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

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Abstract: A qualitative study was undertaken with five people on methadone maintenance treatment (MMT) to better understand their experiences and daily routines. Through an in-depth exploration of their everyday occupations, we sought to reveal the ongoing challenges and barriers they face to accessing treatment. The concept of occupation refers to ‘all that people need, want and are required to do’ but also extends further to encompass ‘how doing contributes to processes of being, becoming and belonging’ (Huot and Laliberte Rudman, 2015). This research employed a qualitative intrinsic case study methodology (Stake, 2005). Using an occupational perspective informed by a framework for occupational justice (Stadnyk et al., 2005), the participants’ narratives are presented according to four themes highlighting key aspects of their experiences: (a) descent into chaos; (b) MMT as a bridge to recovery from addiction; (c) a new normal daily life; and (d) hopes for moving forward. The findings illustrate how structural factors and contextual factors interact to create occupational injustices. Thus, MMT practices and policies should consider the occupational implications described in this article to enhance patients’ experiences and further support their recovery.

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

1. Introduction

Addiction to opioids is a complex substance dependence issue which affects a substantial number of people globally [1]. Methadone is a synthetic opioid that is long acting, prevents withdrawal symptoms, and reduces or eliminates drug cravings [2]. Methadone maintenance treatment (MMT) is a substitution therapy that replaces the drug a person is dependent on with a prescribed substance that is pharmacologically similar, but safer when taken as prescribed. This paper presents findings from an intrinsic case study [3] conducted with five participants who were enrolled in an MMT program in a mid-sized Canadian city. The purpose of the study was to gain an in-depth understanding of the disparities, challenges, and barriers to accessing MMT and performing daily routines and occupations as experienced by individuals on MMT. The objectives were to (i) examine the everyday occupational experiences of MMT clients; (ii) map their daily lives and examine the ways in which these individuals orchestrate the use of their time; and (iii) examine the routines, spaces, and interactions characterizing their occupational lives.

1.1. Background

MMT has been shown to be an effective, safe, and cost-effective treatment for opiate addiction that can enable a return-to-normal physiological, psychological, and societal functioning [4]. It uses a harm reduction approach, characterized by practical strategies and ideas aimed at reducing the negative consequences associated with drug use without requiring a change in behaviour [5]. Harm reduction emphasizes keeping people safe, and minimizing deaths, diseases, and injuries associated with higher risk behavior [6]. MMT clients in the Canadian province of Ontario, where our study was conducted, typically have weekly contact with a physician and daily contact, until stable, with pharmacists and other health care providers. Additional integrated components such as counselling can give clients more time and opportunity to deal with other important issues while they are in treatment. The cited benefits of MMT include reducing illegal use of opioids, criminal activity, deaths due to overdose, the risk of Human Immunodeficiency Virus (HIV) transmission through needle use, and public health risks [7]. MMT may also improve physical and mental health, social functioning, quality of life, pregnancy outcomes, and employment prospects [7].

As patients gain stability (i.e., abstinence, housing, finance, mental health) they can earn carry doses, also referred to as ‘take-home’ doses. The criteria for determining this are based on patient safety, community safety, and clinical stability. Thus, patients must be on a stable dose of methadone, have had no recent problematic drug or alcohol use, be compliant with treatment directives, have stable housing and emotional stability and good insight into carry safety issues. Before patients get carry doses, they must sign a therapeutic carry agreement outlining that they take responsibility for legal expectations (e.g., filing a police report if doses are lost) and for storing the carry doses safely and securely in a locked box. The maximum legally allowable amount of carries in the province of Ontario is six.

The length of treatment with methadone varies, and may continue indefinitely, depending on the individual. Given the time intensive nature of MMT (e.g., frequent clinic and pharmacy visits), it is essential to examine the relationship of treatment with the occupations comprising clients’ daily routines. The term occupation refers to ‘all that people need, want and are required to do’ but also extends further to encompass ‘how doing contributes to processes of being, becoming, and belonging’ [8]. Additional challenges with MMT include lack of treatment accessibility [1]. While MMT is effective and beneficial, it is also challenging, requiring better understanding of the experiences of people on MMT, how they engage in occupations that form part of their daily routines.

