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Walden University

College of Health Professions

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Lizette Keenan

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Walden University
2021

Abstract

The Experience of Women with Opioid Use Disorder Accessing Methadone Treatment

by

Lizette Keenan

MN, University of Windsor, 2009

BScN, University of Windsor, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

May 2021

Abstract

The number of women experiencing opioid use disorder (OUD) in Canada has increased exponentially. In Canada, healthcare is socialized and free for all citizens and often medications like methadone are free as well, yet few individuals with OUD access treatment services. The purpose of this study was to describe the lived experiences of Canadian women with OUD who were receiving methadone treatment. Interpretive phenomenology was used to investigate the treatment experiences of seven women with OUD. The conceptual framework of self-care of chronic illness was used examine this phenomenon. Data was analyzed using a seven step process of interpretive phenomenological analysis. Four major themes emerged: learning how to be you again, reaching out for help, finding your way to methadone, and going down the path of methadone. Women's experiences were influenced by family, friends, and healthcare providers. Accessibility and self-determination were important factors in entering and sustaining treatment. This study contributes to positive social change by providing accurate information regarding women's experiences with OUD and uncovering practice changes that can attract and retain women in treatment.

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Dedication

This dissertation is dedicated to my grandmother Ruth Keenan, RN who unfortunately did not live long enough to see it complete. I wish you were here to share in my accomplishment, but I know you are proud of me. As a nurse and lifelong learner, you encouraged me and supported my efforts in every way. I am forever grateful that you have instilled your staunch determination and love for learning in me. I celebrate this achievement with you. I love you and miss you.

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Finally, I need to thank the women in this study and the addiction treatment centers that allowed me to recruit women at their locations. You have entrusted me with your personal experiences, and I am eternally grateful. I hope your efforts and mine facilitate positive change for women with opioid use disorder who have the courage to enter treatment.

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Chapter 1: Introduction to the Study

Globally, there has been an increase in the use, production, and importation of opioids for non-prescription use (World Health Organization, 2018). Opioid deaths, hospitalizations, and emergency department visits have increased exponentially throughout Canada and the United States (Public Health Ontario, 2018; The Centers for Disease Control and Prevention, 2016). In central Canada opioid abuse in has been increasing dramatically for the past decade (Public Health Ontario, 2018). In fact, since 2016 more than 8,000 Canadians have died from opioid related causes; in Ontario, 734 people died from opioid related causes in 2015 (Canadian Institutes of Health Research, 2017).

Further, there is a significant increase in women experiencing opioid use disorder (OUD) (Public Health Ontario, 2018). In Ontario, since 2015, opioid related emergency department visits by women have increased from 1,808 to 2,972 in 2017 (Public Health Ontario, 2018). Women are also dying at alarming rates (Public Health Agency of Canada, 2018). Since 2015, death rates from opioids have increased from 253 to 352 per year in Ontario women (Public Health Ontario, 2018). Though in comparison, more men have died from opioids (Public Health Ontario, 2018). While fewer women have died from OUD women are entering treatment sicker than men with more physical and psychological illness and significantly higher rates of family psychiatric history compared to men (Bawor et al., 2015).

Men and women also differ when it comes to treatment. Opioid substitutes, such as methadone, are effective for the treatment of OUD (Rawson & Clark, 2017). Retention

rates in the first year of methadone treatment are 70–80% (Peddicord et al., 2017). This rate is comparable to suboxone, another form of opioid addiction treatment, which has a 60–90% retention rate in the first year (Peddicord et al., 2017). Methadone is effective at low doses, with few adverse events and high abstinence rates in addicted individuals (Barrio et al., 2017). However, compared to their male counterparts, fewer Canadian and American women enter opioid replacement therapy (ORT; Belzak & Halverson, 2018; Leone et al., 2017). Women also experience a shorter period from initial addiction to treatment compared to men. However, they experience gender specific barriers to treatment like raising children and socially determined gender roles that are inconsistent with abusing drugs (Bach et al., 2015; Bawor et al., 2015; Leone et al., 2017). The inconsistent findings of these studies indicate suboptimal understanding of how best to support the successful treatment and recovery of women undergoing treatment for opioid addiction.

There are several potential social implications for this study. Studying Canadian women's experiences of OUD and their choice for methadone as treatment needs to be better understood to inform recovery care. What leads women to enter treatment and how they persist is important information for healthcare providers and legislators. Additionally, understanding women's experiences may promote changes in negative stigma associated with OUD. As treatment practices for OUD continue to evolve, this investigation helps to shed light on the impact of treatment. This type of study may help to better understand how the healthcare system and providers can facilitate treatment for women; by targeting gender specific care requirements. More specific treatment can lead

to more successful recovery for women with OUD. Each of these implications may have a positive impact on healthcare and those utilizing the healthcare system for recovery.

This chapter will include a variety of sections previewing the study. First, the background of the study will be presented with a summary of the research literature related to the topic. This will be followed by an overview of the problem including the gap in the literature that the study will help to address, the purpose of the study, the research question, conceptual framework, the nature of the study, key definitions, assumptions, delimitations and limitations of the study, and its significance to practice, theory, and social change.

Background of the Study

The focus of this study was an understanding of women's unique experiences managing OUD with methadone. The number of women experiencing OUD is growing (Public Health Ontario, 2018) as are the number of women dying from opioid overdoses (Public Health Ontario, 2019). The need to attract women into treatment and support persistence in recovery is essential and can only be accomplished with research efforts that focus on women. When women enter treatment, they are sicker (Bawor et al., 2015), significantly younger, more likely to participate in the sex trade, and use different drugs in comparison to men (Palis et al., 2017). Women's experiences in methadone maintenance treatment (MMT) can include physical and psychological health disparities as well as family history of psychiatric illness, social and emotional issues, and initiation of opioid use through prescription (Bawor et al., 2015; Leone et al, 2017). These unique

addiction issues for women speak to the need to investigate women, opioid use disorder, and MMT from the female perspective.

Healthcare factors can challenge a women's ability to access addiction care, and women have unique addiction experiences that need to be considered in care practices. Healthier women are more likely to engage in health-related behavior change (Marks & Leukefeld, 2017), yet many women report not having health insurance coverage, a health card, or access to health practitioners. Women in the perinatal period have additional concerns for finding an obstetrician/gynecologist who has experience and is willing to take on a pregnant woman on methadone treatment (Mattocks et al., 2017).

Subsequently, women have unique addiction experiences that need to be considered in care practices. One study by Rubio (2016), investigates women's unique experience of OUD and MMT. However, the transferability of this study is limited due to participants being from a small geographical location. The women in this study were from a single clinic in Texas, USA where healthcare is mostly privatized. In Southern Canada, where I plan to conduct this study, healthcare is socialized and access to treatment easier. Therefore, Canadian experiences may be different than American experiences regarding: the types of barriers experienced, adequacy of services, and even treatment outcomes. The need for further studies with different groups of women, in unique healthcare environments is warranted to understand the cultural, geographic, and health system related factors; that may influence the lived experience of women entering methadone treatment in other settings.

This study is needed to provide insight into the experiences of women who have chosen treatment with methadone for OUD. Such insights can help healthcare professionals better understand why women enter and persist in treatment and may help identify the best gender specific treatment modalities. The research conducted thus far lends itself to greater knowledge of women's addiction experience. Yet there is a lack of clarity of factors that support or deter women into treatment in a Canadian context. This lack of clarity makes understanding the process of first using opioids to treatment difficult to understand. This study will address this gap in knowledge and is needed to further the understanding of women's unique needs when seeking treatment for OUD.

Problem Statement

Despite the global increase in opioids for non-prescription use, particularly in women (Public Health Ontario, 2018; World Health Organization, 2018), there has been little inquiry into the perspectives of women undergoing treatment for OUD. Rubio (2016) investigated the lived experiences of women in the United States (U.S.) who were accessing methadone as treatment for OUD. While the majority of participants expressed positive perceptions regarding methadone treatment, a few expressed negative perceptions such as that the treatment was simply exchanging one dependence (opioids) for another (methadone) and that the financial cost was too high. However, these findings may not persist if a study is conducted in a different context, as participants in the U.S. treatment program were required to have private insurance or to self-pay. The implications of this are that those who are considered the working poor and those who cannot afford to pay out of pocket but are not eligible for public insurance, are missing

from this study. A recent study found that approximately 40% of U.S. women with OUD reported limited access to health care, and this lack of access to a clinic, healthcare center, or doctor was identified as a major barrier to recovery (Marks & Leukefeld, 2017).

The healthcare system in the United States is mostly privatized and thus stands in stark contrast to that of Canada's socialized healthcare system. Canadian women have access to physicians, nurse practitioners, and various other health services available through a universal healthcare system, which removes the economic barrier to access (Bach et al., 2015). In Canada, all women are allotted the opportunity to access ORT, and therefore a broader demographic of women can be included in an investigation. Many women in Canada are not required to pay for methadone treatment and may not have the same perceptions of methadone treatment. The implication is that Canadian women may experience different barriers and facilitators to treatment initiation and retention than women in the United States due to differences in the context in which healthcare is delivered. Nonetheless, fewer women than men in both Canada and the United States enter treatment programs that use ORT (Belzak & Halverson, 2018; Leone et al., 2017). Thus, it is unknown if such differences in access affect women's experiences of methadone treatment.

Opioid use disorder is an increasing public health concern for both the United States and Canada. A substantial proportion of those seeking treatment for opioid use disorder are women. Yet research that elicits the perspectives of women receiving methadone treatment is limited in the literature. The potential impact of socialized

healthcare on the experiences of women who have accessed methadone treatment has not been studied.

Purpose of the Study

The purpose of this study was to describe the lived experiences of women with OUD who are receiving methadone as their treatment of choice. By understanding their experience more fully, from their perspective, nurses and healthcare professionals will be able to provide women with individualized health promotion strategies and treatment (Rubio, 2016). This can provide insight that leads to further research and eventually to better outcomes for women experiencing OUD, which may improve their quality of life. Interpretive phenomenological qualitative methodology was used to elicit insights and experiences from the participants through interviews and observations.

Research Question

What are the lived experiences of Canadian women with opioid use disorder who choose methadone for treatment?

Conceptual Framework

The conceptual framework of self-care of chronic illness (Riegel et al., 2012) was used examine the phenomenon under investigation. The concept of self-care is important when working with addiction because addiction is considered a chronic illness that requires ongoing care, often on an outpatient basis (Ausili et al., 2014). The foundation of this framework is based on studies of chronic illnesses like heart failure (Riegel & Dickson, 2008). The theory involves three main components: self-care maintenance, self-care monitoring, and self-care management (Riegel et al., 2012). Self-care is defined as

health promoting practices and managing illness. The concept of self-care maintenance is defined as behaviors used by patients to maintain physical and psychological stability. Self-care monitoring is observing oneself for changes in signs and symptoms. Finally, self-care management is person's response to signs and symptoms when they occur (Riegel et al., 2012). The factors influencing self-care are experience and skill, confidence, habits, motivation, cultural beliefs and values, functional and cognitive abilities, support from others and access to care (Riegel et al., 2012). Each of these concepts within the self-care of chronic illness theory can be applied to women experiencing OUD and receiving methadone treatment.

The concepts within the self-care for chronic illness framework can be thoroughly explored in interviews using open ended questions, a technique synonymous with phenomenology. Women's experiences with self-care maintenance, self-care monitoring, and self-care management relate to women's OUD self-care. OUD is a chronic illness like those used to develop this framework. A more detailed analysis of how this theory has been applied will be given in Chapter 2. By eliciting women's perspectives of OUD and treatment, the concepts within the framework provided a lens to better understand their experiences.

Nature of the Study

The use of a qualitative, phenomenological methodology provided an opportunity to explore the lived experience of women with OUD from first experiencing addiction to treatment with methadone. This method explores a common theme or experience among a group of individuals (Creswell & Poth, 2018). This methodology was most appropriate

to address the problem statement and research question. In qualitative tradition, the approach is broad and considers truth and knowledge to be constructed by individuals and groups of individuals (Rudstenom & Newton, 2012). Understanding the lived experience of women living with OUD and treatment calls for a subjective approach that honors their individual experiences, consistent with qualitative research. Additionally, the use of words rather than numbers and measurements are appropriate for answering the research question (Creswell, 2014).

There are several types of phenomenological investigations (Sloan & Bowe, 2014). Husserl's descriptive phenomenology is used to assert that the investigator can transcend the phenomenon to understand its essence that occurs through individual interpretations. Hermeneutic or interpretive phenomenology is like descriptive phenomenology but also considers temporality and the relationship of individuals to existence as defining aspects (Sloan & Bowe, 2014). Once a description of what has occurred and how it is experienced is determined, descriptive phenomenological investigation ceases. However, interpretive phenomenology focuses on meaning and interpretation (Patton, 2015). Understanding the interpreted meaning of the experience to the individual, searching for themes interpretively through out the data, and taking an unstructured approach to data analysis is key to utilizing the interpretive phenomenological method. Interpretive phenomenology was the ideal approach for my study because I wanted to develop a greater understanding of the phenomenon of interest and make sense of the experience in consciousness (Patton, 2015). Further, this approach helped to understand individual and collective interpretations of experiences by

supporting the identification of themes in responses by participants. These themes can contribute to evidenced-based care provision to women experiencing opioid use disorder and methadone treatment.

Definitions

Addiction: A primary chronic disease of brain reward, motivation, memory, and brain circuitry. When there are problems with the circuitry it is manifested in a variety of ways leading to pathological pursuing the substance for reward or relief. The characteristics of addiction include inability to abstain, changes in behavior, cravings for the substance, reduced awareness of the negative effects on the self and others, and an unfitting emotional response (American Psychiatric Association, 2013).

Harm reduction: Attempts to reduce the adverse consequences of substance use without requiring the individual to completely abstain from using the substance. Harm reduction can include but is not limited to access safe injection sites, availability of naloxone, and access to various medications (Vearrier, 2019). Women in the study have chosen methadone, as a harm reduction strategy, to combat opioid use disorder (OUD).

Methadone maintenance treatment (MMT): A long acting opioid used in medical treatment of opioid addiction. Methadone helps prevent feelings of withdrawal and manages associated symptoms. Treatment helps individuals return to normal life; and prevents risky behavior associated with drug seeking. The optimal standard of care in Canada for opioid use disorder in Canada includes MMT, counseling, and other supports (Centre for Addiction and Mental Health, 2019a).

Opioid replacement therapy (ORT): A well-understood and researched method of pharmacological treatment for opioid addiction or dependence. A variety of agents are used in ORT, including, but not limited to methadone, buprenorphine, naltrexone and slow-release oral morphine. Methadone is the most frequently used form of ORT in North America (Bell, 2014). Each of the women participating in the study was actively receiving methadone for opioid use disorder.

Opioid use disorder (OUD): The problematic use of opioids causing serious impairments or suffering. Misusing prescription opioids or accessing them illegally, for their intense, pleasurable effects or to avoid the effects of withdrawal, are elements of the disorder (American Psychiatric Association, 2013). This misappropriation of opioids can have serious or even fatal outcomes. OUD is also known as opioid addiction. Women in the study were experiencing OUD.

Recovery: An ongoing process of change where people attempt to maintain and improve their health by striving to not misuse substances. Recovery is based on the belief that individuals can overcome their substance abuse. A variety of treatments can be employed in recovery including but not limited to professional clinical treatment, medications, support from family and friends, faith-based approaches, and peer support. During recovery, individuals commonly experience setbacks, in the form of relapse, despite prior growth and improvements. For this reason, it is essential that these individuals are resilient and continue on with their recovery despite setbacks. Recovery is a holistic process involving a variety of individuals, treatments and outcomes (Substance Abuse and Mental Health Service Administration, 2010).

Assumptions

Assumptions related to the investigation of women experiencing OUD who choose methadone as treatment include that the women participants want to recover. This assumption was necessary because they are acting on their own free will, which has led them to recovery. How they get to recovery and their experiences leading up to it are more relevant if they are choosing to get help. Additionally, how women persist in recovery is more informative if they are choosing to be in recovery rather than if they are being forced to participate. Even if participants feel as though they have no choice to participate due to parole issues or child protective services (CPS), if they are choosing to come and participate in recovery, their responses are still relevant.

Another assumption was that women are participating in recovery to improve their lives. This was assumed because otherwise ongoing participation in methadone treatment is a moot point. How life improvement is defined is subjective to the individual women and may be expressed in their responses. Examples of life improvements may be holding a job or improving relationships with others.

The final assumption was that the women provided an honest description of their experience from their perspective without intent to mislead me. This assumption was necessary because the insights and experiences of these women provided information that can influence the current and future practices of women's addiction recovery care. If the participants intended to mislead me, the analysis of responses would be inaccurate and inappropriately affect recommendations and suggestions for practice that come from the research. Women were asked to voluntarily participate and had the right to withdraw

from the study at any time. Each woman was made aware of this; therefore, there was no reason to misrepresent their experiences. Each of these assumptions were believed to be true but cannot be demonstrated as such.

Scope and Delimitations

The research problem included a variety of issues that indicate a need to develop a better understanding of women's specific issues with OUD. Gaps in knowledge include how women begin to use, experience, and treat their disorder. By eliciting women's experiences, research can begin to fill these gaps and direct future care.

Adult women were chosen to participate in the study because most women reporting having OUD are adults, and individuals must be an adult to receive methadone in central Ontario. It would not have been reasonable to include children. Further, women are a unique group that is largely missing from the literature on OUD and methadone treatment. Currently, most studies focus on men or have a much greater proportion of men, compared to women participating in their studies.

Many theories and conceptual frameworks were considered but not included in the study due to a lack of alignment with the research question. Other qualitative approaches to research were considered including ethnography, which would have meant studying women who suffer from OUD as a culture sharing group, but this was not the focus of the research question. The research question did not focus on finding contextualized cultural meaning within this group but rather understanding their lived experiences is the aim. Narrative research was also considered, but its focus is on stories that unfold collaboratively with the researcher rather than the experiences told directly by

the individual (Creswell & Poth, 2018). None of the other qualitative approaches were considered because they did not align with the research questions as closely as interpretive phenomenology.

Unlike quantitative studies, generalization of research findings is not the goal of qualitative studies. In qualitative research, the goal is to make the research as descriptive as possible, including the outcomes and context to enable readers to determine if the findings apply or transfer to other contexts, in part or whole (Ravitch & Carl, 2016). By using thick descriptions including detailed accounts of outcomes and contexts, the reader can determine the transferability for additional purposes.

Limitations

Potential difficulties existed in conducting this research study. Finding sites, participants, and maintaining objectivity were major limitations, challenges, and barriers of this research project. Some community addiction clinic sites refused to participate in the study. Two addictions treatment centre locations, with their accompanying pharmacies, elected to participate in allowing for recruitment posters to be posted and space for private interviews to occur but did not have their own institutional review board (IRB). But IRB approval from Walden University was deemed enough for these institutions to allow me to recruit and interview at their locations. Recruiting participants willing to be interviewed and audiotaped was also challenging due to the personal nature of participants' responses, potential illegal activity, and concerns with child welfare involvement, making data saturation difficult (Moser & Korstjens, 2018). This limitation was mitigated by using multiple sampling methods and informing participants upfront

that their identity will be masked. Another challenge was maintaining a professional distance from the data due to the personal nature of what was expressed by participants. Keeping a research journal gave me the opportunity to self-reflect on my thoughts, feelings, and practices throughout the research process (Ravitch & Carl, 2016).

