett@unb.ca