1.2. Need for an Occupational Perspective of MMT

Limited literature exists that examines MMT from an occupational perspective. Previous research has however illustrated a complex relationship between addictions and occupation. Helbig and McKay [9] examined the occupation-based literature to better understand addictive behaviours from an occupational perspective. They argued that addiction should be understood as occupational in nature. They found that some of the issues that may contribute to the cycle of addiction include occupational risk factors, such as occupational deprivation, and alienation. Likewise, Heuchemer and Josephsson [10] argue that occupational imbalance is related to the narrowing repertoire of daily occupations that typifies addiction-related behavior. They explain that “an unhealthy balance of daily occupations may lead to an internal conflict between what people should do and what they want to do” [10] (p. 161). This can lead to feelings of self-deprivation, which could result in relapse and continuation of the cycle of addiction. Similarly, Kiepek and Magalhães [11] demonstrated that addictions should be considered occupational in nature. They conducted a literature review to determine if activities that are classified as “addictions” and “impulse-control disorders” are indeed occupations. They found that these activities give meaning to life, are shaped by environment, organize behaviour patterns, and connect closely to identity [11]. Their literature review and synthesis is the only publication we located in the literature on human occupation that specifically discusses methadone, stating that for people on MMT “change in engagement is determined not only by the physiological

effects of the activity on the body, but also by social, legal, and medical factors, as well as personal choices" [11] (p. 264). Thus, attention to MMT within the occupation-based literature is quite sparse, and while attention has been paid to MMT in other disciplines (e.g., nursing, social work, medicine, anthropology), this literature fails to incorporate an explicit occupational perspective.

A scoping review of the literature on MMT was conducted using Arksey and O'Malley's [12] five stage framework to map the key concepts underpinning this research area. We identified three main themes dominating the qualitative research literature on MMT. First, stigma was found to be one of the most discussed aspects of, and barriers to, daily life for people on MMT [2,4,13–17]. Second, findings across the articles also highlighted ways in which one's sense of identity or self-concept is important and oftentimes transforms throughout the recovery process as individuals deal with a variety of issues that may include emotional disturbances, relationship turmoil or growth, or career changes [2,15,18,19]. Finally, personal relationships with both family and friends were found by many authors to be important, especially during the recovery process [2,4,14–17,20,21].

There was a clear gap in research on MMT concerning the occupational implications of the program. Qualitative research regarding the daily lives of MMT clients and the ways they orchestrate their routines and engage in occupations was limited. There was also limited knowledge regarding how MMT changes people's routines and what their daily lives are like while using MMT. Overall, the literature reviewed lacked a critical examination of the specific occupational implications of MMT for clients.

1.3. Applying an Occupational Justice Framework

The concept of occupational justice offers a unique lens to examine both local and global struggles from an occupational perspective [22]. Described as "a justice of difference that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social, class, or other differences" [23] (p. 57), an occupational justice framework provides a critical approach well suited to examining the challenges for individuals on MMT.

This study was, thus, informed by the Exploratory Theory of Occupational Justice and the related Framework for Occupational Justice [24–26]. The framework outlines how combinations of structural (e.g., policies, health and community supports) and contextual factors (e.g., gender, employment status) contribute to occupational justice or injustice and provides a way of understanding the relationships between factors impacting occupational outcomes of justice. Using an occupational perspective informed by this framework enabled us to more clearly understand how barriers to engagement in daily occupations whilst managing MMT impacted the participants' experiences. It also served to illuminate ways that "people recovering from addictions may redefine the meanings attached to their time use when it is no longer centered on substance use" [27] (p. 184).