Potential issues within the methodology also existed. In qualitative research, the goal is not to generalize the findings to be applied to other people in other settings but to transfer findings where appropriate (Ravitch & Carl, 2016). The validity criterion of transferability was addressed by providing thick descriptions of the data and contexts (Ravitch & Carl, 2016). Consumers of the research can determine transferability to their context based on the descriptions. The issue of dependability is addressed within the study by providing discussion to support the data collection methods of interviews and journal keeping. How these methods map to the research question is also conferred (Ravitch & Carl, 2016). Although these limitations did exist, they were addressed within the study.

Significance of the Study

This study fills the identified gap in current research knowledge by shedding light on the topic of Canadian women with OUD who are using methadone treatment, a population that is growing (Marks & Leukefeld, 2017; Public Health Ontario, 2018). No published studies were found that considered opioid use disorder and methadone treatment from the perspective of Canadian women.

This study also has professional significance to nursing. By deepening the body of nursing knowledge, nursing professionals can understand how to positively influence

women with OUD who are receiving methadone therapy. Current knowledge is key to providing the most relevant care related to women's addiction. Study results can also inform future studies that will continue to grow the body of knowledge for the profession.

This study promotes positive social change by distributing accurate information that gained from the study findings. By producing accurate knowledge of women's experiences with OUD and methadone treatment, negative stigma associated with it can be addressed. This information can inform healthcare professionals and society to establish a more accurate and empathetic understanding of women with OUD.

Significance to Practice

Nurses and other healthcare professionals are in direct contact with women who are experiencing OUD and are in a unique position to provide support and individualized care, encouraging them to enter treatment and to persist in recovery. Research indicates that current practices are inadequate to meet needs of this population of women (Belzak & Halverson, 2018; Leone et al., 2017), but nurses, as advocates, can influence practice changes. The study provides insight on the factors that women feel support them in accessing and persisting with methadone treatment over time. Relapse is common in OUD and brings with it the risk of overdose and death (Stone et al., 2018). Nurses can adapt their practices to meet these needs and advocate for change that may improve current statistics for women with OUD.

Significance to Theory

This study provides knowledge that is missing from the current body of literature. By conducting research into women's experiences of OUD and methadone treatment,

addictions research is furthered. As with all research, the findings from this study elicit more questions and further areas that require investigation. This study utilized the self-care for chronic illness framework in a way that has not been done in previous studies. No research exists using this framework to provide a lens to interpret findings of research with individuals with OUD or any type of addiction or mental health issue. Therefore, this research contributes to theory by adding to current knowledge and developing areas of future study.

Significance to Social Change

Changes in addiction practices for women who are experiencing opioid use disorder and utilizing methadone treatment contributes to positive social change. Changes to inadequate care practices, related to the findings of the research, can benefit women and society. Current practices do not address the unique needs of woman (Raheimi et al., 2018), and research that accurately exposes these needs can support practice change. Once needed practice changes have been identified, organizations can reexamine their individual practices and consider if the care they are providing is optimal. Similarly, this research exposes whether aspects of the healthcare system influence women's experiences with methadone treatment. Information related to these aspects may contribute to changes in public policy related to women's addiction care. This social change can effectively support women's care needs on a larger scale. Research with women with OUD who choose methadone for treatment can begin to evolve to become more comprehensive and reflective of the needs that women themselves see as essential, drawing more women into treatment and retaining them.

Further, women are still overwhelmingly the central caregivers for their families (Claffey & Mickelson, 2009) and important contributors to household incomes (Statistics Canada, 2018); thus, improving OUD treatment for women has the potential to produce positive changes in society that reach beyond those receiving care. Future studies can be initiated based on the findings of this research that can contribute to ongoing evaluation and identification of MMT practices. However, further research with each unique population is necessary. Ensuring that women in Canada and other locations are receiving evidence-based care contributes to positive social change by improving health outcomes and reducing harm, including death from overdose (Rawson & Clark, 2017).

Summary

This chapter provided an introductory review of the current literature related to women's experiences of OUD and their choice of methadone for treatment. The problem is that despite growing numbers of women with OUD in both Canada and the United States, fewer women are consistently entering treatment when compared to men. The reasons for this problem are not well understood as there is currently no research that considers the personal perspective of the experiences of Canadian women with opioid addiction. This study describes the lived experiences of women with OUD who are receiving methadone as their treatment of choice in Canada. In this chapter, the self-care of chronic illness model was also explained as well as the choice of interpretive phenomenology, which was appropriate based on the research question. The key constructs of this study were also delineated as ORT, OUD, MMT, harm reduction and recovery. Assumptions underlying this study include that women are providing an honest

account of their experiences and that they wish to improve their lives. The scope and delimitations of the study were provided to give boundaries to the work. The study is significant in that it expands our current knowledge of addiction care for women. Finally, this study contributes to positive social change by encouraging further research that could result in policy changes regarding the care and treatment of women with OUD. By furthering knowledge of OUD, stigma may be mitigated when realities of women's experiences are exposed.

Chapter 2 provides a more comprehensive review of the literature related to women experiencing OUD and their choice of methadone as treatment. Additionally, the literature applying the conceptual framework of self-care of chronic illness is explored in the following chapter.

Chapter 2: Literature Review

Introduction

In North America, there is growing concern over the dramatic increase in the misuse of opioids leading to OUD (Bruneau et al., 2018). Deaths, hospitalizations, and emergency department visits have increased exponentially over the past decade (Public Health Ontario, 2018; The Centers for Disease Control and Prevention, 2016). In Canada, more than 8,000 people have died related to opioid causes since 2016 (Canadian Institutes of Health Research, 2017). Further, the number of women with OUD is increasing (Public Health Ontario, 2018). Although men experience OUD more frequently, women are entering treatment sicker and have unique barriers compared to their male counterparts (Bawor et al., 2015). Yet women's experiences with OUD are sparsely represented in the literature.

Differences exist in men's and women's experiences with OUD including demographics, health disparities, and barriers to treatment (Bawor et al., 2015; Palis et al., 2017). In comparison to men, women have an increased prevalence of psychological health issues requiring treatment (Bawor et al., 2015; Leone et al., 2017). Women's emotionality is an important factor to consider such as feelings of fear, worthlessness, and power (Hanpatchaiyakul et al., 2017), which contribute to understanding women's psychological well-being. Women's psychological health contributes to their addiction experiences. Women's unique experiences must be considered in future research to provide them with optimal assessment and treatment of OUD. Further research should also focus on access to healthcare services, factors that support women in recovery and

interpersonal relationships (Marks & Leukefeld, 2017) as well as the factors that led to their addiction and decision to seek treatment (Rubio, 2016). Rubio (2016) did conduct a qualitative study examining several factors and reported themes that included women's journey of addiction, the tipping point, and perceptions of methadone (Rubio, 2016). However, limitations of this study include that it was conducted in the United States, limiting the transferability to other populations especially one with a different type of healthcare system like Canada.

Options exist for OUD treatment like opioid substitution therapies, which are a harm reduction treatment, but women access treatment at low rates. Medications such as methadone are known to effectively treat OUD and improve health outcomes (Rawson & Clark, 2017). Though other substitution therapies exist including buprenorphine/naloxone and naltrexone, methadone continues to be the most preferred opioid substitution therapies in Ontario, Canada (Kurdyak et al., 2018). In the United States, healthcare including addictions treatment are privatized; however, in Canada the healthcare system is socialized, making care for addictions virtually free. Yet women access treatment at low rates. However, little is known about women's experiences of OUD and nor their treatment with methadone in Canada.

In the United States, privatized healthcare limits accessibility to women who may desperately need these services yet do not have insurance or the ability to pay for addictions out of pocket. Taking place in a country with socialized healthcare, this study addresses this gap by including the perspectives of women across all socioeconomic backgrounds. The purpose of this study was to describe the lived experiences of women

with OUD who were receiving methadone as their treatment of choice. By understanding their experience more fully, from their perspective; nurses and healthcare professionals can provide women with individualized health promotion strategies and treatment (Rubio, 2016). This study provides insight for further research and better outcomes for women experiencing opioid use disorder like improved quality of life. Finally, outcomes of this research enable our understanding of the facilitators and barriers to methadone treatment. This will assist healthcare professionals to support women who chose OST by supporting facilitating factors and mitigating barriers to treatment.

Major sections of this chapter are organized chronologically to build understanding of the issues of women and opioid use disorder. These sections include the literature search strategy, pathophysiology of opioids and the epidemiology of opioid use disorder, treatments for opioid use disorder, and the current state of OUD nationally, and gender differences in OUD. Each section will provide detailed evidence, analysis, and synthesis of the relevant literature.

Literature Search Strategy

An exhaustive search of the literature was performed on the topic of women experiencing opioid addiction who choose methadone for treatment. The databases searched included CINAHL and MEDLINE Combined search, Cochrane Review and ProQuest Health and Medical Collection. In addition, a Google Scholar search was conducted to look for additional relevant articles and evidence. The search terms *opioid addiction*, *opioid abuse*, *opioid use disorder*, *drug addiction*, *methadone*, *heroin*, *experiences*, *women*, and *female* were explored in the databases. Combinations of these

search terms in each database included *women* and *opioid addiction*, *women* and *opioid abuse*, *women* and *opioid use disorder*, *women* and *methadone*, *women* and *heroin* and *methadone*, *women* and *drug addiction*, and *female* and *opioid use disorder*. The timeframe for the search was 2014 to 2019. The initial search returned 158 articles. I chose to include articles that directly related to the research question. Research that was conducted in foreign countries other than the United States and Canada were not included due to concerns of applicability of their findings. Articles that focused on pregnancy and birthing or included women who were incarcerated were also excluded from the literature review. However, articles that considered the experiences of having children and incarceration as they relate to methadone treatment and opioid addiction were included. The total number of relevant articles to be included in this literature review is 12.

Conceptual Framework

The conceptual framework for this study is derived from the middle range theory, self-care of chronic illness (Riegel et al., 2012). The definition of self-care is a process of maintaining health through health promoting practices and managing illness (Reigel et al., 2004). Self-care of chronic illness theory can be applied to a host of chronic conditions, including those in mental health like opioid use disorder [OUD] (Riegel et al., 2012). Self-care is an essential element of chronic illness that is required to achieve optimal health outcomes (Riegel & Dickson, 2008). Substance use disorder (SUD) is considered a chronic illness that requires ongoing treatment including medication and behavioral interventions, which includes self-care (Morse, 2018). The conceptual

framework can be appropriately applied to patients with OUD, as it is a chronic medical condition that is influenced by self-care practices.

The theory of self-care of chronic illness evolved from the previously identified situational theory heart failure self-care (Riegel & Dickson, 2008). The situation-specific theory of self-care of heart failure in chronic illness along with the corresponding Self-Care of Heart Failure Index formed the theoretical base for self-care of chronic illness theory (Reigel & Dickson, 2008). In the situation specific theory, patients were challenged to care for themselves in a manner that is consistent with the care requirements of their chronic heart condition. Similarly, patients with opioid use disorder are required to care for themselves consistent with the requirements of their chronic condition, which may include counselling and medication assisted treatment like methadone (Morse, 2018). The theory of self-care of chronic illness was also influenced by Dorthea Orem's grand theory of self-care (Orem, 1991). Orem's theory considers broader self-care activity including self-care needs, abilities to perform self-care, and the role of nursing. Riegel et al. (2012) focused on self-care of chronic illness and the role of all professionals in promoting self-care. Specifically, these authors investigated the processes and behaviors in those dealing with chronic conditions (Riegel et al., 2012).

Self-care of chronic illness theory has been applied in a variety of contexts such as heart failure, diabetes mellitus, and caregiver contributions to self-care. Initially, the theory was derived from practice caring for individuals with heart failure. Difficulties having to perform self-care that is consistent with heart failure were evident for these patients. Self-care has been found to be a major contributor to improving heart failure

outcomes including reducing hospitalizations and death in patients with heart failure (Jaarsma et al., 2013). In another context, complex self-care practices are required in individuals with diabetes mellitus (Ausili et al., 2017). Researchers developed a scale based on the middle range theory of self-care of chronic illness called the Self-Care of Diabetes Inventory. The tool was found to be valid and reliable in measuring self-care in individuals with type one and two diabetes. Recently, another situation specific theory has materialized from the continued study of self-care called the situation specific of care giver contributions to self-care (Jaarsma et al., 2013). Correspondingly, the Caregiver Contribution to Self-Care of Heart Failure Index was developed.

Self-care of chronic illness theory is a middle range theory that explains and describes the process of individuals and their families maintaining health while managing symptoms related to the chronic illness (Riegel et al., 2012). Middle range theories focus on a narrow scope of nursing reality and include a limited number of concepts (Peterson & Bredow, 2017). Concepts within the framework of self-care of chronic illness include self-care maintenance, self-care monitoring, and self-care management (Riegel et al., 2012). Each of these concepts in the theory applies to OUD.

The first concept in self-care of chronic illness theory is self-care maintenance. This concept requires adaptation to changes that occur in experiencing a particular chronic illness. Often, required changes involve recommendations by healthcare professionals (Riegel et al., 2012). In OUD, changes can include taking medication such as methadone, naltrexone, or buprenorphine; attending counselling sessions; coping with withdrawal symptoms; and avoiding substance use triggers, such as people and places

where previous opioid use has taken place (Morse, 2018). Reflecting on these changes can assist in determining the ongoing effectiveness of the changes (Riegel et al., 2012). Adhering to self-care maintenance practices facilitates optimal health outcomes for patients with chronic illnesses.

Self-care monitoring is the second concept within the self-care of chronic illness theory. Three criteria must exist for self-care monitoring to be successful (Riegel et al., 2012). The three criteria include the possibility of clinically significant changes, reliable detection of changes and finally, and a reasonable response must be conceivable. Self-care monitoring includes being attentive to the body, known as body listening, and ongoing methodical monitoring of physical and psychological experiences (Riegel et al., 2012). In OUD, self-care monitoring can take the form of blood, urine, and vital sign assessments. Additionally, to prevent relapse monitoring emotions and thoughts can be essential for those experiencing OUD (Sancho et al., 2018). The goal of self-care monitoring is to be vigilant and recognize when changes occur due to the chronic illness. When a change is identified and understood, decisions can be made as to how to proceed to act on the change, including seeing a healthcare provider (Riegel et al., 2012). Self-care monitoring is the link between the other two concepts within the theory of self-care of chronic illness (Riegel et al., 2012). Self-care monitoring requires attentiveness, evaluation, and decision-making.

The third and final concept in the framework is self-care management. When signs and symptoms occur that indicate a change in the chronic condition, action is sometimes required. When an individual decides to act, treatment occurs and evaluation

of treatment effectiveness is needed (Riegel et al., 2012). A healthcare professional may be required in response to the sign or symptom to facilitate treatment. An individual with OUD may decide to seek assistance from a healthcare provider when experiencing withdrawal symptoms or environmental triggers. Relapse can occur when the response to the sign or symptom is inappropriate like using opioids to relieve withdrawal symptoms. Therefore, self-care management requires decision-making and action.

Each of the three concepts within the self-care of chronic illness theory work together and independently, promoting health and managing chronic illness (Riegel et al., 2012). The activities and behaviors within each concept are dynamic; they do not occur in a linear order, nor will they necessarily occur. The processes that influence these concepts and underlie self-care are decision-making and reflection. First, decision-making is a complex process in which an individual is required to choose a course of action in self-care (Riegel et al., 2012). Often, the individual must make decisions quickly and with incomplete information. It is important to consider decision-making due to the potentially dangerous outcomes of some self-care decisions. When experiencing symptoms of withdrawal, individuals taking methadone for OUD may consider using opioids, which can lead to overdose and possibly death due to excessive amounts of opioids in the body (Sordo et al., 2017). Otherwise, they may seek assistance from a healthcare provider for treatment as part of the process of naturalistic decision-making (Klien, 2008). Potentially faced with such circumstances as losing children to protective services, losing a job, or death, individuals must decide how to respond. Serious situations can be stressful, confusing and with competing outcomes, yet decisions must

be timely (Klien, 2008). Decision-making is an essential process in determining the outcome of self-care in chronic illness.

The second process affecting self-care is reflection. Reflection promotes knowledge development and helps to determine the quality and effectiveness of self-care (Fearon-Lynch et al., 2019). When individuals make decisions they can be sufficient or insufficient, purposeful or unintentional, reasoned and reflective, or automatic and unobservant (Riegel et al., 2012). The quality of self-care is dependent on the actions and decisions by the individual. For the individual who has little knowledge or consideration of their self-care, poor quality of self-care can result. The same outcome occurs for the individual who has sufficient knowledge and reflection yet who chooses not to participate in adequate self-care, resulting in poor self-care. For the individual who performs self-care adequately but is not reflective, education is required to improve their understanding of the rational for care. Ideally, the individual is both reflective and knowledgeable with self-care. This occurs when they have received adequate education and know when signs and symptoms warrant assistance from a healthcare provider (Riegel et al., 2012). Accordingly, when individuals with OUD receive adequate education, are reflective, and perform sufficient self-care, the outcome is ideal. Both decision-making and reflection influence self-care and have the capacity to improve care when these processes are done effectively.

Further, three assumptions exist within the theory of self-care of chronic illness. Assumptions are beliefs that are taken for granted and underlie the theory of a phenomenon (McEwen & Wills, 2014). The first assumption is that there are differences

between general and illness-specific self-care practices (Riegel et al., 2012). Examples of general self-care practices can include brushing your teeth or having annual physical exams. Illness specific self-care practices are restrictive and influenced by others such as healthcare professionals (Riegel et al., 2012). In someone with OUD, these practices can include vaccinations for hepatitis A and B and having infectious disease testing completed (Perlman, et al., 2014). The second assumption is that decision-making requires focus, thinking, memory, and understanding (Riegel et al., 2012). To make reasoned decisions, individuals need to be able to consciously consider options and alternatives to make the most informed decision. The third and final assumption indicates that conflict can exist in self-care when multiple comorbidities exist (Riegel et al., 2012). Different healthcare providers may offer advice that stands in opposition from one another, making them difficult to integrate. An individual with OUD may receive a prescription from a general practitioner for a benzodiazepine medication, which can cause further central nervous system depression (U.S. Food and Drug Administration, 2017); however, they received information from their addictions healthcare practitioner to refrain from taking these types of medications while on methadone. Assumptions of self-care of chronic illness state that illness specific care is unique and prescriptive and requires advanced cognitive processes for decision-making. Having multiple comorbidities can further complicate self-care.

Additionally, seven testable propositions of the theory of self-care of chronic illness exist (Riegel et al., 2012). The first proposition is that there are similarities within different chronic illnesses. Next, quality of self-care is influenced by previous

experiences. Furthermore, limited reflection in self-care limits the complexity of situations that an individual can handled. In addition, knowledge deficits, misunderstandings and misconceptions, negatively influence self-care. The proposition of self-care monitoring is required to identify changes in signs and symptoms leading to appropriate action. Finally, evidenced based self-care results in better health outcomes (Riegel et al., 2012). Each of these seven propositions can be tested in studies about chronic illness self-care.

Self-care outcomes can be intended or unintended. Intended outcomes include chronic illness stability, adequate management of symptoms, and improved quality of life (Riegel et al., 2012). However, unintended outcomes can also be important. Managing self-care can lead to a decrease in hospitalization (Boyde et al., 2018), healthcare costs, and death (Abe et al., 2019). This is an important finding considering the current opioid crisis where healthcare expenditures and the death rate are climbing dramatically (Canadian Centre on Substance Use and Addiction, 2018; Government of Canada, 2018). Potentially, self-care is an important component to reduce healthcare spending and reduce the number of avoidable deaths occurring due to opioid related causes. Other unintended outcomes include seeking healthcare prematurely due to hypervigilance; and avoiding seeking healthcare due to over confidence in the ability to manage signs and symptoms independently (Riegel et al., 2012). These unintended factors can lead to additional concerns of healthcare costs and death contributing to the already overwhelming issues in chronic illnesses like OUD.

Self-care is a complex process involving a variety of barriers and facilitators. Factors that influence self-care include: experience and skill, motivation, cultural beliefs and values, confidence, habits, functional and cognitive abilities, support from others and access to care (Riegel et al., 2012). Previous experience with self-care can provide a foundation to compare future outcomes (Riegel et al., 2012). As well, previous experience can contribute to developing skills to perform self-care activities. Motivation is required to perform actions. It can be intrinsic, driven by internal drivers to achieve self-care (Kruglanski et al., 2018). Whereas, extrinsic motivation involves the desire to achieve a specific outcome. Both factors influence motivation to perform tasks like self-care. Culture can also influence the value of performing self-care activities (Riegel et al., 2012). Some cultures may value independence while others value providing and receiving care when there is a need. When an individual performs self-care, confidence positively influences ability (Riegel et al., 2012). Further, the more confident someone is, the more likely they will be to act; when signs and symptoms are recognized (Grafton et al., 2017). Habitual practice of a self-care routine can positively influence behavior. Those who adopt imposed self-care behaviors may have better healthcare outcomes (Riegel et al., 2012). Self-care practices are often complex. They require that individuals have substantial and sustained functional and cognitive abilities to perform them effectively, especially for those with complex chronic conditions (Parham et al., 2017). Self-care is reasonably performed by both self and often in collaboration with others. When family and friends participate in self-care communication, decision making and reciprocity, it is identified as 'shared care' (Sebern et al., 2016). A final factor affecting

self-care is access. Access to healthcare providers is essential in managing chronic illness. Without access to appropriate healthcare providers, individuals may seek alternative sources of information, which may or may not provide evidenced based interventions and treatments (Riegel et al., 2012). Reasons for lack of access may vary including insurance, cost, and geographic location (Riegel et al., 2012). Self-care is a complex multi-faceted process.

Individuals employ a variety of processes, when attempting to manage self-care. First, they need to be able to attentively be aware of and determine changes in their health; in order to intervene appropriately in each situation. Further, they need to continue the course of care that is often determined by healthcare professionals. Having the capacity to make decisions during care and reflect on the care given is essential to achieve the optimal outcomes in chronic illness self-care. Outcomes can be intended or unintended. Individuals must consider a variety of factors that influence these outcomes. Having the motivation and expertise to perform self-care confidently, the support of others and access to care influences the quality of self-care performance. At times, self-care is not possible and shared care must be sought. In this circumstance individuals work together to achieve self-care goals. Individuals must consider each of these aspects, when determining self-care in chronic illness. What is missing from this literature is how the theory of Self-Care of Chronic illness applies to various types of chronic illness, like mental health and addictions. This type of chronic illness requires unique methods of self-care. In my study, I will be able to use this conceptual framework to provide a lens through which to understand the experience of women with OUD who choose methadone

as treatment. In this study, how women experience and perform self-care is illuminated. How they understand, monitor and treat their chronic illness will shed light on themes to help understand their unique experience. Below is an application of the Theory of Self-Care of Chronic Illness in women with OUD.

Women with OUD, who choose methadone as treatment, attend the addictions clinic or pharmacy to receive their oral dose of methadone every one-to-seven days. The clinics may offer counselling services to help those with OUD cope with triggers, answer questions and work through personal issues (self-care maintenance). They are required to do laboratory blood draws, urinalysis and vital sign measurements. Women are encouraged to pay attention to how they are feeling; whether they are experiencing withdrawal symptoms or having difficulty coping with emotions. It is essential they be able to recognize these changes; in order to react appropriately by self-help or seeking help from others, including healthcare professionals (self-care monitoring). Once the woman recognizes changes in her health, she can determine the needed actions. The woman can consider her options and act (self-care management). Women will have the opportunity to express themselves openly, which may facilitate understanding of the processes that underlie self-care; and factors influencing each individual woman. Using their own voice and personal stories, women elaborate on the outcomes of their efforts in caring for themselves. Self-Care of Chronic Illness theory provides a lens to view the research topic, facilitating understanding of women's unique experiences with OUD and methadone treatment. Further, this study assists in evaluating the validity and reliability

of this theory, by applying it to chronic illness, other than heart failure and diabetes care, which have been identified in the literature.

Literature Review

Background

Pathophysiology of Opioids

Opioids are a broad group of powerful narcotic pain relievers that are available by prescription or purchased illegally (Centre for Addiction and Mental Health, 2019b). In their natural form, they are produced from the poppy plant as opium. Some examples of natural source opioid medications are codeine and morphine (Centre for Addiction and Mental Health, 2012). Opioids can be synthetic, as with methadone or fentanyl. They can also be semi-synthetic, as with hydromorphone or hydrocodone. In the body, all types of opioids interact with opioid receptors on cells located in the brain, spinal cord and other body organs (National Institute of Health, 2018). This activity stops the pain sensation from the brain to the body and simultaneously produces dopamine, a neurotransmitter associated with feelings of pleasure and euphoria. The pleasurable feelings produced by taking opioids contribute to their abuse (National Institute of Health, 2018). As users experience pleasurable feelings from opioids, the desire to repeat this experience is reinforced. Opioids in synthetic or natural form effectively relieve pain and increase pleasure resulting in pain control and the likelihood of abuse.

Historically, opioids have been used to treat a variety of conditions. Cough, diarrhea, addiction, and commonly, acute and chronic pain can be effectively treated with opioid medications (National Institute of Health, 2018). Several side effects occur with

the use of opioids including euphoria, respiratory and central nervous system depression, tolerance, addiction and death (Centre for Addiction and Mental Health, 2012). Tolerance occurs when an opioid is taken long term and higher doses of the medication are required to achieve the same effect, as was experienced at a lower dose. Eventually, the desired effect of the medication is compromised, and new treatment is sought (National Institute of Health, 2018). Opioids are an effective treatment option for a variety of conditions; but are at risk of being abused due to their effects. However, opioids come with serious side effects even when used properly.

Types of Opioids

There are several types of opioids and each is known by a variety of names. According to Health Canada's Drug Analysis Service (Health Canada, 2017) the most commonly abused opioids in Canada include fentanyl, oxycodone, hydromorphone, morphine and heroin. Each of these opioids is briefly described below.

Fentanyl. This is a potent frequently abused opioid. On the street, fentanyl is known as apache, China girl, China town, China white, murder 8, jackpot, poison, TNT, and Tango & Cash. It is a laboratory produced synthetic opioid. When taken legally, fentanyl takes the form of pills, lozenges and transdermal patches. Street Fentanyl can take a variety of forms but is often swallowed, smoked, snorted or injected (Centre for Addiction and Mental Health, 2017). Used on the street, fentanyl patches can be smoked or chewed. Street Fentanyl is produced illegally in labs; or by obtaining stolen patches from those who have a legal prescription. Fentanyl is fifty to one-hundred times stronger than morphine contributing to the danger in its use (National Institute of Health, 2018).

When purchased from non-prescription sources Fentanyl is often cut with cocaine or heroin making it particularly dangerous (Centre for Addiction and Mental Health, 2017). As well, it is often sold by another name, so, users may take fentanyl unknowingly. Due to its dangerous attributes, Fentanyl is responsible for seventy-two percent of accidental apparent opioid-related deaths in Canada (Government of Canada, 2018b). Fentanyl is a major contributor to the opioid crisis and when used illegally it brings dangerous consequences.

Oxycodone and Hydromorphone. These medications are potent pain relievers (Centre for Addiction and Mental Health, 2019c) that are chemically like heroin (National Institute of Health, 2018). A long acting oxycodone replaced a medication called OxyContin because of abuse of this medication; which ultimately led to its production becoming illegal in 2012 (Government of Canada, 2013). Oxycodone is a medication that is much more difficult to tamper with than OxyContin. Hydromorphone is used to manage moderate to severe pain relief in a variety of conditions (National Institute of Health, 2018). Both oxycodone and hydromorphone are opioids that continue to be abused and pose potentially dangerous consequences for those abusing them.

Morphine. This opioid is a naturally occurring opioid derived from the poppy plant. It is effective in managing cancer and non-cancer types of chronic pain, of moderate to severe intensity (Kim et al., 2016). Morphine, like other opioids, has the potential for dependence, tolerance, and misuse.

Heroin. This opioid is a highly addictive opioid made from morphine. Rates of heroin use have increased, in part due to the costly nature of prescription opioids

(National Institute of Health, 2018). It is often mixed with additives contributing to the health disparities associated with long-term use of heroin including liver, kidney, lung, and cardiac conditions (National Institute of Health, 2018).

Defining Opioid Use Disorder

Abuse of opioids occurs when they are used in any way that is unintended which includes taking someone else's prescription or taking opioids to experience a high (National Institute of Health, 2018). Euphoria that is produced with the use of opioids, contributes to its abuse. It is concerning considering the dangerous side effects of opioids, including central nervous system depression and death. Abuse of opioids can lead to addiction, the most serious form of SUD (National Institute of health, 2018). According to the American Psychiatric Association (2013), SUD is defined as use of alcohol or other substances that leads to problems in daily life or causes noticeable suffering. Inappropriate use of opioids can lead to problems in personal and professional life, as well as health and well-being.

SUD includes the inappropriate use of opioids. Addiction to opioids is often referred to specifically, as opioid use disorder (OUD). OUD is defined in The Diagnostic and Statistical Manual of Mental Disorders (*DSM–5*) as: problematic use of opioids causing serious impairments or suffering (American Psychiatric Association, 2013). OUD includes those who take opioids more often than prescribed, take improperly, or illegally to experience the pleasurable side effects of this powerful narcotic. Abuse and addiction to opioids can cause serious and even life-threatening consequences. SUD is an overarching category of mental disorders that OUD is a sub-section of.

When someone who is addicted to opioids attempts to stop taking them or reduce their dose, withdrawal symptoms occur. These symptoms can include: widespread pain and body aches, insomnia, diarrhea, vomiting, irritability, agitation, tremors, chills, and severe cravings (Government of Canada, 2019a; National Institute of Health, 2018). The length of time of withdrawal and the severity depends on a variety of factors. However, these negative side effects cause opioid users to actively seek out opioids; making it tremendously difficult to stop using (Government of Canada, 2019a). Withdrawal from opioids can be so severe that in order to obtain opioids, the person may resort to any means to obtain them.

When someone with OUD experiences withdrawal or cravings, the desire to take opioids can cause the user to resort to illegal or immoral means to obtain the drug. Stealing from others to buy drugs and finding drugs on the street, presents immense dangers to the user. Drugs manufactured and sold on the street can contain a variety of substances, some toxic. Additionally, these drugs can contain unknown amounts of different types of opioids that can add to the danger of taking them. In fact, the drug dealers selling street opioids may be unaware of what they are selling. The unknown contents of the street opioids make them much more dangerous than prescription opioids. Street opioids can contain an unknown amount of any opioid including fentanyl, an extremely high potency opioid; that there is a small difference between a dose that will cause a high and one that will kill the user (Centre for Addiction and Mental Health, 2017). Opioids commonly come in tablet, liquid and powder form and used by snorting, smoking, swallowing, and injecting.

Epidemiology Opioid Use Disorder in Canada

The growth in medical use of prescription opioids for issues like pain management has fueled the growing problem of OUD (Government of Canada, 2017). While it is important to note that patients and healthcare providers are best suited to make decisions on care; the use of opioids can cause dependence and therefore should be considered judiciously. In the mid 2000's high dose opioid prescription began to rise and has led to Canada being identified as the second highest users of opioids per capita in the world; the United States is the first highest users globally (Government of Canada, 2017). Prescription opioids, while effective in managing pain, can cause dependence and have led, in part, to the growth of opioid abuse in Canada.

Nationally, the addiction to opioids has reached epic proportion and is commonly referred to as the opioid crisis (Government of Canada, 2017). According to the Government of Canada Report (2018a) opioids are responsible for more than eight thousand deaths between January 2016 and March 2018 and 1,804 (between April and December 2018) suspected overdoses reported by emergency medical services (Government of Canada, 2019b). Eighty-one percent of accidental apparent opioid-related deaths involved Fentanyl or Fentanyl analogues and an average of 17 Canadians were hospitalized every day in 2017 due to opioid poisoning (Government of Canada, 2018b). By province and territory, Ontario is second only to British Columbia in opioid related deaths, experiencing 638 deaths from January to June 2018 (Government of Canada, 2018b). Further, emergency visits in Ontario, attributed to opioid use, increased 73% between 2016 and 2017. The opioid crisis in Canada is growing and is

disproportionately affecting provinces like British Columbia and Ontario. Data on Canada's opioid epidemic shows that some Canadians experience these negative effects disproportionately. Overdoses caused by opioids were more commonly experienced by men (76%) and more commonly occurred in persons ages 20 to 39 (Government of Canada, 2018a). Due to the severity of the opioid crisis and the devastating effects on the lives of Canadians, the Government of Canada is seeking to better understand and guide treatment of OUD. Research that seeks to investigate this phenomenon is much needed to combat this growing epidemic.

Stigma exists around addiction and substance abuse. Although addiction is a common phenomenon in Canada and throughout the globe, stigma persists. Stigma is defined as negative attitudes and beliefs (Canadian Mental Health Association, 2019). Negative judgements caused by stigma can adversely influence the quality of life of those battling addiction and can act as a deterrent from getting the much-needed help to treat addiction (Canadian Mental Health Association, 2019; Government of Canada, 2019a). Stigma can take the form of social, structural, and self-stigma (Government of Canada, 2019a). Social stigma is the negative attitudes, labels, images, and treatment of those with SUD. Structural stigma is treatment by those in social service departments, who ignore their requests, don't provide services, and design social services to promote stigmatization against those with SUD. Finally, self-stigma is when those who are facing SUD internalize the negative attitudes and beliefs of those who stigmatize against them. Cheng et al. (2019), found that self-stigma negatively impacted psychological distress, social functioning, and quality of life in a large sample of heroin users who were in

MMT. These authors found that treating psychological distress effectively reduces the negative effects of self-stigma on the quality of life of heroin users. Despite the much-needed treatment for those battling OUD, many will not seek treatment due to the barriers such as stigma deterring them from seeking and entering treatment (Government of Canada, 2019a). Promoting knowledge of stigma and treating the negative effects like psychological distress, may reduce stigma and promote treatment of those with OUD.

Treatment for Opioid Use Disorder

A variety of treatment options for OUD are examined. Methadone, buprenorphine-naloxone are opioid agonist therapy options. Methadone continues to be the most commonly used drug treatment for OUD in Ontario, Canada. However, recent evidence supports buprenorphine-naloxone as a first line treatment and methadone as the second (Bruneau et al., 2018). Medication with behavioral therapy is considered effective treatment for OUD (National Institute of Health, 2018). Standalone withdrawal management is not recommended due to the increased risk of tolerance and relapse that can result in overdose and death (Bruneau et al., 2018). Similarly, treatment retention is essential since those who relapse have an increased risk of overdose and death (Sordo et al., 2017). The initiation period of beginning on Methadone and the cessation of methadone treatment are particularly vulnerable periods where the risk of death is increased.

Methadone. Methadone is a long-acting, synthetic, full agonist opioid. It has been extensively studied as a first-line drug to treat OUD since 1964 (Canadian Institute of Health Research, n.d.). Studies have indicated that methadone is a safe and effective

method of treatment reducing or eliminating death, heroin use, and criminal activity in opioid users (McCance-Katz et al., 2010). Safe dosing and administration of methadone are required to follow national and provincial guidelines for the management of OUD as well as product monographs approved by Health Canada (Bruneau et al., 2018; The College of Physicians and Surgeons of Ontario, 2011). The goal of methadone dosing is to eliminate withdrawal symptoms, cravings, avoid opioid toxicity, and block the euphoric effects of other opioids (Canadian Institute of Health Research, n.d.; Socias et al., 2018). Maintenance doses of methadone are 60-120 mg/day with daily witnessing of ingestion. Take home doses, often called “carries”, can eventually be allowed once a healthcare provider deems it appropriate based on individual stability (Socias et al., 2018). Methadone is an effective treatment for OUD with appropriate dosing and maintenance therapy.

As with all medications, there are benefits and challenges with taking methadone. Among these challenges is attending witnessed dosing for the medication (Bruneau et al., 2018). Attending methadone dispensing clinics exposes those on methadone maintenance therapy and can be the cause of humiliation by an otherwise misinformed public (Woo, et al., 2017). In fact, one study found that participants were willing to drive hours away to a methadone clinic to avoid being seen fearing stigmatization by others (Woo, et al., 2017). In an attempt to taper opioid therapy independently, others reduced their doses too quickly resulting in withdrawal and having to increase the dose of methadone (Woo, et al., 2017). Stigmatization by others associated with methadone therapy, negatively influences MMT outcomes and the emotional well-being of patients.

Facilitators and Barriers to Treatment

Treatment for OUD presents unique challenges that can prevent or delay care. Feelings of stigmatization and discrimination based on ethnicity, drug use, chronic pain needs, and residency can prevent resource access by those in need of treatment (Muthulingam et al., 2019; Olding, et al., 2018; Rivera-Suazo et al., 2015). In a study by Olden et al. (2018), those with SUDs experienced inadequate treatment, were denied treatment, and treatment was ended abruptly due to their drug use. These aspects of experience led individuals in Canada's west coast to hesitate when accessing services or refuse them all together. This lack of access to care resulted in poor outcomes.

Financial barriers exist in accessing treatment for OUD. Lack of ability to pay for medications, medical devices and dental services act as barriers for both men and women despite having a universal healthcare system in Canada (Olden, et al., 2018). Financial barriers to treatment are commonly noted in the uninsured population of the United States (Ali, Teich & Mutter, 2016; Browne, et al., 2016). In a study by Gueta (2017), women noted that economic hardship, lack of social support, immigration status, and being postpartum acted as barriers to treatment. Financial barriers to treatment act to prevent men and women from accessing necessary services.

Other barriers limit accessibility to care for individuals seeking treatment for OUD including police presence around clinics, inadequate number of providers accepting new patients, and untimely access to treatment services (Olding, et al., 2018). Individuals experiencing these barriers may find it difficult to access care and continue to use substances. In contrast, Muthulingam et al. (2019) found that the side effects of both

methadone and buprenorphine acted as barriers to ORT. Switching to buprenorphine either from illicit opioids or methadone, resulted in experiencing moderate withdrawal symptoms for a period of seven to ten-days. Noted barriers to treatment with ORT included the inconvenience of daily treatment requirements with short acting ORT (methadone) and unmet expectations of treatment (side effects). Finally, participants in Muthulingam et al. (2019) considered ORT as trading one addiction for another which individuals found frustrating. Each barrier is important to consider as they may play are role in whether individuals' access or persist in treatment for OUD.

A variety of factors contribute to treatment access and retention of individuals with OUD. Individuals in Olding et al. (2018) identified harm reduction or low barrier approaches as supportive treatment practices. Harm reduction includes measures to reduce the harmful effects on health, social, and economic status for individuals who use drugs without requiring them to stop using substances (Government of Canada, 2018c). Low barrier approaches to care improve accessibility by removing barriers to treatment using a non-judgmental approach that does not require abstinence from substances (Carter et al., 2019). Additionally, continuity of care with a trustworthy care provider, centralized access to care needs, and having peer navigators facilitated individuals into treatment (Olding, et al., 2018). In a study by Muthulingam et al. (2019), ORT was considered the most significant facilitator of treatment. Specifically, methadone was seen to relieve withdrawal cravings, improve quality of life, save money, improve employment opportunities, foster and improve familial relationships, reduce legal issues, and omit the need to obtain illegal opioids. A study with only female participants identified custody of

children, treatment availability, social support, and formal financial backing as supportive in their journey to treatment for OUD (Gueta et al., 2017). These supportive practices may help contribute to successful treatment access and retention. Care providers should advocate for practices that facilitate treatment and attempt to mitigate or eliminate practices that deter care access.

Focused Literature Review

Gender-Based Differences Among Methadone Treatment Participants

Both men and women experience OUD. Bawor et al. (2015) examined gender specific issues in methadone treatment in Ontario, Canada. Demographic information, treatment characteristics, psychiatric history, addiction severity, and drug use patterns were determined in a purposive sample of 503 participants to determine different factors effecting men and women. All participants had OUD and were receiving methadone for treatment. Of the sample, 54% were men and 46% women. Reported outcomes included differences in substance use, health, and social functioning among a group receiving MMT for OUD. The researchers used univariate analysis and logistic regression to identify the significant factors affecting both groups in this investigation. For most women, their initial contact with opioids was through a doctor's prescription. The women in the study were younger and had commonly abused both opioids and benzodiazepines in the past three months, while their male counterparts had higher rates of smoking and cannabis use. Substance use was measured using urine toxicology over a three-month period. The findings indicated the following frequency of substance use: 48.5% illicit opioids, 39.6% benzodiazepines, 34.7% cocaine and 23.1% cannabis. Heroin use

decreased in women as a result of increased opioid dependence. Women experienced more psychological and physiological issues compared to men and they reported greater prevalence of family psychiatric history. Additionally, women in the study reported high unemployment rates and children to care for. The comorbidities to OUD and the socioeconomic challenges that women face when enrolled in MMT programs are unique.

Limitations of the study include the cross-sectional design. Disorders such as this are chronic, as is treatment, and would benefit with longer times frames for study. There were also numerous strengths of the study. The large number of participants from 13 sites yielded a robust, geographically diverse sample. In addition, the researchers provided a comprehensive update of characteristic factors of those with OUD using methadone as treatment. The authors identified gender differences in treatment and used urine toxicology with self-reporting to strengthen the report findings. There were considerably more strengths than limitations of this study.

Gender differences also exist in access to MMT in Canada. Bach et al. (2015) examined gender differences in MMT initiation, among a sample of individuals who injected drugs within a community setting. The nature of the study was quantitative using data collected with the Vancouver Injection Drug Users Study. Semi-annual blood samples were drawn, and interviews were completed. The researchers used Cox proportional hazards modelling to examine gender differences in rates of MMT enrollment. A large and diverse group of individuals made up the participant group of 1848 opioid addicted individuals were included in the investigation. Only 32% of participants were female. The authors followed the community recruited sample of

individuals between May 1996 and May 2013. This allowed the authors to determine the time to initiation of treatment with methadone.

The study findings indicated that female participants were younger than men when entering MMT. Being female was also associated with a shorter time from first opioid use to time of entry into treatment. The authors speculate that this is related to the unique bio-psycho-social aspects associated with addiction in women. Pregnancy and heroin use were also identified as factors strongly associated with initiating MMT.

There are limitations and strengths to this research. The disproportionate number of males to females is a noted limitation of the study. The study was based on self-reported data on methadone initiation, drug use patterns, sex work involvement, and housing. The use of self-reports can contribute to under or over reporting. Strengths of this research include the large number of participants and that the participants were from a group receiving community-based methadone treatment rather than impatient treatment. As well, the results of the study demonstrate differences in behavior related to MMT highlighting the need for gender-based recruitment and retention in care.

Understanding the predictors of retention and opioid abstinence during MMT is important to support patients entering MMT and to reduce their drug use. Levine et al. (2015) performed regression analysis stratified by gender with a convenience sample of 290 individuals (173 males, 117 females) admitted to outpatient MMT at an urban university affiliated program in the United States. The authors conducted the study to determine if predictors of retention and abstinence during MMT were different for men and women. The marker of one year in treatment was considered treatment success; urine

drug screens were taken initially to determine intake values and were included in the study analysis. The findings indicated that gender itself did not predict treatment retention. Methadone dose was not significantly related to opioid abstinence or treatment retention, in either gender. However, the predictors of MMT retention and long-term abstinence differed between men and women. For men, significant predictors of greater than one-year retention in MMT included urine samples negative for opioids and cannabinoids during the first month and not being cocaine dependent. Predictors of greater long-term opioid abstinence for men were first month urine samples that were negative for opioids and cocaine. First month urine samples that were negative for cocaine and cannabinoids; and no history of sexual victimization were significant predictors of greater than one-year retention in MMT for women. Sexual abuse had an impact on treatment outcomes for women. It is necessary to address the psychological impact of victimization experienced by women, to promote treatment retention. The only significant predictor of greater long-term opioid abstinence for women was first month opioid free urine samples. These differences noted between genders warrants further understanding; in order to support individuals to persist in treatment and be abstinent from other drugs that can impede their treatment success.

There are several limitations to the study by Levine et al. (2015). The first limitation is that the intake data that was collected was not detailed enough to provide a clear understanding of the characteristics of the sample. Future studies should focus on extrapolating details about each variable. The second limitation is the low retention rate. The rate was 39% which is lower than anticipated by the authors. They suggest that the

older age of the sample, fifty years of age on average, and higher amounts of previous attempts to complete treatment may have resulted in influence the low retention rates. However, this study is one of the few that has investigated differences in the variables of treatment retention and opioid abstinence between genders. The findings suggest gender specific, targeted interventions to prevent treatment failure and inform policies.

Outcomes of MMT among those using other illicit drugs are an important consideration. Understanding gender differences in the use of cannabis during methadone treatment is the focus of a study by Zielinski et al. (2017). The researchers performed multivariable logistic regression analysis to determine gender differences in the association between any cannabis use and illicit opioid use. A convenience sample of 414 men and 363 women with opioid use disorder (OUD) who were receiving MMT were recruited for participation in the study from sixteen Canadian Addiction Treatment Centre site in Ontario, Canada. The quantitative method of multiple logistic regression allowed for a comparison between groups, by gender, on cannabis, and opioid use. Other methods of analysis would not allow for this type of comparison. Data was collected using self-reports by participants regarding demographic information and drug use, and urinalysis to detect for cannabis and illicit opioid use.

The findings of the study indicated that there were gender differences in the association of methadone treatment and cannabis use. Men used more cannabis than women in the past thirty days; but women experienced significantly worse physical and psychological functioning compared to men. The use of cannabis during MMT was found to be a predictor of illicit opioid use in women. The authors indicate that cannabis use is a

gender specific predictor of poor outcomes during MMT. Further, they suggest systematic screening for cannabis use in women with OUD promotes better outcomes of treatment because it can be used to initiate addiction counselling for illicit drug use and psychological issues.

There are limitations and strengths of the Zielinski et al. (2017) study to consider. The cross-sectional nature of the study limits the authors from making causal inferences. Also, self-reported data on cannabis use by participants may lack accuracy because of short-term memory loss among chronic cannabis users. Nonetheless, this was the largest study of its kind to investigate the relationship between cannabis used and illicit opioid use in men and women on MMT.

Other research has compared psychosocial factors affecting men and women in MMT. Polenick et al. (2019) investigated loneliness and illicit opioid use among MMT patients. The study included a convenience sample of 371 participants, from four opioid treatment programs, in southern New England and the Pacific Northwest. Participants completed self-reports that included sociodemographic and health information, loneliness, illicit opioid use, and MMT characteristics. Logistic regressions were then performed to investigate the relationship between odds of illicit opioid use in the past month and perceived loneliness. Using these methods, the authors determined if illicit opioid use and loneliness varied by gender.

The results of the study indicated that both men and women used opioids during MMT and reported experiencing loneliness. One third of participants reported use of illicit opioids during the month and one quarter reported severe loneliness. However,

gender modified the outcomes of illicit opioid use and loneliness differently. Women who reported severe loneliness were three times more likely to use illicit opioids while in MMT, compared to those reporting little or no loneliness or moderate loneliness. Whereas, men reported illicit opioid use when they had little or no loneliness versus moderate or severe loneliness. Therefore, the researchers offer that a better understanding of the relationship between loneliness and illicit opioid use, in women receiving MMT for OUD, would support effective treatment to sustain recovery. Limitations of the study include the inability to make causal associations due to cross-sectional analysis. Additionally, a convenience sample of self-selected participants and self-reported data may introduce bias in the findings. While the researchers controlled for marital status, they did not consider living conditions and relationship quality; which may play a role in drug use and loneliness. A final limitation for consideration is that of missing data. Missing data for loneliness and depressive symptoms were 10% and 11% respectively; potentially indicating that those who experience these feelings may have been less likely to report them. This could indicate bias in the data collection with those experiencing severe symptoms not represented in the data. Strengths of the study include a large sample from multiple sites. As well, participants from wide range of ages participated in the study. Numerous characteristics were included in the analysis and gender differences in the statistical comparisons. The method of multivariate analysis controlled for many confounding variables; to ensure that the resulting relationship between illicit opioid use and loneliness in women in MMT was valid.

Synthesis. The studies of gender-based differences in methadone treatment contain similarities and differences. All the studies had ample sample sizes to draw conclusions from the data. Further, many of the studies include data from multiple sites (Bawor et al., 2015; Polenick et al., 2019; Zielinski et al., 2017). All the research studies have more men than women represented in the sample. In fact, Bach et al. (2015) has only 32% female representations. Women were younger and entered treatment sooner than men in the studies by Bach et al. and Bawor et al. (2015). Yet, what leads to their early initiation of treatment was not determined. More men than women continue to enter MMT, however, the demographics of opioid addiction are changing.

The five studies utilized quantitative methods of analysis; most of the studies used regression analysis (Bawor et al., 2015; Levine et al., 2015; Polenick et al., 2019; Zielinski et al., 2017) and many used self-reporting for data collection (Bach et al., 2015; Bawor et al., 2015; Polenick, et al., 2019; Zielinski et al., 2017). Studies using qualitative methodology to describe men's and women's perspectives on methadone treatment were absent in the literature.

Among the research reviewed, several unique outcomes were found. In both Canadian and American studies there was an increased prevalence of physiological and psychological issues in women entering treatment (Bawor et al., 2015; Levine et al., 2015; Polenick et al., 2017; Zielinski et al., 2017). For example, findings from Levine et al. (2015) included the negative relationship between sexual abuse history and MMT outcomes. Whereas, Zielinski et al. (2017) reported cannabis use among women as a predictor of poor MMT outcomes. Similarly, Polenick et al. (2019) related severe

loneliness in women with illicit opioid use during MMT. Using illicit opioids during MMT can lead to poor outcomes during treatment. The findings indicate that certain psychosocial and behavioral factors influencing the successful completion of MMT are unique to women.

Three of the studies are Canadian where healthcare provision is provincially and federally funded (Bach et al., 2015; Bawor et al., 2015; Zielinski et al., 2017); two of the studies were from the United States where healthcare is mostly privatized (Levine et al., 2015; Polenick et al., 2019). Yet, in the two Canadian studies, women experienced higher unemployment rates and the responsibility of children to care for which may challenge womens' ability to access healthcare services and obtain extended healthcare coverage through an employer (Bach et al., 2015; Bawor et al., 2015). Thus, the role of healthcare systems in treatment success requires further exploration.

Perspectives of Women in Treatment for OUD

The trajectory from addiction to treatment for opioid addiction is not well understood. Women with OUD begin by either using illicit opioids or transition from medically prescribed opioids to using illicit opioids to manage their addiction symptoms (Marks & Leukefeld, 2017). Marks and Leukefeld (2017) examined strength-based factors that support women in recovery from non-medically prescribed prescription opioid use, in a recovery framework. The focus of the strength-based factors was on physical health. Self-reported secondary data from Kentucky's Targeted Assessment Program was used in the analysis. The purposive sample of 1,247 women self-identified as having problematic non-medical prescription opioid use. Participants had also been

identified as having substance use as a barrier to self-sufficiency and had completed pre-treatment services for substance abuse. Bivariate and logistic regression analysis was used to analyze whether physical health and access to health services were associated with substance-related behavior change when pre-treatment was completed.

The authors found that the healthier women reported they were, the more likely they were to engage in substance-related behavior change (i.e. taking action to change problematic substance use). Women engaged in substance-related behavior change, reported better health and less pain than those who were not engaged in change. All women in the study indicated that access to healthcare services was a significant barrier but especially those with a low income. Forty percent of women in the study reported issues with accessing health insurance, a clinic, health center or physician. Women receiving additional financial support through various government services were more likely to participate in substance-related behavior change, than those who were not. Women's physical health was directly related to participation in substance related behavior change, but health service accessibility was a problematic.

This study had several limitations. Retrospective analysis and self-reporting limits the reliability of the findings. However, the study provides important insight as to women's perceptions of their health, which can directly influence their resilience (Marks & Leukefeld, 2017). The study was also limited by the homogeneity of race of participants; most participants were white (96.2% in the no behavior change group and 95.7% in the behavior change group). Another limitation is that the data from the study is from one point in time and neglects to consider that health is a continuum, changing

throughout one's life. Finally, only physical health was considered as a strength-based aspect of recovery, neglecting other strengths that women may possess that positively influence their journey to recovery. Despite these limitations, strengths of the study were evident.

The study sheds light on the importance of accessibility of healthcare services. Access to health services was a barrier for low income participants. According to the authors, health insurance is a critical factor for women's treatment of OUD. The research findings support previous findings in women's health literature that impoverished women with non-medical prescription opioid use experience limited healthcare service access (Larson et al., 2005; Rosenblum et al., 2003). Finally, the findings provide evidence of the strength-based factors of women experiencing this phenomenon. These strengths are essential to women's recovery and health behavior change.

Understanding the process of moving from using opioids to OUD and then recovery is the focus of a study by Rubio (2016). The researchers examined women's experiences from their perspective using an interpretive phenomenological approach (IPA). The authors focused on reasons for using drugs, entering recovery, the choice of methadone, and treatment experiences. Individual interviews were performed with a purposive sample of 13 women from an outpatient methadone treatment clinic in the southern United States. Women's experiences were collected using interviews. Three major themes were developed from the data: the journey of addiction, the tipping point and perceptions of methadone. In their journey to addiction, women identified a moment when they began to use drugs. Contributors commonly included stressors, peer pressure,

as triggers that began their addiction. Drug experiences all began positive, according to the women, and eventually spiraled out of control, leading to addiction and treatment. Each of the trigger events were unanimously extrinsic. The tipping point included a "rock bottom" event that was a choice they made, or others made for them. Wanting to have their normal life back was a common thread among participants entering treatment. Finally, perceptions of methadone were mixed; both positive and negative experiences were described. Nine of the 13 participants felt that methadone treatment was a positive experience to get back to a "normal life". Two of the participants had mixed feelings about methadone treatment and two others had entirely negative views. One of the two participants with negative feelings described methadone as evil, a trap and a money grab.

Limitations in this study are related to the methods used for conducting research. By using purposive sampling and a smaller sample size, the generalizability of the findings is limited. However, the purpose of the study is not generalizability; it was to develop a deeper understanding of women's experiences. The research is performed in a large urban center in the United States. Finally, participants were from a fee-for-service clinic which limits the participant pool to those who can afford to pay for care. Due to the interpretive phenomenological methodology of the study, the experiences of women through their own words and phrasing were brought to the fore. The statements made captured the uniqueness of the experience for each of the 13 participants. This research provides important insights that may not have been discovered using an alternate methodology.

Farrell-MacDonald et al. (2014) examined the return to custody rates of three convenience samples (n=137) of Canadian federal women offenders, with problematic opioid use. This quantitative study used the Cox proportional hazards model to determine the time to return to custody and Pearson's X or ANOVA to determine associations between the sample group and study variables. The control group, those who did not receive MMT while incarcerated was compared to those who received MMT while incarcerated. Women in this study, who received MMT while incarcerated and continued MMT once transitioned into the community, were less likely to return to custody. Some continued to use MMT post transition into the community, while others did not. The group that continued MMT post transition into community programs had much lower rates of return to custody. This finding suggests that community MMT is an effective measure to reduce crime and improve opioid recovery in women. This study suggests that MMT acts as a support to women opioid users, who leave the custody of the correctional system in Canada.

This study had several limitations. The study sample was small and only offenders who had community-based urinalysis data available were included in the study. Since women offenders are not required to share treatment information once released, the measure of urinalysis as evidence of participation in community MMT are flawed and the findings of the study may inadvertently be biased. Length of time participants were in MMT prior to and after release was not included in the study but may have been helpful in explaining study outcomes. Finally, the potential benefits of illegitimate use of MMT, those who used methadone to get high rather than for treatment uses were not considered

in the study. Strengths of the study included the finding that return to custody rates were lower in the MMT group that continued treatment into the community. Additionally, the design of the study included comparison of three groups including a group of women offenders identified as having a substance use problem that was predominately opioid related. The study took place in Canada where MMT is available free of charge to federal Canadian women offenders.

Synthesis. In the studies by Rubio (2016) and Marks and Leukfeld (2017), OUD and was influenced by a variety of factors. According to Rubio, the journey of addiction included triggers such as family stressors and peer pressure, especially from a male significant other. However, when women reach a tipping point, which they can relate to a specific event, they seek recovery for opioid use. Poverty, poor physical health, and lack of access to health services contribute women's addiction experiences including OUD (Marks & Leukfeld, 2017). The healthier women were, the more likely they were to participate in substance related behavior change which can include methadone treatment (Marks & Leukfeld, 2017). Rubio describes the time when women choose to change addiction behavior as the tipping point. Strength based factors noted in Marks and Leukfeld including resilience and positive perceptions of quality of life can positively influence women's recovery from OUD.

Women offenders had varied experiences with MMT. Farrell-MacDonald et al. (2014) found that some women chose MMT while incarcerated while others did not. According to the themes identified in Rubio (2016), some women reached a tipping point while incarcerated while others did not. Some of the women who chose MMT while

incarcerated chose not to continue MMT once transitioned into the community (Farrell-MacDonald et al., 2014). What factors influenced these results are unknown. Incarcerated women are a unique group receiving MMT.

Differences in the methodology of the studies provided unique insight into women with OUD and their treatment. The phenomenological methodology of Rubio's (2016) study gave insightful descriptions of women's experiences with methadone: positive, negative, and indifferent. Marks and Leukfeld (2017) and Farrell-McDonald et al. (2014) both utilized quantitative designs. Marks and Leukfeld's quantitative study sheds light on how women's strengths that supports recovery from OUD and the barriers that they experience. Farrell-McDonald et al.'s (2014) quantitative study offers that women who continue to use methadone when transitioned into the community are less likely to return to custody than those who do not. Marks and Leukfeld investigated outcomes for a variety of factors of a large sample and Rubio concentrated on the experiences of a very small and specific group of women. Farrell-McDonald et al.'s quantitative study had a relatively small sample size; participants were separated into three groups for comparison. Rubio and Marks and Leukfeld's study relied on self-reported data for analysis. Farrell-McDonald et al. evaluated community-based urinalysis results and reports from Corrections Services of Canada data, removing the limitation of self-reporting. The chosen methodologies provide a unique perspective on women's experiences of methadone treatment for OUD but are very different in their approach and findings. This may be an indication of why there is little consensus on the most effective practices to support woman's access, retention, and successful completion of MMT.

Perspectives of Mothers in Methadone Treatment

Many women who receive methadone treatment are also mothers. Using phenomenological qualitative methodology, Letourneau et al. (2013) conducted a study in Atlantic, Canada. They examined the experiences of mothers, who are receiving MMT and their relationships with care providers to better understand the effects on parenting. A second aim was to gain knowledge of the impact of MMT on mother-child relationships, in order to facilitate retention in MMT. Twelve women in a community MMT program and six of the care providers participated in semi structured interviews. A mix of convenience, snowball, and word of mouth strategies were used to recruit the participants. Themes and sub-themes emerged after interviews that focused on answering the research questions.

In their study, Letourneau et al. (2013) found that accessibility, safe childcare, and family responsibilities act as barriers to mothers participating in MMT. Parent and family-based interventions were identified by women to help support and build relationships with their children and assist the children to understand the parent's addiction. The women in the study reported that they relied predominately on friends and family for support and then community, and social supports. Finally, the women discussed service provision preferences, including individual counseling, to address more sensitive issues; followed by group sessions to receive support from other mothers. Telephone access to service provider support was indorsed by women in the study. The findings of the research identify specific needs of mothers to attend and persist in MMT, from their perspective.

Themes identified in this qualitative study were trajectory of addiction and treatment, parenting and parent-child relationships, and support needs and preferences. The article provides excellent insight of the facilitators and barriers associated with being a mother and attending MMT. A strength of this research was the use of triangulation of the data by source. Mothers in MMT, service providers and researchers reviewed the data for accuracy enhancing the value and validity of the study outcomes. However, women in methadone treatment for OUD can come from a variety of backgrounds and experiences. A limitation of Letourneau et al.'s (2013) study was that participants were unanimously white. Responses from both groups, mothers and service providers, shared commonalities which led the researchers to believe the themes were accurate. The study was published six years ago, and the findings may not still be relevant due to changes in the demographic of those using opioid drugs (Hedegaard et al., 2018) and legislation surrounding opioids that has changed over time. This legislation includes Bill C-32 which incorporates several amendments from the Controlled Drugs and Substances Act like making the application for safe injection sites more accessible, changes to offences and penalties, and amending regulation-making authorities (Canadian Centre on Substance Abuse and Addiction, 2017). Limitations of the study's design and age warrant consideration.

Mothers, who use opioid drugs, may find themselves faced with concerns from CPS. Falletta et al. (2018), using general qualitative methods, examined currently or recently pregnant women's perceptions about CPS. Convenience sampling was used and 16 women from a drug treatment facility in Ohio, USA, participated in the study. The

authors performed semi structured interviews with each woman. Themes and sub-themes were identified in the data. Two primary themes appeared. The themes were: participants' feelings/emotions about CPS and interaction-based perceptions of CPS functions and performance. It is evident in the findings, that mothers had strong feelings related to CPS.

While they were receiving substance abuse treatment, women's feelings about CPS involvement were varied. On the one hand, many women saw CPS positively; especially when the outcomes of the involvement ended favorably. CPS involvement was an opportunity for children to be cared for while mothers attended treatment to recover. One participant indicated that CPS removing her child from her care was beneficial to her in that she was able to focus on and be successful in treatment for OUD. Case workers who listened and were not judgmental facilitated mothers' involvement in services including OUD treatment. On the other hand, some of the women feared CPS involvement; which in turn acted as a barrier to receiving treatment. One participant considered detoxing and birthing her child at home to avoid seeking treatment for OUD and inevitably having CPS involved. Insincere and negative attitudes of CPS workers facilitated womens' disengagement from services including treatment for OUD.

Study limitations include the small sample size. Although the sample size was 16, the intent of the research was not to generalize, and the researchers felt that they reached saturation to identify themes in the responses. Additionally, the participants were from a small geographic area presenting with context specific issues. Women from other geographical areas with differing contexts may have very different experiences and perceptions of CPS; future research will need to be pursued in different areas and

contexts. A final limitation of this research is that participants had both opened and closed cases with CPS. Responses may be limited based on their current or past involvement with CPS and therefore may differ.

A strength of this research is that by understanding participants perceptions of CPS, women can be encouraged into treatment. Facilitating addiction care of women who are pregnant or have recently been pregnant can occur if their fears of CPS involvement can be alleviated. Another strength of this research is that it is part of a larger mixed methods study that will elaborate on the issues of women's experiences of CPS when in treatment for OUD. The qualitative nature of this part of the larger study allows for important insights of how women perceive CPS. Obtaining this information would have been difficult using other methods. A final strength of this research is the number of participants in the study. Saturation was achieved due to having enough participants to reach that end.

Initiating and engaging with methadone treatment among pregnant and postpartum women was the focus of another study. Mattocks et al. (2017) explored the perceptions of experiences and challenges with MMT and obstetrical care among pregnant and postpartum women enrolled in a methadone maintenance program. Grounded theory approach was used, and the data was collected using two focus groups at a methadone maintenance clinic in a large urban area in Worcester, Massachusetts. A convenience sample of 14 women participated in the focus groups; five of the women were pregnant and nine were postpartum. Eighty percent of the participants were

Caucasian, and 20% were Hispanic/Latino ethnicity. The interviews were completed during the regular scheduled support group times at the addiction treatment center.

Five themes emerged from the study. First, guilt along with fear of negative outcomes for their infants, determines women's MMT decisions. Women were concerned with the withdrawal symptoms their babies would experience when born, due to their methadone treatment during pregnancy. Although the women understood the importance of continuing or starting methadone when pregnant, they considered alternative recovery strategies other than methadone. Second, finding an obstetrician with experience treating women receiving MMT can be challenging. Some women in the study found that obstetricians would refuse care due to their MMT. Some physicians admitted that they had little knowledge and experience caring for pregnant women on MMT. Stigma amongst care providers was also noted among women. Third, methadone clinic physicians are instrumental in helping women find the right methadone dose during pregnancy. Physicians needed to adjust the dose of methadone for pregnant and post-partum women. This caused anxiety for some women due to fear of effects on the fetus. Additionally, women experienced some difficulty distinguishing symptoms of withdrawal and pregnancy symptoms. Overall, women noticed significant improvement when doses were titrated properly by physicians. Fourth, some of the women in the study expressed strong preferences for methadone over buprenorphine. One woman expressed that her preference for methadone was due to having someone else administer it. Others expressed preference for methadone due to experiencing sickness while on buprenorphine. Fifth, women experience substantial substance abuse treatment challenges

after delivery. Women expressed the challenge of having to travel back and forth each day from the neonatal intensive care unit and methadone treatment. Other post-partum treatment challenges included finding the right dose of methadone while experiencing hormone changes and suffering from post-partum depression while trying to maintain methadone treatment. Each of these themes derived from women's responses directly affect the women's ability to access and utilize methadone while in the perinatal period.

Limitations exist in this study. The study takes place in a large urban setting, an investigation in rural setting may yield different results. Another limitation is that women may not have felt completely comfortable disclosing information in a focus group; individual interviews may have yielded more intimate experiences. Despite the noted limitations, there are strengths of this study. This study supports the idea that a multidisciplinary approach is beneficial to women in addiction recovery. Further, the study findings shed light on the fact that obstetricians need to be knowledgeable of the treatment options of women experiencing OUD.

The experience of addiction and the process of recovery for women with children must be understood to effectively engage them in MMT. Secco et al. (2014), performed a mixed methods study with a convenience sample of 12 mothers who had been in methadone treatment for three months or more. The quantitative analysis was completed using three separate tools to evaluate strengths, stress, and parenting. Interviews using open ended questions were performed for the qualitative portion of the study. The authors describe characteristics of mothers who successfully engaged in MMT and how addiction and MMT affect mothering and the mother child relationship. The qualitative aspect of

the study focuses on mothers' perspectives of their experiences of mothering and the mother-child relationship during addiction, MMT and recovery. The study was completed in New Brunswick, Canada.

Maternal identity and the mother-child relationship played a pivotal role in the mothers' choice to enter MMT and begin recovery. Findings indicated that women had more strengths than stressors, high social support, and better family functioning. Yet, mothers in the study struggled with high depressive symptoms, difficult life circumstances, and family dysfunction. Three themes emerged from the data: diminished maternal identity, choice for mothering, and redefined maternal identity. The authors explained that during addiction the mothers' limited in their ability to care for their children. Interrupted mothering occurred due to physical removal of the child from the mother or from the inability of the mother to care for children due to illness caused by withdrawal. The second theme occurred when mothers eventually chose to begin recovery using MMT. Mothers indicated that they made the choice in order to retain custody of children and build relationships with children. Restored maternal identity occurred with successful MMT and recovery which allowed mothers to lose their preoccupation with drugs and enhance their performed mothering and mother-child relationships. Unfortunately, some never reached this stage of relationship recovery. This study yielded insights into mothers' characteristics of strengths, stress and parenting as well as mothers' experiences in MMT.

Limitations included the homogeneity of the sample and the small sample size. The mixed method design used in the study is a strength because it allowed for

triangulation of qualitative and quantitative findings confirming the strengths, stresses, and experiences of mothers in MMT.

Synthesis. Similarities exist between each study on perspectives of mothers in methadone treatment. All four studies utilized qualitative methodology and homogeneity of the samples was consistent; each study contained predominately or completely white participants. Consistency was also noted in the study's findings. Mothers in Falletta et al. (2018) identified fears of removal of their children by CPS as a barrier to accessing MMT. In fact, some of the mothers attempted to detox on their own due to these fears, often leading to failure to recover. Participants in Mattocks et al. (2017) also attempted to detox on their own, but their attempts were out of concern for infants' withdrawal symptoms rather than CPS. Sicco et al. (2014) indicated their desire to enter MMT to retain custody of children. However, fear of removal of children was not mentioned in detail by participants. Services that involve the entire family are emphasized by Letourneau et al. (2013) but there is no mention of CPS.

Letourneau et al. (2013) and Falletta et al. (2018) noted the need to access outside resources for support with the families. Letourneau et al. indicated that partnerships with community agencies that provide parenting support and education, specifically, for women attempting to recover from addiction, would be essential. Sicco et al. (2014) also indicated the need for social support and parenting assistance to support mothers into early engagement with MMT. As well, these authors note the importance of family functioning and support on mothers' experiences in MMT. Similarly, participants in Falletta et al. reported the need to integrate services and provide essential resources to

women in addiction recovery. Referrals to community agencies for a variety of resources including healthcare, counselling, and employment assistance were identified by participants. Community and service providers were viewed as vital supportive elements to recovery. In fact, Mattocks et al. (2017) noted the essential supportive relationship between the patient and provider as vital element of support throughout pregnancy and post-partum period for women. All articles reported on the influence of interactions with others in the community as either encouraging or discouraging their recovery experiences as women and mothers.

All four of the studies utilized qualitative methods. Yet, differences exist between the studies. Sicco et al. (2014) utilized mixed methods including both qualitative and quantitative aspects. However, Mattocks et al. (2017) was the only research that performed focus groups, all other studies performed individual interviews. Although each study uses a different qualitative methodology, the foundation of qualitative studies is the same; it is descriptive or interpretive and focused on meaning and building an understanding of phenomenon. Participants in Falletta et al. (2018) and Mattocks et al. (2017) were from geographically small areas in the United States where healthcare is privatized. Participants in Letourneau et al. (2013) and Sicco et al., were from Atlantic Canada consisting of small east coast provinces where there is public healthcare. The articles were similar in many ways but were diverse in each qualitative method and focus.

Summary & Conclusions

Woman in Canada are experiencing OUD at an alarming rate (Government of Canada, 2019). Further, opioid related morbidity and mortality rates are also increasing

for women. Despite this growing problem, few women enter treatment for OUD. This is particularly perplexing due to socialized healthcare in Canada making treatment free to many who wish to receive it, removing the financial barrier to treatment. Still, women experience addiction differently than men (Bawor et al., 2015). Yet, there is a deficiency of research on women's experiences with treatment. Specifically, Canadian women's perspectives on their experiences in methadone treatment is absent in the literature. This absence of vital information in the literature contributes to a lack of evidence in which to determine the most effective practices in women's addiction care.

The studies in this literature review exhibit consistencies and inconsistencies in their methods. Seven of the 12 articles in the literature review utilized quantitative methods to analyze their data. All seven of the articles used regression analysis to determine the relationship between two or more variables. Self-reported data was used in all but one of the quantitative studies. Each of the studies had ample sample sizes to reach power and to make predictions about their findings. Each of the studies contributed to our understanding of MMT and OUD in women. Five of the studies in the literature review utilized qualitative analysis methods. However, there was diversity in their methods. Rubio (2016) used a phenomenological approach; Falletta et al. (2018) and Letourneau et al. (2013) used a general qualitative approach, however, Falletta et al. used this approach as part of a mixed methods study; and Mattocks et al. (2017) used grounded theory approach when analyzing their data. Each of the studies reported homogenous groups of participants with ample number of participants to reach saturation and provide insights from participant experiences. All studies except Mattocks et al. used interviews for data

collection: Mattocks used focus groups to collect data in their study. The qualitative studies were varied in their approaches and provided information regarding experiences of OUD and MMT in women.

There were equal numbers of Canadian and American studies. Yet, only one of the studies found for this literature review considered the perspective of women with OUD using methadone (Rubio, 2016). That study took place in a large urban city in Texas, USA; no Canadian studies have addressed this issue. The results from Rubio (2016) cannot be assumed to be consistent in a Canadian context due to differences in various factors including the healthcare systems. Nevertheless, in both Canadian and American studies issues of poverty, health, and access to healthcare services were identified as contributors to women's addiction experiences (Bach et al., 2015; Bawor et al., 2015; Letourneau et al., 2013; Marks & Leukfeld, 2017). Studies must be considered in the context of their geographical location. Differences attributable to location can contribute to differences in participant outcomes.

The studies in this literature review exhibit consistencies and inconsistencies in their findings. Several of the studies noted the importance of resources to attain successful MMT outcomes in the community (Falletta et al., 2018; Farrell-McDonald et al., 2014; Letourneau et al., 2013; Mattocks et al., 2017; Sicco et al., 2014). The researchers determined that continuing with methadone once released from custody; providing support for parenting; recovery that involved families and social support; all involved outside resources that were essential in supporting women into recovery and retaining them. Individual relationships were also seen as important factors in the

trajectory of MMT for women. In fact, Polenick et al. (2019) reported that interpersonal relationships contribute by facilitating or hampering recovery and should be seriously considered in recovery care. Mattocks et al. (2017) regarded the relationship between service providers and patients as essential in the recovery process. Similarly, Letourneau et al. (2013) and Bawor et al. (2015), noted that women initiated opioid use after seeking care from a healthcare provider for a medical condition. Many of the women in Rubio (2016) described relationships with others as key to their initiation into opioid use; including family stressors and peer pressure most noted from a male significant other. However, in Levine et al. (2015) many women reported experiencing interpersonal abuse at some point in their lifetime. Interpersonal abuse negatively influenced MMT outcomes for women in the study and requires intervention to mitigate the negative effects. Relationships with children encouraged women into MMT (Sicco et al., 2014) or created fears for their removal which led them to avoid seeking treatment (Falletta et al., 2018). In fact, pregnancy itself is associated with increased MMT enrollment in women (Bach et al., 2015). Relationships had significant effects on women's MMT experiences and decisions.

Perspectives on methadone treatment were mixed among women. Two of the 13 participants in Rubio (2016) expressed feelings toward methadone that were negative calling methadone a 'trap' and 'money maker'. The participants did not want to remain on methadone for any length of time. Conversely, the remaining participants in this study had predominantly positive comments regarding methadone. Mothers in Mattocks et al. (2014) had concerns about the use of methadone during pregnancy and sought to detox

independently to avoid their babies having to experience withdrawal symptoms. Whereas, participants in Letourneau et al. (2013) offered that MMT strengthened their relationships and improved their parenting. Perspectives on methadone varied among women. Women's perspectives contribute to whether they choose treatment.

Other similarities among the articles existed including demographic variables for women. Studies Zielinski et al. (2017) and Bawor et al. (2015) found that women with OUD experienced more physiological and psychological symptoms then men. Moreover, several studies found that women entered MMT sooner, during their trajectory of addiction and younger than men (Bach et al., 2015; Bawor et al., 2015; Polenick et al., 2019). Each of these factors contributes to women's experiences in SUD care. The demographic composition of women who enter treatment is unique. Therefore, it is important to examine how to develop practices that are gender specific and encourage women to enter and remain in treatment.

Resources, relationships, characteristics of methadone, and unique demographic characteristics of women contribute to their experience with MMT. Yet, there is little consistency regarding treatment needs with methadone for women experiencing OUD (Rice et al., 2018). Further, gender specific care is not consistently provided. Gaps exist in the knowledge of how women in Canada experience addiction, choose to enter recovery and seek methadone for treatment. Understanding these aspects help to provide comprehensive gender specific care to this unique population. Research that examines this chronic issue, from the human perspective, provides insight for understanding the needs of women with OUD, who choose methadone treatment. The trajectory from

opioid use, to treatment, facilitates understanding of how to support women into treatment and encourage them to persist. Therefore, filling a gap that exists in the literature contributes to providing optimal care for women with OUD who choose methadone for treatment.

Chapter 3: Research Method

Introduction

The purpose of this study was to describe the lived experiences of women with opioid use disorder who are receiving methadone as their treatment of choice. By understanding their experience more fully, from their perspective, nurses and healthcare professionals can provide women with individualized health promotion strategies and treatment (Rubio, 2016). This study provides insights that may lead to further research and eventually to better outcomes for women experiencing OUD, thus improving their quality of life. The research question was addressed by using interpretive phenomenological methodology, which elicits insights and experiences from the participants. Interviews and field notes were utilized to develop an understanding of women's experiences. This chapter describes the research design and its justification, the sample selection and measures for ethical protection, and finally, the methodology for collecting and analyzing the data.

Research Design and Rationale

There is a gap in knowledge regarding women's experiences with OUD and their choice of methadone for treatment in Central Canada. Although one American study addresses this issue (Rubio, 2016), the healthcare systems between the countries differ greatly. The Canadian healthcare system is socialized, allowing access to healthcare services at no cost to any Canadian citizen; the American healthcare system is largely privatized. As such, the experiences of women as described in the research conducted in the United States may be substantially different from those of women receiving treatment

in Canada. The following research question was developed to investigate this gap: What are the lived experiences of Canadian women with opioid use disorder who choose methadone for treatment?

The central phenomenon was the experiences of Canadian women with OUD who choose methadone treatment. The focus of the study was women's experiences from their perspective to develop a deeper understanding of this phenomenon. From first experiences with opioids to experiencing addiction, seeking help and how this experience affected them or those around them was addressed by participants. Participants determined what their experience was and how they wanted to convey it. Once responses were gathered, findings were interpreted. The data from responses helped to develop my understanding of how women experienced OUD and treatment.

A qualitative, interpretive phenomenological design was the best approach to investigate the lived experiences of women and give meaning to their responses. Through the research question, I gathered detailed descriptions of women's experiences. Using this data, I interpreted responses by naming the data and isolating themes (Smith et al., 2009). Interpretive phenomenology is focused on the subjective human experience, which reflects the research question. Qualitative research, as a tradition, has an ontological understanding that the world is socially constructed, complicated and fluid in nature (Glesne, 1999). In qualitative research, subjectivity, experiences of the life-world, and in-depth descriptions of experiences are foundational. Interpretive phenomenology focuses on normally hidden human experiences of the life-world and how individuals experience it (Lopez & Willis, 2004). The term *life-world* is used to indicate the inseparable nature

of an individual's reality and the world they live in. Thus, responses to research questions are narratives of individual experiences from everyday life. Additionally, a central concept in interpretive phenomenology is situated freedom, which indicates that all individuals are free to decide their actions but are subject to conditions of their lives (Lopez & Willis, 2004). From these decisions, meaning arises, as meaning is derived by individuals' being-in-the-world, which is influenced by political, social, and historical contexts and in turn influences their choices (Lopez & Willis, 2004). A final concept considered in interpretive phenomenology is constitutionality (Koch, 1995). The concept implies that findings are a combination of meanings of the investigator and participant. The background of each of these individuals is unique and contributes individually and collectively to the research findings. For this reason, there is no one interpretation of the data, only plausible interpretations justified by participant responses (Annells, 1996).

Performing interpretive phenomenological research requires the investigator to collect data, analyze and interpret the data, and report on the findings (Sloan & Bowe, 2014). The findings of the research with qualitative interpretive phenomenology are a collection of the meanings or essence of lived experiences of individuals (Sloan & Bowe, 2014). The essence of the experience is presented in written form to give voice to the human experience. The investigator has expert knowledge that guides the inquiry and facilitates meaning making in responses (Lopez & Willis). Prior knowledge of the topic and awareness of previous research are essential in conducting interpretive phenomenological inquiry. For this reason, bracketing as a practice to hold back investigators preconceived ideas and bias, contradicts the interpretive tradition.

Other approaches and designs were considered for this study. Quantitative methods were not appropriate for the research question. A narrative approach was not appropriate to the research questions because the focus of narrative research is on stories of experiences, often by individuals, rather than a collective (Patton, 2015). Similarly, a case approach was not applicable because the focus of the research is on a common experience of a variety of women who may not be from a bounded system (Creswell & Poth, 2018). Culture based sharing was not the focus of the study; therefore, ethnography was not the ideal approach (Patton, 2015). Grounded theory was also inappropriate because the intent of the research was not to find themes and develop a theory; rather, the goal was to interpret lived meaning of the experience to develop a deeper understanding. Although a variety of approaches and designs were considered, interpretive phenomenology fostered the most applicable information to address the research question. By using this approach in the study of women with OUD who choose methadone treatment, interpreting meaning and the essence of the experience helped to better understand women's meaning making of this phenomenon.

Role of the Researcher

My role in the study was a researcher–observer. By explaining my role as an observer, the participants were put in the position of experts of their own experiences, which helps manage any power dynamic that may have existed (Lather, 1991). Additionally, the qualitative method of interpretive phenomenology requires that the investigator is an integral part of not only data collection but also the interpretation (Creswell, 2014). The investigator interprets the data while interviewing, observing, and

writing. Because people are intricately situated in the world and cannot be separated from it, acknowledging my experiences and assumptions related to my research topic was important when interviewing, observing, and interpreting the data. Unlike descriptive phenomenology, the researcher does not bracket their experiences—rather these experiences are considered in the research process (Lowes & Prowse, 2003). Personal assumptions must be considered during the research process using a phenomenological approach, which is why I provide an explanation of my personal experiences in the following paragraph.

I have personal experience with SUDs. A close family member experienced SUD throughout my life and sought treatment through a local 90-day inpatient facility. The person continued the journey of recovery, as a member of Alcoholics Anonymous (AA), until death in 2014. For this reason, addiction and recovery were central to my life throughout my childhood, adolescence, and adulthood. Professionally, I have worked in community mental health as a registered nurse, as a clinical instructor for students on psychiatry, and as student advisor and liaison to students for placement in recovery homes and at inpatient mental health facilities. My personal and clinical practice experience has given me a unique perspective and in-depth understanding of SUD and recovery. However, my experience also creates inevitable researcher bias. Specifically, confirmation bias occurs when the researcher interprets data to support their own hypothesis whether consciously or unconsciously (Nickerson, 1998). The researcher can form an early explanation that confirms their previously held beliefs. Due to my experience with substance use, I have beliefs related to substance abuse and individuals

that abuse substances that may cause me to focus on the responses of participants that confirm my beliefs. To manage this, I maintained an analytic memo (Ravitch & Carl, 2016) and used triangulation with my committee to substantiate my research findings. These measures ensured that the reported results were not solely a function of my personal experiences.

Further, no conflict of interest existed related to my role as the researcher in this investigation. The research was conducted at community addictions clinics and pharmacies. I attended one community clinic as a faculty advisor to students only. No contact with patients was ever made at the clinic.

I provided a participation incentive to those who agreed to be interviewed for this study as a token of appreciation for their time. Participant incentives are anything offered to individuals to encourage their participation in a study (Tri-Council Policy Statement, 2018). A concern with incentives is how they influence voluntariness of participation. However, I provided an incentive that was reasonable and not so attractive as to encourage reckless abandon of decision making (Tri-Council Policy Statement, 2018). A $20 gift card was provided to any participant prior to the beginning of the interview. If participants decided at the onset of the interview that they did not wish to participate or after the interview they withdrew consent for their responses to be used, they were still given an incentive. One participant received a gift card and decided to leave the study prior to participating in an interview.

Methodology

Participant Selection Logic

The population of interest for this research investigation was Canadian women who identify as having OUD who are in recovery treatment using methadone for any length of time. A purposeful sampling approach was used to recruit participants who met the pre-determined criteria that were important to the study (Moser & Korstjens, 2018). This type of sampling ensures that participants were information-rich, providing in-depth understanding of the phenomenon (Creswell, 2014; Patton, 2015; Ravitch & Carl, 2016). The inclusion criteria are as follows: adults over 18 years of age and able to understand and speak the English language. Since too few participants responded to participate or met the inclusion criteria, snowball sampling was used to recruit participants through referrals made by those who had already participated in the study (Creswell, 2014; Patton, 2015; Ravitch & Carl, 2016). By recruiting from community addictions treatment centers and local pharmacies, I was be able to ensure that all participants were adults and seeking addiction methadone treatment.

The number of participants was determined by reaching saturation. Determining saturation is an iterative process that requires the researcher to continuously evaluate the data (O'Reilley & Parker, 2012). In qualitative phenomenology, the sample is small and differs between studies (Moser & Korstjens, 2018). Saturation occurs when no new information arises in subsequent interviews. Once the study has collected the maximum information on the phenomenon, data collection is complete. Saturation for data collection shows patterns, categories, and demonstrates variety in the content. Though

posing an exact number of participants is not feasible, in most cases, no more than 10 participants are required for phenomenological inquiry (Moser & Korstjens, 2018).

Study participants were informed of the study and provided contact information through recruitment flyers posted in the community addictions clinics and in local pharmacies. The flyer contained important information including the name of the study, the inclusion criteria for participation, and my contact information. The criteria for participation was females 18 years of age or older who experienced an OUD, understood and spoke English, and were undergoing treatment with methadone, which was assessed when potential participants contacted me. Any individuals who did not meet the criteria were thanked for their interest and dismissed. Once participants arrived at the interview, they were presented with the consent to participate in the study. I offered to read the consent with them to address any literacy concerns and ensure informed participation. Otherwise, participants read the consent form independently. Participants signed the consent form prior to commencement of the interview. If an interview was done by phone, the consent was read to the participant and they responded with "I consent." Participants were recruited by these methods until saturation was determined.

Instrumentation

Data collection occurred using face-to-face interviews and field notes. Interviews are considered a conversation where the interviewer is the sole instrument (Cypress, 2018). Using the responsive interview method, a mutual relationship of trust was formed. A friendly supportive tone was taken with minimal confrontation, and questioning was flexible in nature (Rubin & Rubin, 2012). In phenomenological research, face-to-face, in-

depth interviews are the most common type of data collection method (Moser & Korstjens, 2018). In-depth interviews allow for time and privacy with each person to elicit rich, thick descriptions of their experiences. In-depth interviews addressed the research question, which related to women's experiences. Additionally, an interview guide (Appendix) was used to ensure that all topics could be covered but the interview remained flexible and responsive to the participant (Patton, 2015). The interview guide included open-ended questions as well as detailed questions, follow-up questions, and initial demographic data to describe the sample (Moser & Korstjens, 2018). I created the interview guide maintaining focus on the research question and the conceptual framework. Information gained from the literature review helped formulate questions for the interview guide (Rubin & Rubin, 2012). Finally, questions were revised and reworded based on responses and information gained from the first initial interview and continued to be revised based on subsequent interviews.

As part of data collection, field notes were taken to contribute to the detailed descriptions and environment that are part of data collection. Field notes provided a means to collect needed contextual information from the interview and audio recording the interviews ensured verbatim transcription of responses (Phillippi & Lauderdale, 2018). Immediately after the interview, I wrote field notes that describe the setting, participants, and the interview including each question answered. Finally, I wrote field notes of critical reflection of the overall interview and my performance. Writing field notes of critical analysis helped improve successive interviews by refining questions and

beginning analysis. Using these data collection methods, audiotaping interviews and field notes, I fostered detailed descriptive accounts of participant experiences.

Procedures for Recruitment, Participation, and Data Collection

Data were collected from participants by telephone in-depth interviews. Participants determined the time of the interview within my availability. The location of the interview was intended to be at the addiction treatment center or at the location of the participant's choice if by phone. Two of the centers agreed to allow me use of a private room with a door to conduct interviews with participants, which would have been convenient for participants since they are familiar with the location and would not have had to make an additional trip to the center, thus promoting their comfort. However, this was not acceptable to the participants due to the current COVID-19 pandemic, so I allowed for telephone interviews.

I collected the data using an audio recording device and transcription software purchased for this study. A notepad was used for field notes that needed to be recorded in real time or immediately after the interview to prevent losing important information that may have been otherwise forgotten. One interview was done with each participant. Telephone interviews took between 30 and 90 minutes to perform (Moser & Korstjens, 2018). Allowing the participant to express themselves and divulge their experiences descriptively takes time. Therefore, each interview differed in length, depending on the individual participant. Transcription software was used to record participant responses in real time. An additional audio recording device was also used to ensure accuracy of the transcription. It ensured clarification if any accents or background noises negatively

affected the transcription. It was also a secondary measure to ensure the interview was recorded if the software had failed. When there were not enough participants to reach saturation, I continued with the snowball sampling technique to gain participants. Additionally, a few of the flyers for requesting participants had been taken down, so I put them back up in the clinics and in additional areas with the institutions' permission.

Participants exited the study having received a small token of appreciation for their time in the form of a gift card. Resources for follow-up emotional and psychological support were provided to participants in the event they required them. Phone numbers for a crisis hotline was also given to participants. My contact information was again provided to participants if they had any questions or concerns about the study. Further, if participants were interested in receiving the study results, I offered to send them a copy using my Walden email or hardcopy when it becomes available. Closure was provided at the end of the individual interview by thanking participants and offering the support resources.

Data Analysis Plan

The data collection methods connected to the research question: What are the lived experiences of Canadian women with opioid use disorder; who choose methadone for treatment? The question was most effectively investigated using in depth interviews. Lived experiences were expressed from the individuals' own perspective using their voice. As well, interviews provided a more intimate interaction, where participants could express themselves. Individual interviews, as opposed to focus groups, allowed for privacy between the participant and I. The participant discussed personal in-depth

expressions of their experience; that they may not otherwise have felt comfortable expressing in a group environment. Additionally, individual interviews removed the concern of dominance of one or more participants in a focus group. Each individual participant was given ample time to express themselves which also enabled me to probe and focus eliciting thick and rich descriptions of participant experiences (Rubin & Rubin, 2012).

Field notes compliment interviews. Once interviews were completed, impressions were made with field notes of the entire interview that contributed to my understanding of the phenomenon of interest. Field notes include important information that contributes to answering the research question. When asked about their experiences, participant responses elicited emotional reactions: anger, fear, shame, sadness, pride that were some of the many emotions exhibited by participants. These reactions are not always evident in audio recordings but contributed to my understanding of the individual experience. My own reactions were uncovered and presented. Biases and feelings that were experienced during the interviews were relevant and contributed to my interpretations of the data (Phillippi & Lauderdale, 2018). The environment was also included in field notes. The location of the interview including the neighborhood and the room itself can influence the interview and was recorded. Field notes provided another layer of understanding of participant experiences by providing additional information that may have otherwise been lost by interviews alone.

Once the data was collected, I transcribed the interviews using voice to transcription software called Otter.ai. I used an additional audio recording device to

ensure that all the interviews had been transcribed accurately, by the software. In IPA, the analysis of data is flexible and dynamic focusing on meaning within the responses (Smith & Osborn, 2008). I conducted the data analysis using the seven-step guide by Smith et al. (2009). The first step in the data analysis guide is reading and re-reading the data. Reading the transcribed interviews multiple times; and listening to the audio recorded interviews assisted me to be immersed in the data (Pietkiewicz & Smith, 2014). The second step in IPA is initial noting (Smith et al., 2009). I freely examined the data for ideas and meanings of words or phrases, noting them in the margin of the document. The third step is developing emerging themes from the data. Considering chunks of the data; including the notes that I have made; I identified potential themes. The fourth step in IPA analysis is searching for connections across emergent themes. At this stage, themes that can be integrated or brought to a higher level of abstraction were identified in the analysis. The fifth step is moving to each sequential case. When moving from one case to another, I bracketed the themes I identified: in order to be open to any new or different themes. The sixth step in the guide is looking for patterns across cases. This includes finding similarities and differences within the cases. I noted patterns and higher order relationships in this step. Finally, the seventh step is taking interpretation to deeper levels. According to Smith et al. (2009), the use of metaphors and meaningful words or phrases deepens the analysis. Additionally, applying theory to the analysis, as a lens for interpretation deepened my understanding of the analysis.

My first attempt at analysis was traditional, using paper and highlighters in order to have greater control and ownership over the process (Saldana, 2016). After I noted the

data; I transferred this information to electronic format. Using some basic functions of Microsoft Office, I added notes to comment boxes in the right margin of the Word document. Further, I used color coding for each emergent theme identified in the passages. Thematic analysis continued in Microsoft Word and connections between themes were easily noted using track changes. Patterns and interpretations of the data were identified within Microsoft Word. Handling the data, both manually and in electronic format helped me explore the data in different ways leading to a more thorough analysis of the data (Saldana, 2016).

Data analysis concluded after a complete review of the data with my chairperson and committee member. Analytic memos, field notes and triangulation with my committee contributed to data analysis, as a reflexive measure. Discrepant cases were reviewed with my committee for clarification. Results of the analysis were examined in detail in chapters four and five of this dissertation.

Issues of Trustworthiness

Credibility

The measure of quality for all qualitative research studies includes credibility, transferability, dependability, and confirmability. The first criterion of credibility is confidence in the interpretation of the data reflecting the insights and responses of the participants (Korstjens & Moser, 2018). In other words, is there truth in the findings as they are represented by the researcher (Lincoln & Guba, 1985). In the study, prolonged engagement contributed to credibility of the data as well as data saturation. Semi-structured interviews included questions distinctly related to opioid use disorder

experiences, and methadone treatment. Participants were requested to provide examples of their responses, and asked follow-up questions. Studying the detailed interview responses at length constitutes prolonged engagement (Korstjens & Moser, 2018). In addition, methods triangulation and investigator triangulation were employed to enhance the quality of the study. By employing multiple data collection methods including in-depth interviews and field notes in the study, data from both methods were compared to determine credibility (Korstjens & Moser, 2018). Using investigator triangulation, my chair, committee member and I reviewed the data and discussed coding, analysis, and interpretation decisions I made (Lincoln & Guba, 1985; Sim & Sharp, 1998). However, the position of my chair and committee member is supportive; I conducted the interviews and completed the analysis. Credibility was achieved in the study employing prolonged engagement in interviews and triangulation of data collection methods and interviewers.

Transferability

The criterion of transferability is the extent that the findings from a qualitative study can be applied to other contexts and settings, with other groups of individuals (Lincoln & Guba, 1985). Although, some authors feel that transferability is not completely achievable, due to the nature of qualitative research (Erlandson et al., 2003). Lincoln and Guba (1985) proposed gathering as much contextual data as possible to encourage sense making. Thick rich descriptions included behaviors and experiences but also included the context from which the events and experiences occurred. By exploring context, behaviors, and experiences, it becomes more meaningful for those interested in the research outcomes. Conducting semi-structured interviews with an interview guide,

including follow up and probing questions, elicited thick rich descriptions from participants (Morse, 2015).

The conceptual framework of the theory of self-care of chronic illness supported transferability. By using this conceptual framework to guide the study data collection and analysis, others who choose to do research using the same or similar theoretical concepts, are able to determine if the findings of my study can be applied to aspects of their own. Other researchers will need to consider aspects such as population and setting when they determine if transferability is appropriate. Transferability was achieved by providing thick rich descriptions of participant experiences and the use of a conceptual framework.

Dependability

Dependability is the next criteria for trustworthiness. For a study to be dependable, the results must be stable over time and under the same conditions (Connelly, 2016). Dependability is often achieved through credibility measures (Lincoln & Guba, 1985). In order to achieve credibility and dependability in the study; I provided, a detailed description of the research methodology, data gathering, analysis, field notes and produced reflexive analytic memos (Korstjens & Moser, 2018). Documenting decisions made during the entire research process provided a transparent view of the research and setting. Aspects of the interview, my subjective responses to the setting, and the relationship with the participants was contained in field notes, and analytic memos demonstrating dependability.

Confirmability

The final criterion for trustworthiness is confirmability. This criterion is determined by the ability of other researchers to ascertain the same findings from an independent analysis, of the same data (Lincoln & Guba, 1985). Confirmability is intended to protect participants' experiences; rather than being a function of the interviewers aims (Shenton, 2004). To achieve confirmability, I utilized reflexive analytic memos, reported my assumptions upfront and managed bias through triangulation methods. Finally, using theory as an orientating framework also reduced my influence.

Ethical Procedures

Women with addictions receiving care are more vulnerable than the general population; therefore, they require additional protections when participating in research. Participation in this research did not interfere with their treatment progress, I am not a trusted authority figure to the participants, and participation in the research study was voluntary (Walden University, n.d.). Some of the information participants shared in the interviews was private and was emotionally upsetting for them. To ensure the wellbeing of the participants' mental health, they were referred to counselling services available at some community addictions treatment clinics and a hotline phone number for the Community Crisis Center. The crisis phone service is available 24 hours a day, seven days a week. In addition, if physical or mental health issues were revealed during the interview, the participants were encouraged to seek follow-up care from their care provider. Next, due to the private nature if what was shared by participants, the interviews took place in a private area, at the community addictions treatment center. The

location was private, but participants were given the option to be interviewed via telephone. Since the interviews took place at or near where participants are receiving treatment, or by phone, participants were not challenged with additional travel expenses, inconveniences, or being exposed to an environment that was uncomfortable for them.

To safeguard the protection of human subjects, the Walden University's Ethics Guidelines for Clinical Research (n.d.) were followed meticulously. As well, I applied for and received Walden's Institutional Review Board (IRB) approval. I had the community addictions treatment organizations (planned interview sites), sign a letter of cooperation from Walden University. Treatment clinics and pharmacies where I only posted the research recruitment flyer demonstrated cooperation by posting the flyer.

Consent forms-were provided to each participant and a signed informed consent was required prior to participation. If participants had conducted their interview and decided they did not want their responses used in the research, their responses were removed from the research data. Participants were informed of their right to refuse to answer any of the questions or withdraw their participation in the study, at any time during the interview. This was indicated within the consent form and I reiterated this verbally at the onset of the interview. All other ethical concerns that involved recruitment, data collection, and analysis were addressed with careful methodological planning.

Every effort was made to protect the data and participants' identity. Data from the interviews was audio recorded using transcription software and a recorder that was purchased for this study. Interview transcripts were saved on my password protected

computer at work, located in my locked office. The printed versions of the transcripts were stored in a locked file cabinet in my office and stored separately from other work documents. My committee members and I were the only individuals with access to the data for the purposes of feedback and triangulation during analysis. The transcripts were kept in a locked cabinet in my office and will remain there for five years and at that point, they will be destroyed. Transcripts saved on my work computer will also be deleted at this time. Although anonymity cannot be guaranteed, efforts have been made to protect the identity of participants including assigned pseudonyms for each participant which was used when interviewing and reporting the data. Also, masking the locations from which participants were recruited helped to ensure confidentiality. These methods were used to protect the identity of participants and integrity of the interview data. When reporting the data, some individual responses were used as exemplars of thematic patterns, but no real names were used, only pseudonyms.

Each participant received a small token of appreciation for the time and travel they had contributed to this project. A $20 gift card was given to each participant who agreed to participate and attended their interview. The gift card can be used at a store to purchase personal care items, baby items, and food that might be helpful to participants. If the participant changed their mind and did not want to participate, or if they decided they do not want their responses used in the research report, they were informed they would still receive the token of appreciation for their time and travel.

Summary

Interpretive phenomenological method was chosen to investigate the lived experiences of women in Canada with OUD, who use methadone for treatment. IPA focuses on the hidden experiences of human beings and how they interpret it (Lopez & Willis, 2004). The role of the researcher in IPA is to report on the meanings or essences of the experiences of the participants, through their responses (Sloan & Bowe, 2014). The potential for confirmation bias was mitigated using field notes and triangulation.

Participants were recruited from community addictions treatment centers and from customers of local pharmacies. Purposive sampling was used to ensure that the research question could be answered; snowball sampling was used when too few individuals chose to participate to reach saturation. In-depth interviews and field notes were the sources of data collection for this study. Interviews are the most common data collection method in qualitative analysis (Moser & Korstjens, 2018). Transcription software and an additional recording device were used to ensure all responses were captured accurately. After data collection, data analysis proceeded using the seven steps of IPA data analysis by Smith et al. (2009). The steps included reading and re-reading the data, initial noting, developing emergent themes, searching for connections across emergent themes, moving to the next case, looking for patterns across cases, and taking interpretations to a deeper level. My committee contributed to triangulation of the data. Issues of trustworthiness of the data were addressed using the framework from Lincoln and Guba (1985).

Ethical considerations were applied to this study to protect participants. Participation in this research did not influence their current treatment. All aspects of the Walden University Ethics Guidelines for Clinical Research (n.d.) were followed meticulously. Approval from the Walden IRB was obtained before commencement of the data collection process. Chapter 4 will report the findings of the research. Chapter 5 will provide a comprehensive interpretation and discussion of the findings.

Chapter 4: Results

The purpose of this study was to describe the lived experiences of women with opioid use disorder who were receiving methadone as their treatment of choice. By understanding their experiences from their personal perspective, healthcare professionals will be able to provide women with individualized health promotion strategies and treatment (Rubio, 2016). This could lead to further research and eventually to better outcomes for women who are experiencing OUD. Thus, these findings may eventually improve the quality of life for these women. To investigate the research question on addressing the lived experiences of Canadian women with opioid use disorder using methadone for treatment, an IPA was taken for this research.

In this chapter, there will be a detailed description of the setting of the research and presentation of the study participants' demographic information as it relates. Next, details of data collection, including interviews and field notes, are presented. Only participant pseudonyms are used when presenting the data. The process of data analysis is discussed next. Methods of coding, secondary coding, subtheme development, and final themes are presented in detail to provide a clear image of how final themes were developed in a stepwise fashion. Evidence of trustworthiness, including credibility, transferability, dependability, and confirmability, are also addressed. Finally, a detailed exploration of the results of the study is provided along with a summary of the answers to the single research question.

Research Setting

Changes in the conditions at the addiction treatment center included organizational and personnel. The arrival of the COVID-19 pandemic during the months of data collection also contributed to variations in the treatment center operations. First, the organization where the research participants were recruited had undergone changes in personnel. The counselor that was employed in the addiction treatment center had recently begun maternity leave, which meant that there was no onsite counseling for participants if there was a personal concern after their interview. However, the participants of this study were presented with other counseling service options in the consent form, and resources for psychological support were addressed with participants verbally prior to the interview.

Another personnel change occurred with a member of the clerical staff, as the intake person was not working at the present time due to the COVID-19 pandemic. The intake person's absence meant that one of the participants was unable to receive injections for pain in her back and forehead as she had at a previous treatment center because no one was available to process her information.

Other changes had been made in the addiction treatment organization in response to the COVID-19 pandemic such as the availability of hand sanitizer, distancing from the pharmacy and treatment center desks, and requirements for wearing a mask. In addition to this, attending the addiction treatment center to receive care and methadone medication during the pandemic may have produced additional stress that might influence participants' experiences at the center. Staff members indicated that patients usually

come to the center and leave quickly after receiving their treatment. However, it is not known if this is due to concerns regarding exposure to the COVID-19 virus. These changes in conditions at the addiction treatment center may have influenced participant responses and ultimately the interpretation of the study results.

Demographics

Women in the study did not vary widely by demographics. The women were between the ages of 28 and 42 years old with a mean age of 36. Most participants, four of the seven, were in their 30s. Six of the seven women were in relationships with a male or female partner. Five of the participants indicated that they were living common law with their partners, meaning they were unmarried but cohabitating. Six of the seven participants had children, with two of the participants having children still living in the home. Four of the participants had children, but they were living elsewhere other than with them. This demographic information is related to the research question and contributes to a fuller understanding of women's experiences of OUD and choosing methadone for treatment.

Data Collection

Seven female participants volunteered to be part of the study and participated in a single interview. The interview included a collection of demographic data and responses to interview questions. Interview questions evolved with each consecutive interview based on responses and information gained from each participant. Each woman met the following inclusion criteria: adult women over 18 years of age and able to understand and

speak the English language. In addition, each woman was using methadone for the treatment of opioid use disorder.

Recruitment flyers were posted in two additional treatment centers in central Ontario. Flyers were also posted in the attached pharmacies at both treatment centers. Initially, the flyers were posted throughout the centers and pharmacies. After two weeks, the flyers were removed, and a single flyer was posted in a designated area at the entrance of the facility, where a new bulletin board had been created.

All data collection occurred by telephone interview. I completed interviews in my home office, where I have a private work area with a locked door. Each interview took less than 90 minutes. The first interview happened within a week of posting recruitment flyers at both sites of the addiction treatment center and pharmacies. In fact, the first six interviews occurred between June 12, 2020, and July 2, 2020. The final interview occurred on September 11, 2020. No more than one interview per day was scheduled to allow me to review each recording and download it to transcription software and make notations in my field notes. Additionally, the deeply personal nature of the women's shared experiences made it necessary to take time for myself in between interviews.

Field notes allowed the collection of information related to the setting, the participants' privacy, and interruptions when they occurred. Emotional responses to interview questions such as hesitating, crying, shame, pride, or frustration were also noted in the field notes. Unfortunately, due to the COVID-19 pandemic all interviews were completed by phone; therefore, no facial expressions or body language was observed. However, this information contributed to a clearer understanding of

individuals' experiences. Finally, I used field notes to critically reflect on the overall interview and my performance as an interviewer. By collecting this information, I was able to consider my responses and how the questions were asked. This led to improved interviewing and refined interview questions as the interviews progressed. Additional notes made were based on my own personal reactions to participant responses. For example, a participant whose pseudonym was "Amanda" discussed her experience with having her son taken by CPS and how she has re-established a trusting bond with him over time. This information was difficult for me as a mother, and I could feel my own emotions during the interview. In my field notes dated July 2, 2020, I wrote,

> Amanda's deep love and sacrifice for her son is something I can relate to. I feel admiration and sadness at her sacrifice to leave her home and allow her ex-husband to have custody. This must have been heart-wrenching for her. I would hope that I would display this courage if I were in her place.

These feelings and any biases are relevant and contributed to my interpretation of the data.

Data were recoded using a Sony recorder purchased for this dissertation. The recorder was then plugged into my personal laptop, and the interview was downloaded into Otter.ai, transcription software. Once the software finished downloading, the interview transcripts were saved on a password-protected computer. Notations were recorded on a small, coiled notebook beside my computer.

There was little deviation from the original data collection plan. Deviations from the original research plan include the number of participants and the opportunity to

conduct face-to-face interviews. The number of participants diverged from what was planned. in the third chapter of this dissertation. After each interview was conducted, I was able to listen and re-listen to participant responses, transcribe the interviews with assistance of the transcription software. At this time, the initial noting was completed and as this was accomplished for each interview, comparisons were made and noting refined. After the sixth interview, I was convinced that I had reached saturation. But on September 11, 2020, I had the opportunity to complete a seventh interview and continued data analysis; however, again I was convinced that the data had reached saturation. After a lengthy discussion with my committee, I was confident that I had reached saturation. Saturation is not reached by a specific number of participants but by continuously evaluating the data (O'Reilley & Parker, 2012). In qualitative phenomenology, the sample is small and differs between studies (Moser & Korstjens, 2018). Saturation is determined by exhibiting patterns, categories, and demonstrating variety in the content, which had occurred. For these reasons, I was certain that saturation had been reached, though it was with a different number of participants than expected as noted in Chapter 3.

The second variation from the plan in Chapter 3 was completing face-to-face interviews. Due to restrictions of the COVID-19 pandemic, all interviews were conducted by telephone, which posed challenges. Audio recordings were not always clear and required repeated playing to ensure accuracy. Moreover, telephone interviews removed the opportunity to observe facial expressions and body language, which can provide valuable interpretive data. Participants also indicated that using their telephones for lengthy interviews was a challenge. Some potential participants used calling cards and

would not participate in a lengthy interview for that reason. Others found it challenging to find privacy for the length of the call and were interrupted, although infrequently, during the interviews. COVID-19 may have also discouraged participants from participating and potentially increased stress levels that may have influenced their behavior. However, the telephone interviews still provided the valuable data needed to answer the research question despite these challenges.

Data Analysis

The inductive process moving from individual coded units to broader representations was completed using the 7-step process of IPA by Smith et al. (2009). In the first step of this process, I was able to listen to the audio recording and read through the transcribed recordings, making changes where the Otter.ai software was not accurate. Once this was complete, I read each transcript in its entirety for clarity. This process immersed me in the original data.

I performed another reading of each transcript, once the interviews were completed and transcribed, to complete initial noting of the data and form codes. This is the second step of IPA. I coded each transcript, first using hard copies of the data. I indicated the codes in the margins of the transcript. The first cycle coding method used was initial coding, otherwise known as open coding (Charmaz, 2014). Using this method, the data are broken up and examined as parts of the larger whole (Strauss & Corbin, 1998). Initial coding is intended to be flexible, as the codes may change as the analysis progresses. When coding, the coded parts are scrutinized for their similarities and differences and decisions are made to maintain or modify codes. A word or short phrase

is given as a code for each part. This type of coding is done line by line and is appropriate for interview transcripts (Strauss & Corbin, 1998). After using the open coding method, I reviewed all transcripts and completed a second round of coding, finishing with a total 384 codes. All codes derived from the data were transferred into a code book that make analysis more organized and logical. Themes began to emerge within the codes of each individual transcript.

In this third step of IPA, I used color highlighting on my computer to cluster the codes and begin to develop themes. In this cycle of analysis, I used a pattern coding method to collapse the large number of codes into more meaningful, focused units of analysis (Miles et al., 2014). The intention of using this process was to support the eventual development of larger themes in the data as analysis continued.

The fourth step of IPA, thematic analysis, occurred next. The purpose of this step was to find connections between the themes, as they became more conceptual and cohesive (Smith et al., 2009). Again, I used color codes to chunk the themes. Each subsequent interview transcript, or case, went through the same process; step five of IPA. A total of 34 subthemes emerged from the codes. After conferring with my committee, I chose to complete a second round of subthemes, collapsing the 34 subthemes into 14 second level subthemes. As each case was examined, patterns of shared higher order qualities were considered between the cases; the sixth step of IPA. Once this process was complete, four major themes were established. The major themes included sense of self, experiences with methadone, accessibility, and supportive others.

In the final step of IPA, interpretation is taken to a deeper level. Once again, I reviewed the transcripts to find deeper and more meaningful ways to represent the data in the four major themes. Participant statements were discovered that encapsulated the themes and it was felt that using the participants own words would enhance the meaningfulness of the themes. The major themes were then renamed as learning how to be you again, reaching out for help, finding your way to methadone, and going down the path of methadone.

Using the seven steps of IPA from Smith et al. (2009), each step of analysis allowed for deeper interpretation, allowing the essence of lived experiences of participants in written form (Sloan & Bowe, 2014). This process produced four major themes that best represented the data. Data analysis occurred with ongoing feedback from my chair and committee member. The discussions included topics of saturation, analysis measures, and suggestions for improvement. Analysis concluded after multiple reviews and discussion with my committee member and chairperson. Discussion and feedback contributed to data analysis as a reflexive measure.

Discrepant Cases

Discrepant cases existed among the data set; however, when discovered, discrepant cases were factored into the analysis. One discrepancy in a response from a participant whose assigned pseudonym was “Ella” was that she could not get “carries” because she was still using “Ice.” Carries are doses of methadone that are taken independently, meaning that the person taking the dose does not have to attend the pharmacy for witnessing ingestion on those days. Getting carries occurs once the person

demonstrates their commitment to receiving treatment daily and have had urine specimens that are negative for street drugs for a defined period. Ice is a methamphetamine not an opioid drug. Even though Ella was still using illicit drugs, she felt that the purpose of accessing methadone was to get off opioids, which she states she was. Ella felt that since she was not using opioids, she should still get carries regardless of her urine samples coming back positive for Ice, a methamphetamine. Ella admitted to still using illicit drugs and was the only participant to do this. However, the inclusion criteria did not limit her participation, only that she was on methadone for opioid use disorder, which she was. Additionally, it is not uncommon for individuals receiving methadone treatment to use illicit drugs simultaneously. This discrepancy in the participant's response was handled by incorporating it into a broader theme of going down the path of methadone.

One participant also provided a discrepant response related to the effects of COVID-19 on their treatment experience. A participant whose assigned pseudonym was "Evelyn" indicated that due to the changes in the current work environment, her boyfriend was not working. She offered that if he was working, she would be forced to take her two children with her to treatment, possibly taking two busses to get there and back. Otherwise, she would have to find childcare each day. Since Evelyn's boyfriend was not working, he was able to take care of the children while she attended treatment. Although her oldest child is school age, schools were closed during this time due to COVID-19. Evelyn did indicate a negative influence of COVID-19 on her treatment; she spoke of changes in the bus system that challenged her ability to attend methadone

treatment including limited bus times and limits to the number of passengers on each bus. However, one good outcome was Evelyn had childcare in home. In contrast, all other participants who spoke of the effects of COVID-19 on their treatment experience identified negative effects only. This discrepant case was included in the data analysis and contributed to creating the theme of effects of COVID-19. In this way, all responses were included in a broader context. Additionally, all discrepancies in responses were discussed with my committee.

Evidence of Trustworthiness

Credibility

To ensure trustworthiness in this qualitative study, the criteria of credibility, transferability, dependability, and confirmability were addressed. The first criteria of credibility relates to confidence that the data is representative of participant responses and insights (Korstjens & Moser, 2018). In other words, has the researcher truthfully represented participant responses? Prolonged engagement and data saturation were used as measures of credibility. Reading and reading transcripts, reviewing audio transcripts, and studying responses in detail to perform analysis constitute prolonged engagement. After prolonged engagement with the data and confirmation with my chair and committee member, it was determined that saturation had been reached after seven participants. Semi-structured interviews were performed, and questions reflected experiences with OUD and treatment (Appendix). Questions were modified after the first interview and throughout the data collection to address participant experiences more adequately. Participants provided detailed examples of their experiences and answered follow up

questions, for clarity and detail contributing to credibility of the data. In addition, methods of triangulation and investigator triangulation were employed. Data was collected through in-depth interviews and field notes. Data from each data collection method was compared for accuracy and clarification, during data analysis. As well, my chair, committee member, and I conferred over the data and engaged in discussion regarding my coding, analysis, and interpretation decisions. This led to revisions and additions to the analysis. Credibility was achieved using the methods of prolonged engagement in interviews, saturation, and triangulation of data collection methods and interviewers (Korstjens & Moser, 2018; Lincoln & Guba, 1985; Sim & Sharp, 1998).

Transferability

Transferability criteria is described as the ability of a qualitative study to be applied or transferred to other contexts while still maintaining context richness (Lincoln & Guba, 1985). Thick, rich descriptions help to achieve transferability. In this study, behaviors and experiences became more meaningful when the context was explored in semi-structured interviews. Participants responded to interview questions previously developed in an interview guide (Appendix C). However, the interviews remained flexible and participants provided insights and interpretations, from their perspective. Follow up questions were asked and elicited more robust responses and provided context, contributing to deeper sense- making of the data (Lincoln & Guba, 1985). Semi-structured interviews that remained flexible with follow-up, probing questions, provoked thick rich descriptions from participants during data collection.

The conceptual framework of the Theory of Self-Care of Chronic Illness supported transferability. By using this theory to guide the study data collection and analysis; others who choose to conduct research with similar theoretical concepts, can make the determination of applying my study findings to their own. Population and setting are additional considerations for researchers to determine transferability. Analysis and interpretation of the findings, in the context of the Theory of Self-Care of Chronic Illness, are further delineated in chapter five of this dissertation. Thick rich descriptions of participant experiences and the use of the conceptual framework, The Theory of Self-Care of Chronic Illness, endorse the criteria of transferability.

Dependability

The next criterion for trustworthiness is dependability. A study is considered dependable if the results are stable over time, under the same conditions (Connelly, 2016). In qualitative research, dependability and credibility measures are often mirrored (Lincoln & Guba, 1985). Dependability and credibility were achieved by providing a detailed description of the research methodology, data gathering and analysis, within chapter four. Reflexive analytic memos were produced during data analysis and provided evidence of each step in the analytic process. A data analysis table indicating codes, first and second level themes, and finally, larger themes was made. Developing this table was not a strategy planned in chapter three. However, the document materialized as an organizational measure and provides a transparent view of the rational for moving from codes to larger themes. Descriptions of research methods, data gathering, analysis and reflexive analytic memos; all contribute to dependability in this study.

Confirmability

The final criteria considered for trustworthiness is confirmability. Confirmability is determined by an independent researcher finding the same results of a study based on their own analysis (Lincoln & Guba, 1985). The intent is to prevent researcher bias from dominating the findings; rather than exposing participant experiences (Shenton, 2004). To achieve confirmability reflexive analytic memos were utilized to delineate each step of the research process. Field notes were used to expose researcher assumptions that may contribute to bias. Additionally, triangulation methods and researcher triangulation were utilized. Finally, using the Theory of Self-Care of Chronic Illness further reduced my influence in the analysis and interpretation of the data. Memos, fieldnotes, triangulation, and an orientating theory supported confirmability in the research.

Study Results

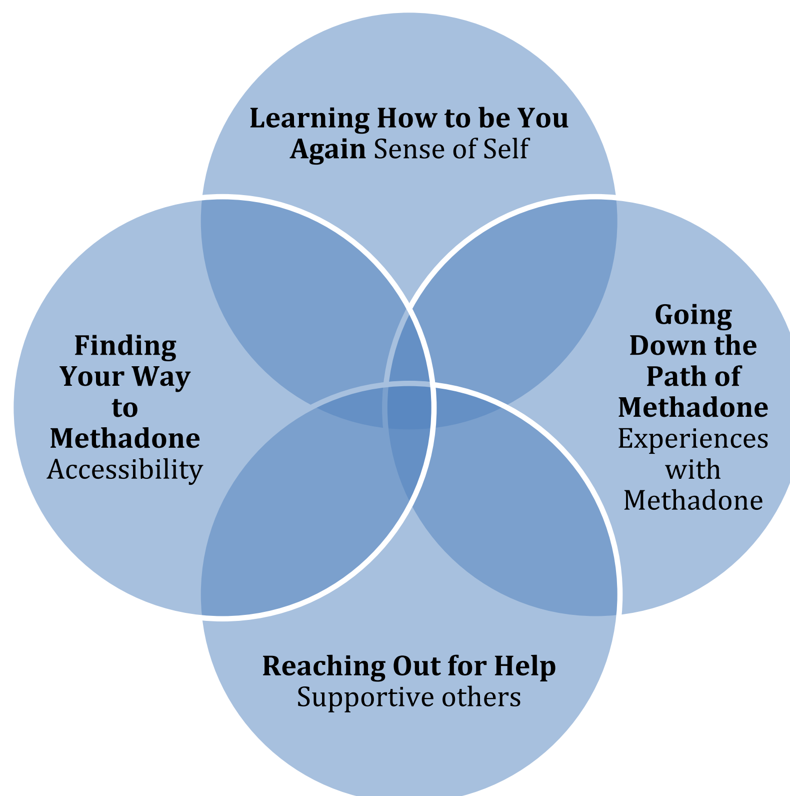
The single research question for this dissertation is What are the lived experiences of Canadian women with opioid use disorder who choose methadone for treatment? The process of data analysis using IPA by Smith et al. (2009) led to four major themes that evolved in the interpretation of participant responses. The themes derived from participant statements include learning how to be you again; reaching out for help; finding your way to methadone; and going down the path of methadone. Each of these major themes offers insight into participant experiences with methadone treatment and are illustrated more clearly in the Venn Diagram of Major Themes (Figure 1).

This section of this dissertation is organized by major themes. Detailed information to support the evolution of each major theme is presented. Direct participant

quotes provide textual descriptions of their lived experiences to support the identified major themes. However, consistent with the concept of constitutionality in qualitative research, findings are a combination of meanings of the investigator and participant; leading to plausible interpretations justified by participant responses (Annells, 1996; Koch, 1995). Essentially, there is no single interpretation of the data. In this section, women's experiences with OUD and methadone treatment are offered with interpretation; to better understand women's meaning making of this phenomenon. The collective narrative summary was constructed to highlight the essence of women's accessing methadone treatment. Each major theme presents a segment of the interpretation of women's experiences.

Figure 1

Venn Diagram of Major Themes



Learning How to be You Again

Many of the women in this study made statements pertaining to their ability to be themselves and independently make decisions. Women offered a sense of self determination that was captured in many of the statements. Each woman may have phrased it differently, but each indicated a sense of self and how their recovery with methadone was dependent on their decision making and self-determination. The second sub-themes were evident in their sentiments including: motives for change, mothering role, hiding and gender specific understanding.

Amanda, the sixth participant, was asked what helps her stay in methadone treatment? She answered: “myself”. She also indicated that “just not wanting to use” was her internal motivation for staying in treatment. Jen, the final participant offered insight related to her self-determination to remain in treatment.

> I don’t want to be like that no more. I want to be better. Honestly, I don’t want to be like that (addicted to opiates). I want to be happy. I don’t want to be miserable on drugs. It’s not fun. I enjoy life so much better (on methadone).

Another participant named Becky offered the following insight regarding her plan to complete her treatment with methadone and move forward with her life. Other participants also felt as though methadone treatment was not a lifelong treatment. Becky expressed desire to transition off methadone at some point in the future.

> And I find that I am a strong enough women because I’ve done it before without and I just gotta find, I gotta find me, right? So, I’m gonna go to counselling and

> I'm gonna try to empower myself through other things. And I'm hoping that I can cut that ball and chain off my ankle for the rest of my life.

All but one participant indicated that they had experienced relapse during their methadone treatment or previous suboxone treatment. Yet, despite setbacks such as relapse, women continued to be resilient and were determined to work towards treatment rehabilitation. Despite being disappointed in herself for relapsing, Mary indicated that she was confident in her ability to be successful in treatment again.

> …and then I relapsed, used again for a while and relapsed and went back again. Around March, I went back in to start treatment over again. I knew I could do it, I did it before.

Some women indicated that methadone treatment offered an opportunity to restore their lives. Jen offered that her decision to go on methadone changed everything. She now had an apartment, her children in her life and a supportive significant other. Another participant named Daisy indicated that she had to relearn many of the skills that she had forgotten or left behind when she began to use opioids. Daisy compared being addicted to opiates, to being like a child.

> You have to learn to rebuild your life. You got to figure out how to be that adult again. When you're a drug addict, it's like you are worse than a kid. Like, you will cry and steal from people, just to get what you want right? Your basically worse that a child. Because a child has reasons, you know, they are kids, they are learning. There's reasons they act the way they do. The drug addict knows… how not to act like that and still chooses to just so they can get their high. Like, I know

> it's not okay to steal from this person but hey, I need to get high. Like, you have got to learn how to be who you are again.

Becky expressed how methadone treatment can present possibilities for women living with opioid use disorder to improve their lives. Her statements were hopeful and positive for the future.

> We have treatment that betters human beings lives, that means they can better themselves. And that means they can be more productive on an everyday basis. So that they will be able to study and get a job and you know, they can get off of welfare and they can maybe have a family and have kids and just live a normal everyday life and be happy. It's happiness at the end of the day that people look for right?

Collectively, the women noted a point at which their opioid use disorder led them to decide that change was critical. Many of them noted that losing custody and contact with children finally was a culminating factor that led them to decide to stop taking opioid drugs and get treatment. However, each participant had their own version of a breaking point that led to methadone treatment. Becky, who had adult children who lived abroad for school, indicated a multitude of factors that culminated in deciding to get treatment for OUD.

> So realizing, no I actually OD'd (overdosed). That sort of gave me a wake-up call. And the fact that everything in my life was falling apart. I found myself without work, I lost my job. I lost my family. I lost my friends. I was losing my relationship, my wife and myself. So I decided to go into treatment.

In the final interview, Jen's experience included violence and homelessness as factors leading to her deciding to get methadone treatment. When asked what led her to methadone treatment, Jen provided the following answer.

> My life was completely over. Like, I was in a motel. The guy I was dating beat me. I was worried about how I'm gonna pay my motel. How am I gonna live? I don't want to have all my bags and be in the street. I'm losing everything. I can't even pay my room to live in let alone have a drug problem and pay for that. It was terrible. I got to a point where I was on the street with bags and nowhere to go. And my boyfriend said you need to get on methadone at that time. I was very, very sick from withdrawals.

All the women who had children indicated their role as a mother was prominent in their decision to get addiction treatment. Many women saw methadone treatment as an opportunity to get access to their children and begin to re-establish their relationships with them. As Mary indicated "A lot of them (women) are going through the methadone program to show, and get clean, so that they can get their children back". After experiencing opioid use disorder and receiving methadone treatment, Evelyn indicated that "being a mom, it (methadone) makes me feel more alert and happy, before I wasn't…" Ella, a study participant, discussed how methadone provided an opportunity to get her "family back together". Ella had lost custody of her children, who live with their father, her husband, and her home.

> I am a mom of three and they are with their dad. I'm on methadone so I'm just trying to get my life together right now. And I am waiting to get into rehab right now. I want to get my kids back into my life.

One participant Amanda expressed a close loving bond with her son. Despite being on methadone for more than 15 years and not living in the same home as him, Amanda felt that her decision to have her son live with his father was the best for him.

> ...I knew it would be no life for him in the city. I knew it would be a better life for him in the country with his dad. Leaving him in the school, leaving him in the matrimonial home…

Similarly, Daisy discussed "a mother and child's bond" expressing her love for her son and his attachment to her. However, the decision, as a mother, knowing what is best for him, is priority.

> That's my baby, you know, but he still loves me to death (despite her drug use). He's like; I'm his number one mom no matter what I do. I am the best person in his world, like he wants to live with me still and everything and I'm like, oh babe, I wish that was possible.

The theme of hiding was prevalent in many of the woman's experiences. Woman hid their opioid use and methadone treatment from several others including families, significant others, bosses, and landlords. When women experienced relapse, they also expressed hiding this from others due to feelings of guilt, shame, and embarrassment. For example, Becky relapsed while in treatment with suboxone, before going on methadone, and was hiding this, among other things, from her spouse. Unfortunately, that meant that

she had to go through relapse and treatment initiation alone. Similarly, Amanda hid her opioid use from her family after she completed detoxification treatment and was without any illicit drugs for four months. Amanda admitted that she didn't admit this to her family because she felt like a failure. After attaining methadone treatment completely on her own, Amanda still had fears related to her ability to care for her son and concerns of how her relapse would affect others.

> I just didn't want to be sick (going through withdrawal) because if I went home sick, everybody would know what I was going through again and then my son, I wouldn't be able to take care of him as good as I should be able to and I just felt like I was letting everybody down. So it was scary.

Ella hid her methadone treatment from her landlord due to fears that he might discriminate against her. Unfortunately, Ella was right and at the time of the interview was having to actively look for another place to live due to being harassed by her landlord once he found out. Amanda had similar concerns with telling a potential employer that she would need to have one afternoon off a week for her appointment with the addiction treatment doctor. She indicated that she would hide her treatment from them "because then they look at you like you're a drug addict."

Some of the women did not recognize their experiences with methadone being different than men's. Daisy answered that she had not considered it and stated that "we are all the same". Yet, Amanda, who initially stated that she looked at it as the same as being a man in methadone treatment, paused and stated that since women care for children and also carry children; that women's experiences are different. She elaborated

on how women, such as her sister, who are pregnant and on methadone are discriminated against, referring to her nephew as a “methadone baby”. Mary interpreted the question a little differently than Daisy and Amanda and discussed the gender stereotypes that women with opioid use disorder experience.

Participants in the study offered valuable insight into their sense of self and self-determination as indicated in the major theme of Learning How to be You Again. The second sub-themes were evident in their sentiments including: motives for change, mothering role, hiding and gender specific understanding. These women discussed how they saw treatment as an opportunity to improve their lives, their motivations for getting into treatment despite setbacks and how they arrived at a point of readiness to change their substance use behavior. Additionally, the influence of children on treatment decisions and reasons for hiding treatment was evident in women’s responses.

Reaching Out for Help

When seeking treatment for opioid use disorder, women in this study experienced a variety of responses from those who were considered supportive others. These responses came from family, friends, significant others, healthcare professionals and community support. The responses from supportive others included positive encouraging statements and behavior; as well as negative discouraging statements and behavior. Each woman experienced reaching out differently; but expressed common threads that led to the major theme of Reaching Out for Help. Participant responses included elements from the following second sub themes: systems of support, referred ignorance, and positive emotional engagement.

Woman in the study indicated that there was a difference in treatment by healthcare professionals, from those who worked in addiction treatment and those who worked in other sectors. However, responses from participants were positive overall when asked about treatment for opioid use disorder. Jen felt very strongly that healthcare providers were a source of support to her and others. This is evident in her statement:

> …if you really want help, everybody in healthcare would in turn, put their back down, like everybody will help you as long as you want help That's what I believe. I … I've had nobody, when I asked for help, I've had nobody say no, like especially if you're in a really bad moment and you feel like using, talk to somebody, you can call the crisis line.

On the one hand, all the women in the study were complimentary when discussing the pharmacy at the addiction treatment center. Additionally, participants were sincerely appreciative at the care they received from the addiction treatment physician. Evelyn's response was poignant and warrants repeating; "But my doctor, he saved my life. I owe my life to my doctor, he's, he's, he's amazing. …not everybody has those, right?"

On the other hand, women felt that treatment, from larger pharmacies and healthcare providers that were not specifically associated with addiction treatment, were not supportive and sometimes were judgmental. After attending a large pharmacy for methadone treatment initially, Mary found that when it was time to go for treatment, she was experiencing anxiety due to judgement from the staff. Her statements are concerning because she revealed that their judgmental treatment deterred her from receiving treatment, at times.

> …there were times when I had so much anxiety from the buildup to go (to the pharmacy) and be judged. Like, I think they thought I looked high, like I would make sure I was always showered right before I go. I didn't want them to like, if I was cleaning up around the house and like a little bit sweaty with my hair in a bun, I didn't want them thinking that like I was just coming off a bender and like just constant judgment from the bigger chain pharmacy.

Although the treatment by healthcare providers in non-addiction treatment roles were found to negatively influence treatment experiences; two of the women in the study expressed understanding of the frustration that healthcare providers must feel, when dealing with patients who have SUDs. For example, Becky discussed attending the emergency department and while she felt the treatment was not positive, she did express empathy for all the staff who cared for those with SUDs.

> I understand their frustration because, I'm not there every day, I don't see them [individuals with SUDs] and I don't experience what they are experiencing daily, having to deal with people who don't want help and just want to get high, so it's gonna be frustrating. But…you know, you chose that occupation, and you need to be prepared for these things. You need to know that with that occupation, these kinds of things are gonna happen. So, you need to have patience with them. And if you don't have patience…they're not going anywhere; those things are never going to change (drug seeking).

Significant others and close friends and family had an influence on treatment for women accessing methadone for opioid use disorder. Often women felt that when there

was a lack of support it was due to ignorance or lack of knowledge of methadone. Evelyn's boyfriend did not understand that methadone was used for opioid use disorder. Initially, he thought that methadone was only for individuals taking methamphetamines. When Evelyn told her boyfriend, she felt attacked by his emphatic reaction. However, once she reviewed the information with him and he saw the positive effects of methadone treatment on her life, he became supportive. Similarly, Mary's significant other discouraged her from receiving methadone treatment due to her significant other's initial ignorance.

> She clearly didn't understand the disease and I believe it is a disease. Addiction is a disease and is genetic and runs in my family. She actually didn't understand it. She just thought it was a choice. And I tried to explain to her you know, at first it might have been a choice but now its, its, its not a choice anymore.

Unfortunately, some of the women did not receive support from their families and friends. Ella discussed her best friend who commented that she shouldn't be on methadone or anything else. She told Ella that she should "just be clean". It did not come as a surprise that Ella felt that more positive support services would be helpful for women receiving methadone treatment. Similarly, Daisy had experienced negative interactions with friends and a family member who were not supportive of her treatment. