Original Article **Addiction and Health**
Vol 1, No 2, Fall 2009

Received: 5.9.2009
Accepted: 29.9.2009

Experiences of Opium Dependents from Performance of Methadone Centers of Kerman, Iran

Nabi Banazadeh Mahani MD[*], Ali Kheradmand MD[**], Heidarali Abedi MD[***]

* Assistant Professor of Psychiatry, School of Medicine, Kerman University of Medical Sciences, Kerman, Iran.
** Psychiatrist, School of Medicine and Neuroscience Research Center, Kerman University of Medical Sciences, Kerman, Iran.
*** Associate Professor, School of Nursing and Midwifery, Khorasgan Branch, Islamic Azad University, Isfahan, Iran.

Abstract

Background: To assess patients' satisfaction and to evaluate methadone therapy program, it is important to understand the experiences of opium dependents during the treatment period in methadone centers and determine the quality of this program and revise standards based on that. This study aimed to describe the nature and structure of patients' experiences during treatment in methadone centers.

Methods: This was a qualitative method using phenomenology. Sampling was purposive and the participants were selected from opium dependents referred to Kerman methadone centers during 2007. Sampling continued until data saturation and the sample size was 32. Colaizzi's method was applied for data analysis.

Findings: The findings of this study included 27 codes categorized in four main groups: experiences of structure, personnel, patients, and regulations. These four categories showed the main structure of experiences in methadone centers.

Conclusion: Lack of treatment centers in near-by cities or the problems of those centers suggest that it is necessary to establish new centers or solve the problems of centers in near-by cities. The type of patients referring to the centers plays a role in treatment process. The regular presence of physicians and other personnel and their concerns and care for patients as well as longer working hours of the centers have roles in patients' satisfaction and increase of consistency with treatment. Discussing the rules and regulations of the center with patients including the obligatory of daily reference to the center to obtain medicine and injections sound necessary. Also, it is necessary to find ways for solving problems of urine tests.

Key words: **Experiences, Methadone, Performance, Qualitative study.**

Page count: 7
Tables: 1
Figures: 0
References: 16

Address of Correspondence: Ali Kheradmand MD, Psychiatrist, School of Medicine and Neuroscience Research Center, Kerman University of Medical Sciences, Kerman, Iran.
E-mail: dr.alikheradmand@yahoo.com

Introduction

Researchers usually look at the problems from their point of view when assessing and evaluating the quality of treatment programs and investigating factors involved in the treatment quality.[1] However, assessing the patients satisfaction and their view is very important in this regard and can provide information for better evaluation of services.[2] For this reason, qualitative studies can be very helpful in these fields.[3] Methadone treatment for opium dependents of Iran is one of the treatment plans which is conducted widely with the help of various institutions including Ministry of Health and Treatment and State Welfare Organization throughout Iran[4] in order to reduce the problem of drug addiction. Policy makers of this project believe that methadone therapy has positive long term outcomes for the society including decreasing the mortality rate, reducing the pressure of drug dependency, cost of social crimes related to drug dependency, usage of syringe, risk of infective diseases and etc.[5]

The main stand of methadone therapy is longer stability in treatment and the length of treatment period is directly related to achieving other positive outcomes.[6, 7] Some of the main policies of methadone therapy include public acceptance, informed consent, on time evaluation, immediate crisis management, primary evaluation, total evaluation, distribution and control and management in consumption of methadone, specific and sufficient amount of drug, unlimited length of treatment period, clear criteria for ending the treatment, methods of determining drug use during treatment, patient-focused management, reducing dosage of methadone.[5]

Attitudes and experiences of patients referring to methadone centers towards these policies can affect the length of treatment. Therefore, as it was mentioned it is important to assess patients' satisfaction and access their viewpoints to evaluate this treatment project. Investigating these experiences can help better and deeper understanding of the project's quality and revising standards of methadone centers. This study aimed to describe the nature and structure of patients' experiences during treatment in methadone centers.