2. Methodology

A case study approach allows for the exploration and description of complex phenomena within their contexts using a variety of data sources [28]. This methodology is useful when researchers want to understand contextual conditions that are believed to be relevant to the phenomenon being studied [29] because it "provides a means of exploring the particulars of occupations, at the same time as they are bound together as a whole within the contexts in which people go about their everyday lives" [30] (p. 118). An intrinsic case study methodology, in particular [3], was adopted for this study given its focus upon studying unique subject matter where the results may have limited transferability, but where researchers have a genuine interest in better understanding the case [28]. More specifically, a holistic, single-case design was used to focus on a single group of MMT patients recruited from a single environment (an MMT clinic in Ontario) in order to focus on their unique situation (daily living while on MMT). The methodology adopted is described in further detail elsewhere [31].

Using purposive sampling participants were recruited through a methadone clinic located in a mid-sized Canadian city following approval from the university's research ethics board. Eligibility

criteria included being 18 years of age or older, fluent in English, and on MMT consistently for at least one year at the time of recruitment. Five people participated in the study (the sample is further described below).

2.1. Methods

Case study methodology traditionally employs multiple data sources [3]. In-depth individual semi-structured interviews, occupational mapping [8], and demographic questionnaires were used over two sessions with each participant, which lasted from twenty minutes to two and a half hours per session. The use of combined techniques for data collection facilitated crystallization and helped to establish further in-depth understanding [32].

2.1.1. In-Depth Semi-Structured Interviews

Narrative-style in-depth interviews were first conducted with the five participants. They were asked to share their stories of daily living, in as much or as little detail as they liked, to emphasize the issues that were important to them. Questions were open-ended and prompts were used to support this storytelling (e.g., what is a typical day like for you? How did you go about planning your daily activities before you started MMT? How did you go about meeting your daily living needs? How are you going about planning your daily activities now that you are on MMT? What has changed?). Follow up semi-structured interviews were conducted with each of the participants during a later session to obtain more detail and clarify aspects from the initial interviews.

2.1.2. Occupational Mapping

Occupational mapping is a form of cognitive mapping that “can offer researchers a view into how people view their world, what is important to them, what their lived social relations are, and where they spend their time” [33] (p. 553). The occupational mapping exercise highlighted the daily occupations that participants engaged in and enabled them to describe their lived experiences of time and place [8]. Following the interview during the initial session, participants were asked to draw their mental map of the city and describe places where they routinely went and the types of occupations that occurred there. This visual method was useful for this particular population as they sometimes faced challenges to completing routine occupations, such as doing laundry or going grocery shopping. They could choose to draw whatever they liked and when completed were asked to explain their maps. This method resulted in a *process* through a discussion about the map that generated further textual data following transcription, as well as a *product*, including the map itself, which was a form of visual data [33–35].

2.1.3. Demographic Questionnaires

During the first session participants provided information about their age, gender, marital status, children, level of education, employment status, city of residence, current housing situation, main mode of transportation, duration of opiate use before MMT, current use of opiates, opiate of choice, additional drug use, length of time on MMT, length of time at clinic, and carry status.

2.2. Data Analysis

The interviews were audio-recorded, transcribed verbatim by the first author and analyzed using a three stage approach. The transcripts were read while listening to the audio recording to ensure accuracy. First, whole text analysis was completed by the two first authors who read and re-read individual transcripts to get a sense of the whole, to familiarize themselves with the data and to identify key threads [36,37]. Line-by-line analysis with open coding of the text was then completed by the first author.

Once open coding of transcripts was complete, codes were reorganized and collapsed into categories and each category was explored to examine its component codes to develop key themes. The themes were not developed a priori, but were rather inductively constructed as a reflection of the participants' temporal organization of their narrated experiences. Most discussed their addictions prior to addressing their experiences of MMT. Using an iterative approach, the participants were asked about their expectations for the future in follow up interviews. Themes were, thus, likewise temporally organized with their content constructed through the codes associated with the identified periods of the participants' lives. For instance the theme of "moving forward" comprised a range of associated codes (e.g., hope for the future, uncertainty, returning to school).

Finally, the data were further interpreted using the occupational justice framework. This was a critical approach that is consistent with examining the challenges for individuals on MMT as it aims to address "justice related to opportunities and resources required for occupational participation sufficient to satisfy personal needs" [22] (p. 421).

2.3. Trustworthiness

Quality criteria for rich rigor and sincerity [38] guided the trustworthiness of this study. Achieving rich rigor entailed ensuring sufficient, abundant, and appropriate data, complex theoretical constructs, time in the field, and sampling, context, data collection, and analysis processes. To address this criterion we aimed for depth as opposed to breadth by collecting richer data with a smaller number of participants, we ensured a minimum length of time in MMT so that participants could adequately discuss their experiences, among other strategies (e.g., peer-debriefing with research supervisors). Sincerity [38] was achieved through self-reflexivity and transparency. We acknowledged our own positionality and motivations for undertaking the study, and the first author generated field notes during data collection and kept a reflexive journal to address her presence in the study and role in co-constructing the data with participants.

3. Results

Five participants were recruited (Table 1), consisting of three females and two males, between the ages of 27 and 42 who were currently on MMT. Three participants lived with family members (one paid rent) and two were living on their own. One participant was married, one was divorced, and the other three had never married. Two participants had children, but neither lived with them. The highest level of education obtained by two participants was a Bachelor's degree. One participant had completed some university. One had a high school diploma and one participant had not completed high school. None of the participants were formally employed at the time of the study. The main mode of transportation for the participants was public transit. The length of time they had been at the clinic where recruitment occurred ranged from eight months to six years. Three participants had only ever been to their current clinic and the others had previously been to another clinic.

Table 1. Participant characteristics.

	John	Bonnie	Patrick	Karen	Mia
Age range	35–39	25–29	35–39	40–44	30–34
Length of opiate use prior to MMT (years)	5	3	11	10	7
Length of time on MMT (years)	2	3	1	7	3.5
Carry level	0	0 *	6	6	6

* Eligible for carries but chose not to use them.

Results are presented according to four themes that highlight key aspects of the participants' experiences. First, participants revealed a "descent into chaos" as their addictions began to worsen over time. Second, participants' described their experiences of "MMT as a bridge" to recovery from addiction. Third, their "new normal" daily life was characterized by liminality and shown to be linked

to people's experiences of MMT. Finally, participants' discussed having hopes for "moving forward". The interrelationship between these themes is depicted in Figure 1, which serves to visually represent the main topics that emerged as people shared their experiences. Pseudonyms are used when referring to participants.

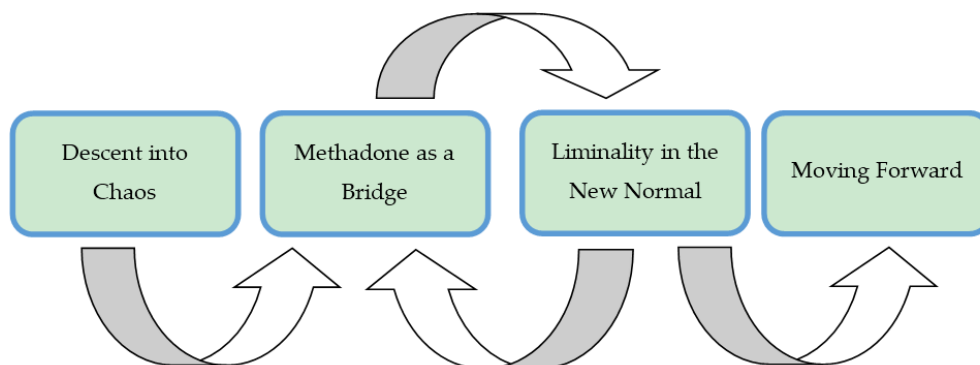


Figure 1. Participants' experiences of MMT.

3.1. Descent into Chaos

The first theme detailed a "descent into chaos", describing participants' routines before and during their addiction, entailing a downward trajectory as they became addicted and their addictions progressed, leading them to a point where they decided to go on MMT. The participants explained that they had relatively stable lives prior to their addictions. As Bonnie explained, "Before I got into all this mess I was working. I had a great job, car, great place. Everything was awesome. I never would have anticipated ending up homeless but it happens." She went on to describe how things changed:

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

Becoming addicted was a different experience for each of the participants and linked to different factors in their lives. As they started using drugs, they noted a shift in their daily occupations and routines. John described trying to manage his addiction:

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

Once they were addicted, participants' described their routines as hectic and chaotic, consisting mainly of finding money for drugs, and for some this often entailed engagement in criminal activity. Karen described several challenges she faced related to her addiction:

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

Participants explained how, over time, their addictions progressively got worse. Some evolved to polysubstance use, escalating in frequency and altering the route of administration allowing for

more rapid uptake of the drug and further building tolerance to the point where they were using more frequently.

Some participants talked about ultimately hitting rock bottom. Mia shared in detail some of the issues contributing to her decision to seek treatment:

I just felt like there was just such a waste of people and such a waste of life and I felt like really guilty for putting everyone in my life, like through so much hell. But at the same time, I like wasn't really ready to like die, you know, on the street. Cause I feel like I was just at a crossroads where it could have gone either way. [. . .] And also a lot of the times I felt like I had had such a better chance at life than like so many people I've met because, while there are like a lot . . . like professionals and people from good homes that like get caught in like addictions with opiates, I felt like a lot of the people I had met were from like broken homes, had like some severe trauma, like when they were children. Or had like mental illness and sort of always been on the street or like transient and I sort of felt like I had come from a different place so maybe I had a better chance of getting back out.

The participants ultimately decided that they did not want to continue living the way they were living and described feeling ready to make changes, at which point they sought treatment in the hope of ending their substance abuse.

3.2. *Methadone as a Bridge*

The second theme refers to MMT as something that facilitates change from one context to another. Participants described their overall experience of MMT, including their decision and readiness to seek treatment leading up to how they began the program and their perceived barriers to treatment. Despite their desire to get clean, starting MMT was not an easy decision. Some described being hesitant and scared to make significant changes and to leave their lifestyles behind. For instance, Mia discussed her initial apprehension about the program:

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

The decision to go on MMT was a personal choice that participants described making on their own. They explained that choice being important because they felt their recovery would not have possible if they did it for anybody else, including for their family. Initially, recovery for a lot of the participants was a "trial and error" of different treatments (e.g., detox centre). Sometimes they tried these treatments multiple times without success. Starting MMT involved being educated about what methadone is, how the program works and what is involved. Participants noted that the two major difficulties to getting started on the program were being able to obtain sufficient information, and barriers to accessibility. Karen discussed how it can be challenging to begin treatment:

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

Participants described their MMT experience as helpful in terms of reducing or stopping their use of opiates. Several discussed general aspects of the MMT program including the methadone dose, urine testing, and carry doses. Most explained that carries made their daily routine logistically less demanding as they were not required to make the trip to the pharmacy for their methadone on a daily basis. Participants, such as Karen, shared various opinions of how they experienced these aspects of the program and also the different experiences they had at various clinics and pharmacies:

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

Participants also discussed the rules, regulations, and protocols involved with MMT that govern the administration of the therapeutic program. While some find the structure promotes their recovery, others find the guidelines to be punitive in nature. For instance, despite understanding why the program is strictly designed, Patrick described the need for more "grey areas" in the program to better accommodate the unique needs of the some of the clients:

The group, for lack of a better word, but the people, the grouping of people that I've met since I've been on the methadone program are not the likes of people that I would've normally would have hung out and met and been associated with. I can fully understand because of them people and what I've seen, why these protocols are in place. But on the other end of it though, not everybody who has an addiction to opiates was a homeless street bum who sells themselves to get the money to get their next fix.

MMT was an important commitment and participants emphasized that it was a gradual process of recovery that enabled them to gain stability in their lives and focus on other issues, rather than drug seeking.

3.3. *Liminality in the New Normal*

The third theme speaks to transition from what was before to what might be. Participants described their lack of meaningful occupational engagement while on MMT, which resulted in much free time and a sense of boredom as they were no longer spending their time looking for money or drugs. They described their shift in routine once they got on MMT as well as their change in self-concept and identity in this new stage of their lives. A "new normal" daily life that is characterized by liminality was shown to be linked to people's experiences on MMT. The participants described being in a liminal stage in their life as they were no longer regularly using drugs but were not back to where they were prior to their addictions beginning, or had not yet achieved the new goals they had set for themselves. John explained having to adjust to a changed occupational routine:

So for me, I think I made that transition and for me, it was much more difficult because I had a lot of money, for me, relatively speaking to where I am today I made a lot of money. I was very busy. I used to go out to eat all the time. I used to do things. I had a nice car. I had to, for the sake of recovery, I had to get used to doing nothing. I had to be able to be a homebody. I think in a way that might be kind of a contradiction, I have to get used to getting bored and being at home and watching TV.

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

reading, playing video games, and bike riding. The daily lives of the participants were described as fairly simple and lacking social interaction. Mia discussed strategically limiting her occupations to avoid risking relapse by staying in places she felt safe:

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

Avoiding certain occupations was a recovery strategy that was also described as having to be appropriately managed. Engagement in occupations was mediated with respect to potential exposure. Participants avoided going certain places, seeing certain people, or doing certain things that may lead to triggers that could harm their recovery. Their options for occupation were further limited by the restrictive nature of MMT. John explained why such a change in routine was essential for his recovery:

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

Many participants said that they were embarrassed about being on MMT and often did not disclose to others that they were in the program. Their experiences were all different despite the fact that they were all transitioning, but most found it challenging to transition into a more mainstream lifestyle when they were not yet "back to normal". Instead, participants' were in a "new normal" that appeared stuck in a middle stage, somewhere between where they used to be and where they ultimately wanted to be.

3.4. *Moving Forward*

The fourth theme depicts participants' various possibilities for their future. This encompassed their discussion of their upward trajectory as well as the potential for relapse and overall uncertainty when it came to moving forward. While each participant's hopes for "moving forward" differed from others, for many, the future nonetheless seemed to be very unclear and ambiguous. Patrick discussed how there were multiple possible futures for people on MMT, including the future they hoped for and the future that might happen if they struggled in their recovery and relapsed:

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

Despite the ongoing uncertainty of their situations, an upward trajectory was evident for most participants, and many described MMT as lifesaving. Many participants were volunteering, earning carry doses, getting counselling, and looking into going back to school. Some participants talked about tapering off methadone and eventually getting off the program altogether, while for others MMT was considered a much longer term, if not lifelong, treatment to maintain recovery.

Several participants explained that they would have to continue to overcome stigma and misconceptions about MMT at both clinics and pharmacies. Several addressed the relationship between being in the MMT program and their experiences with other systems and services. For example, participants addressed how the being labelled as a methadone client would get used against them in hospitals and in the court system. Thus, although participants primarily thought MMT was a great

program, some recommended changes included having easier access to clinics, more information on the program, more respect at pharmacies, and more time to talk to the doctor at the clinic. Bonnie described the lack of respect she received at a particular pharmacy to highlight why she felt changes were needed to the MMT system:

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

Despite how far they had come in their recovery, participants admitted that it would not be hard for them to relapse and end up back where they were during their addictions. While they faced ongoing challenges, they were proud of the goals they had already achieved and others they were working toward, such as going back to school, getting a job, being more physically active, travelling, dating, and moving to a different city. The participants nonetheless expressed a great deal of uncertainty in terms of where they would end up and what the future would bring.

4. Discussion

The findings suggest that participants did not follow a strictly linear route to recovery, but generally shifted from chaos to boredom with the ever present possibility of relapse. This transitional experience conveys important aspects regarding individual issues of occupational engagement shaped by broader conditions of occupational injustice [25]. Structural factors influence whether certain occupations are available or unavailable, as underlying occupational determinants (e.g., type of economy, policies, and values) become operationalized into specific occupational forms as instruments or programs. Some of the occupational forms that were most discussed by participants included health and community supports, income supports, housing, education, employment, transportation, and universal design and accessibility. These reflected issues that participants had with more general aspects of the social system. For instance, health and community supports were said to be lacking in the city as the participants struggled to find information on MMT prior to starting treatment and to find information on accessing additional support programs or resources once in recovery. In Smye et al.'s [17] study many of the participants also expressed mistrust with the healthcare system due to everyday experiences both within and outside the system that further marginalize them.

Contextual factors are described by Stadnyk et al. [24] as creating conditions where there is equal or unequal access to resources, programs, and services. Some of the notable contextual factors for the participants in this study were income and wealth, employment status, homelessness, family and friend support, and health status. These factors referred to the unique experiences that each participant had. For example, three of the participants had experienced homelessness at some point and many emphasized that social networks and support were very influential in their recovery. Similarly, Higgs et al. [3] suggest that family can play an important role in maintaining and facilitating treatment.

Structural factors were experienced differently for each participant depending on their varying contextual factors. As outlined by the Framework for Occupational Justice [24,25], when structural and contextual factors combine "positively" (e.g., when jobs are available and the individual is employed) the occupational outcome is justice characterized by the rights of choice, participation, meaning and balance. When they combine "negatively" (e.g., there are adequate financial resources but they are not distributed equally) people may experience the outcomes of injustice, which are characterized

by imbalance, marginalization, deprivation, and alienation. The findings from this study illustrate how structural factors, such as health and community supports, income supports, transportation, and universal design and accessibility; and contextual factors, including income, employment status, homelessness, and family/friend support, interacted to create mostly negative occupational outcomes that subjected the participants to both occupational imbalance and occupational marginalization in particular.

With respect to occupational imbalance, which is defined as “an individual or group experience in which health and quality of life are compromised because of being over-occupied or under-occupied” [22] (p. 420), the participants on MMT were often “under-occupied”. They were precluded from engaging in a range of fulfilling activities that could promote well-being and experienced a shift in occupational imbalance from chaos to boredom in which they often felt segregated and bored. Participants had a limited routine before starting MMT, describing their time as being comprised mainly of seeking drugs (and seeking money to buy drugs). They also described having a limited routine now while on MMT, consisting mainly of going to the clinic and pharmacy, going to other appointments, volunteering, and grocery shopping. Boredom was noted by Helbig and McKay [9] as contributing to the cycle of addiction. They examined the occupation-based literature in order to gain a better understanding of addictive behaviors from an occupational perspective and explained that boredom was related to restricted access to occupation due to costs, individual and societal values about the occupation, time restraints, or lack of awareness.

In addition to simply being bored, the participants appeared to be experiencing a sense of being stuck as they expressed uncertainty about their futures, therefore, making it difficult for them to move forward. This echoes findings from Aldrich and Laliberte Rudman’s [39] study of long-term unemployment. Using situational analysis, they found that unemployed workers described themselves, and were described by service providers, as being stuck in their situations. Difficulty moving forward was also an issue discussed by participants in Radcliffe and Stevens’ [19] study where they conducted interviews with people who have had MMT. They found that supervised methadone consumption was seen as hindering progress to the desired ‘normal’ life of conventional employment. Heuchemer and Josephsson [10] argued that occupational imbalance is related to the narrowing repertoire of daily occupations that typifies addiction-related behavior. They explain that “an unhealthy balance of daily occupations may lead to an internal conflict between what people should do and what they want to do” [10] (p. 161). Participants in this study struggled with this internal conflict; however it was often expressed in terms of what they would want to do versus what they thought they might actually end up doing.

The participants also discussed some of the spatial implications related to MMT, such as difficulty travelling due to lack of vehicle ownership, having to attend clinic appointments, and going to the pharmacy for their methadone. Being in the program meant they were essentially “stuck in place” and created a paradox of needing the program to move forward, but not being able to move forward while in the program. They experienced a different kind of imbalance where they were unable to develop skills for work or leisure. Most of their daily lives were dominated by medical appointments and this finding is consistent with Järvinen and Miller’s study [18] that found MMT increased participants’ sense of stability, which allowed them to better address their economic, housing and other daily needs, but also represented a context of physical, emotional, and social dependence.

Occupational marginalization is described as occurring when people are not able to participate in occupations because they are restricted from experiencing autonomy through lack of choice in meaningful and health-promoting occupations [24]. People who are occupationally imbalanced may, likewise, experience occupational marginalization. Marginalization can occur when individuals or groups, such as persons on MMT, are discriminated against explicitly or implicitly in relation to contextual factors such as homelessness and unemployment. In a society that largely prioritizes paid productive occupations, other important occupations across the lifespan, such as recovery, are under-recognized [22]. Our findings suggest that being on methadone is negatively valued by society

and is not recognized as a legitimate and life sustaining occupation, thus remaining outside dominant or mainstream discourses. Participants in this study did not have full time paid employment and were not 'contributing' to society in the traditional sense. Instead, their main occupation was MMT and, in contrast to the perception that people on MMT are unproductive and "lazy", participants were proud of themselves for having come so far in their recovery journey. Despite the fact that participants had a limited routine prior to and during MMT, they had progressed from the drug-seeking lifestyles they once had to strategically engaging in certain occupations and purposefully avoiding other occupations to help their recovery. They chose not to do certain things and, thus, took some control by being on MMT and trying to be successful on the program.

The participants' experiences of the program were different based on what they did prior to it, and what they were hoping to do afterwards. They described working hard at getting clean, but that did not imply that they would return to their pre-addiction lifestyles. They were working hard at getting to a new point in their life where they were healthy and feeling positively about themselves. Two key directions for future comparative research stemming from this work are recommended. First, since participants in this study were all unemployed and felt that it would be difficult for people who are working to access MMT due to the rigidity of the program, we suggest future research consider the experiences of MMT clients who are employed to help add new perspective and insight on how different contextual factors (e.g., employment status) can influence people's occupational justice outcomes. Second, since this study recruited from a single clinic and some participants noted different experiences in various clinics, it would be useful to recruit from multiple clinics in urban and rural settings to examine how people's experiences elsewhere are similar or different.

5. Conclusions

This research makes a novel contribution to the literature on occupation, which has marginally addressed addiction [9,11], but has not specifically examined recovery or opiate addiction nor the daily lives and routines of people on MMT. It was clear from the sessions with participants that there is a difference between what people were doing while addicted and what they were doing in recovery, but the MMT label created an ongoing stigma that shaped their occupations. The stigma of being on MMT was not specific to the clinic and pharmacy settings but followed them elsewhere. MMT was shown to not strictly be an individual experience; rather it was shaped by the broader factors that adopting the occupational justice framework helped to identify. Future comparative research should be conducted to further consider differences in experiences (e.g., people who are employed, enrolled in different clinics, or living in rural areas).

Participants explained that MMT should be more open and accessible, such as being centrally located on bus routes. It is important for MMT practitioners, researchers, and occupational scientists to understand the occupational nature of MMT. It is vital to consider how the structure of MMT promotes recovery but also how the guidelines can be punitive in nature. MMT programming should consider the structural and contextual factors shaping the occupational aspects of those who have had MMT and their experiences in order to better attend to the centrality of MMT in the recovery process and concomitantly to people's lives. We strongly urge that people on MMT should be better supported by policy-makers, healthcare providers, and society in general, while taking this positive step in their lives and should be treated with dignity and respect.

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