Methods

Determining human emotions is not easy with quantitative methods. Qualitative methods are used to study emotions.[8] Qualitative methods can interpret people's experiences of the environment they live in. The base of qualitative method is interpretation of understanding social facts and description of life experiences.[9] The method of this study was phenomenology, which aimed to describe experiences the way it is expressed by the participants and as interpreted by the researcher.[10]

Study area included methadone centers in the city of Kerman and the study population included patients referring to these centers from October 2007 to March 2008. The sampling was purposive. It means that the selected subjects had a lot of information to provide. This method can give a sharper illustration of the study topic.[11] Since the sample size was decided based on the data needed,[5] sampling continued until data saturation which was achieved by open deep interviews with 32 participants (2 women and 30 men). Before the interviews, the participants received necessary explanation and their permission for recording interviews was taken and they were assured about the secrecy of data. The interview time was between 30 to 45 minutes and the maximum time was 90 minutes. In addition to recording the interviews, non-verbal acts during the interview and observations of communications in the interview environment were noted and recorded. The interviews were started with the general question "what is your experience of methadone centers' performance?" and other questions were asked based on the interview conditions. Notes were taken from the interviews.

In this study, 7-step Colaizzi's method was used for data analysis. In the first step, interviews were transcribed and read several times. In the second step, main statements were identified in each interview and in the third step the primary concepts were extracted from the main statements. In the fourth step, primary concepts were categorized and in the fifth step the categories were joined to make less-detailed categories. The sixth step was clear and unambiguous comprehensive description of the phenomenon as much as possible. The seventh step was standardization, which was done by referring to interviewees and asking them about the findings.

Also, findings and extracted codes were sent to scholars of qualitative research to check the validity of results.[12]

Results

After transcribing interviews and reading them (the first step of Colaizzi's method), the main statements were identified (second step). For example, participant number 4 who was a 24-year-old married man with two years of treatment history residing in a town near Kerman was coming to Kerman for his medication and the reason according to him was: "The clinic in my town has no physician and no assistant. There is just a secretary who comes to give medicine to 40 to 50 patients, without changing the dosage. In this center, the doctor prescribes the necessary dosage for me and prevented further pain. For example, I write to the psychiatrist about my behavior, I can also share my problems with him and trust him."

Participant number 9, a 29-year-old single man who started treatment with 8 pills 5 years ago, said: "Outside the center, people sit and sell their medicine and consume other drugs."

Participant number 23, a 22-year-old married man who was under treatment with 6 pills for 3 months, said: "In that center, they were not strict about taking the pills in the center and patients exchanged the pills they received for the holidays with heroin."

Participant number 27, a 28-year-old single man who was under treatment with 12 pills for one year said: "If the test was positive, the center staff would suggest that you have been sitting with smokers or took acetaminophen and would ask you to go and come back in a couple of months."

Table 1. The list of extracted codes in this study

Main concepts	categories		Main statements	Row
Experiences of performance	Center		Coming to the city because of problems in town centers	1
			Project failure in town centers because of problems	2
	Center personnel		Lack of physicians and assistants in town centers	3
			Prescribing medication in this center by physicians and consultation with psychiatrists	4
			Being supervised by physicians in the project	5
			Health personnel's lack of understanding	6
			Inducing ways out of positive drug test results by the center's staff	7
	Center patients		Temptation by obvious signs of addiction in the center's patients	8
			Trading syrups in the center's yard	9
			Most patients of the center having crime history	10
	Center rules	Center guidelines	Powdering pills becoming cause of distrust towards patients	11
			No restriction to taking pills in the centers which leads to patients' exchanging them with drugs	12
			Being dismissed from the program due to a few days of absence for relatives funeral	13
			Dissatisfaction by strict rules of the program	14
			Risk of abuse and selling pills because of not powdering them	15
			Lack of authority to increase dosage	16
			Difficulties of daily transportation to take medicine	17
			Restlessness and trance in the center after taking all the pills at once	18
			Frequent change of medicine because of frequent prescriptions by doctor	19
		Center work hours	Having no clear work hours and off days of center	20
			Few work hours of the center	21
			Drug consumption in center's off days	22
		Testing method	Lack of restriction in urine test in the previous center	23
			Marking special days for urine tests	24
			Lack of proper places for urine test	25
			Wrong test results because of non-standard test kits	26
			No urine test after 4 months of treatment	27

Participant number 30, a 23-year-old divorced woman who was under treatment with 20 pills for 10 months, said: "In that center, tests were always at the end of the month; my brother-in-law who was taking heroin along with methadone would just take his pills 2-3 days before test."

After identifying main sentences, the most significant statements were extracted from interviews and then primary concepts were developed. For example, from the description made by participant number 4, the concept lack of success in continuing the project in town centers, from the description made by participant number 9 concept of patients' problems in the center and from the description by participant number 23, concept of performance guidelines for centers and from the descriptions by participants 27 and 30, testing method were implied. In total, 27 codes were extracted, which are presented in table 1.

After extracting these main statements, based on the fourth step of Colaizzi's method defined concepts were categorized. Codes 1 and 2 were in center structure's category, codes 3 to 7 were in center personnel's category and codes 8 to 10 were in center's patients and codes 23 to 27 in testing method category. As it is shown in table 1, categories with similar concepts were joined in bigger categories. For example, center guidelines, center work hours and testing method were joined in the category of center rules and finally the more general concept of center performance was developed from these descriptions.

Discussion

Experiences of center personnel (codes 3-7) included experiences of physician, psychologist, nurses and health personnel in center. Patients who referred from near-by towns to take medicine said that there was no center there or if there was, it was problematic.

Lack of physicians and nurses and lack of regular services for patients, closing the center in some days, few work hours of centers and, no dosage change by center physician were mentioned as problems of these centers and some participants had to immigrate or frequently travel to the province center. In other centers, regular presence of physician and other health staff, their better services, and longer working hours were satisfactory for patients and led to an increase in consistency of treatment.

The type of patients in centers (codes 8-10) had also a role in treatment process. For example, in the center for after jail care, in which all patients had spent some time in jail and also had lots of personality problems, prevalence of drug abuse and selling methadone pills were higher than other centers. Even patients without criminal history and personality problems, who referred to this center, frequently reported drug abuse along with methadone. These patients said that watching hangovers and drug trades in the center tempted them.

Experiences of center rules included guidelines, work hours and test method. Obligation in taking pills in the center and daily trips to the center to take pills and also powdering pills were questions in the patients' mind. Patients considered those as lack of trust by centers, which effected communication between centers and patients. However, some patients were aware of the reasons for such rules and considered them useful in treatment. Satisfaction with treatment and especially relationships with treatment centers were higher in these patients. Therefore, it seems that holding discussion sessions about these guidelines with patients can improve relationship between centers and patients. In a study by Stone on methadone treatment patients' opinion about controlled and supervised treatment, all patients believed that methadone consumption method was very important and useful and they believed in controlled daily dosage.[13] In spite of such opinions Stone got from his patients, he said that flexible plans for methadone prescription (monthly prescription instead of daily one) can be provided.[13] Harris in 1999 compared methadone medical maintenance (MMM) in which methadone was prescribed monthly and not daily with the previous methadone maintenance on patients in New York and found that some patients who were in bad socio-economic conditions had longer treatment period when methadone was prescribed monthly.[14] Closing centers in weekends and formal holidays was leading patients to return to drugs, making their treatment unsuccessful. Drug abuse and exchanging methadone for drugs and dissatisfaction with treatment in patients who could receive services from centers even in holidays was much less than those patients who could not receive services in holidays. An off day of center was the day of

drug abuse and fun as they call it for patients specially those who just started the treatment. In these centers the day before holiday was the work peak for methadone traders, who were exchanging holiday dosage of medicine with drugs. Also, satisfaction and success of treatment in patients of those centers which had two shifts of morning and afternoon services was higher than those of centers with just one morning shift. Difficulties of fasting during Ramadan considering the centers' work hours was among problems patients mentioned and it sounds necessary to revise methadone distribution during Ramadan.

In centers where urine tests were frequent, without previous announcement and well-controlled, there was less return to drugs by patients. However, patients were not happy with that and it was an obstacle in communication between patients and centers. This lack of acceptance by patients was especially higher in centers where there was no proper place for the test. Moreover, in some centers the results were not accurate and test kits were not standard, which led to patients' dissatisfaction. However, in a study in Sydney, Australia, on 314 patients receiving methadone, the relationship between patients' reports and the test results were studied and it was found that patients reported twice as much drug abuse then the test showed and for most drugs, the test results and patients' self-reports were relatively proportional.[15] Considering patients' interviews, in some centers the urine test were not done for several months and in some other centers, patients reported deception in tests, especially in after jail treatment centers.

In a study, the spectrometric and chromatographic results of methadone maintenance receiving patients' urine, sweat and hair samples were compared and findings showed that sweat samples are better than urine samples for test, being less invasive and having less potentiality for deception. In this study, methadone main metabolite that is from dimethyl-diphenyl pyrolidine to methadone in patients' sweat and hair samples was a good indicator of their medicine acceptance.[16] In Iran also, it is possible to replace urine test with hair and sweat samples test, since it is easier and patients accept it better, and prohibit deception in tests.

Conflict of interest: The Authors have no conflict of interest.

References

1. Lebow JL. Similarities and differences between mental health and health care evaluation studies assessing consumer satisfaction. Eval Program Plann 1983; 6(3-4): 237-45.
2. Marsden J, Ogborne A, Farrell M, Rush B. International guidelines for the evaluation of treatment services and systems for psychoactive substance use disorders. Geneva: WHO, UNDCP and EMCDDA; 2000. p. 28.
3. Rafar SA, Zamani GH, Asasi N. Qualitative evaluation of treatment and rehabilitation system at Isfahan self-introduced outpatient clinic. Addiction J 2008; 2: 49-53. [Persian].
4. Bethesda. Methadone Maintenance treatment: Translating research into policy. National Institute on Drug Abuse. 1995. 4-22
5. Ball JC, Ross A, Jaffe JH. Cocaine and heroin use by methadone maintenance patients. NIDA Res Monogr 1989; 95: 328.
6. Ward P, Sutton M. The effectiveness of methadone maintenance treatment 4: Cost-effectiveness. In: Ward J, Mattick RP, Hall W, Editors. Methadone maintenance treatment and other opioid replacement therapies. Amsterdam: Harwood Academic Publishers; 1998. p. 117.
7. Haber J, Wood GL. Nursing research: methods, critical appraisal, and utilization. 5th ed. St. Louis: C.V. Mosby; 2002. p. 140.
8. Holloway I, Wheeler S. Qualitative Research in Nursing. 2nd ed. Australia: Wiley-Blackwell; 2002. p. 86-181.
9. Burns N, Grove SK. The practice of nursing research: conduct, critique, and utilization. 5th ed. Philadelphia: Elsevier Health Sciences; 2005. p. 747.
10. Abed Saeedi J, Amir Ali Akbari S. Research methodology in medical and health sciences. Tehran: Salemi Publication; 2002. p. 192. [Persian].
11. Abedi HA, Ravanipoor M, Karim Elahi M, Yusefi H. Qualitative research methods in nursing. Tehran: Boshra Publication; 2006. p. 135-48. [Persian].
12. Polit DF, Beck CT, Hungler BP. Essentials of nursing research: methods, appraisal, and utilization. 5th ed. Philadelphia: Lippincott; 2001. p. 174.
13. Stone E, Fletcher K. User views on supervised methadone consumption. Addict Biol 2003; 8(1): 45-8.
14. Harris KA, Jr., Arnsten JH, Joseph H, Hecht J, Marion I, Juliana P, et al. A 5-year evaluation of

a methadone medical maintenance program. J Subst Abuse Treat 2006; 31(4): 433-8.

15. Digiusto E, Seres V, Bibby A, Batey R. Concordance between urinalysis results and self-reported drug use by applicants for methadone maintenance in Australia. Addict Behav 1996; 21(3): 319-29.

16. Fucci N, De Giovanni N. Methadone in hair and sweat from patients in long-term maintenance therapy. Ther Drug Monit 2007; 29(4): 452-4.

مقاله پژوهشی

اعتیاد و سلامت

سال اول/شماره ۲/پاییز ۱۳۸۸

تجارب افراد وابسته به مواد افیونی از عملکرد مراکز توزیع متادون شهر کرمان

دکتر نبی بنازاده ماهانی[*]، دکتر علی خردمند[**]، دکتر حیدرعلی عابدی[***]

[*] استادیار روان‌پزشکی، دانشکده پزشکی، دانشگاه علوم پزشکی کرمان، کرمان، ایران.

[**] روان‌پزشک، دانشکده پزشکی و مرکز تحقیقات علوم اعصاب کرمان، دانشگاه علوم پزشکی کرمان، کرمان، ایران.

[***] دانشیار، دانشکده پرستاری و مامایی دانشگاه آزاد اسلامی واحد خوراسگان، اصفهان، ایران.

تاریخ دریافت: ۸۸/۶/۱۴

تاریخ پذیرش: ۸۸/۷/۷

چکیده

مقدمه: جهت رضایت سنجی و ارزیابی طرح درمان نگهدارنده متادون، درک چگونگی تجارب حین درمان افراد وابسته به مواد افیونی از عملکرد مراکز توزیع متادون اهمیت داشته، باعث فهم بهتر و عمیق‌تر کیفیت این طرح درمانی و تجدید نظر در استانداردهای مراکز درمان متادون می‌گردد. این مطالعه با هدف توصیف ماهیت و ساختار تجربه از عملکرد مراکز درمان با متادون حین درمان انجام شد.

روش‌ها: این مطالعه از نوع کیفی بود و به روش فنومنولوژی انجام گرفت. نمونه‌گیری مبتنی بر هدف بود و از بین افراد وابسته به مواد افیونی مراجعه کننده به مراکز متادون شهر کرمان در سال ۱۳۸۶ انتخاب گردید. نمونه‌گیری تا اشباع اطلاعات ادامه یافت و حجم نمونه به ۳۲ نفر رسید. برای تجزیه و تحلیل اطلاعات، روش Colaizzi به کار رفت.

یافته‌ها: حاصل این پژوهش ۲۷ کد بود که در چهار دسته موضوعی اصلی تجربه از ساختار، پرسنل، مراجعین و قوانین مرکز قرار گرفت. این چهار دسته موضوعی ساختار اصلی تجربه از عملکرد مراکز توزیع متادون را نشان می‌داد.

نتیجه‌گیری: نبودن مراکز درمانی و یا مشکلات زیاد در مراکز درمانی در شهرهای اطراف، لزوم راه‌اندازی و یا رفع مشکلات مراکز شهرستان‌ها را نشان می‌دهد. ترکیب مراجعین مراکز نیز در سیر درمان نقش دارد. حضور منظم پزشک و سایر پرسنل و رسیدگی‌های بیشتر آن‌ها و ساعات بیشتر کاری مرکز در رضایتمندی مراجعین و افزایش ماندگاری در درمان نیز نقش دارد. بحث و گفتگو با مراجعین در موارد قوانین مرکز از جمله اجبار در مصرف دارو در مراکز و رفت و آمد روزانه به مرکز جهت مصرف دارو و کوبیدن قرص‌ها لازم به نظر می‌رسد. همچنین تدابیر لازم جهت رفع مشکلات آزمایش ادرار ضروری می‌باشد.

واژگان کلیدی: **تجارب، متادون، عملکرد، تحقیق کیفی.**

تعداد صفحات: ۷

تعداد جدول‌ها: ۱

تعداد نمودارها: –

تعداد منابع: ۱۶

آدرس نویسنده مسؤول: دکتر علی خردمند، روان‌پزشک، دانشکده پزشکی و مرکز تحقیقات علوم اعصاب کرمان، دانشگاه علوم پزشکی کرمان، کرمان، ایران.

E-mail: dr.alikheradmand@yahoo.com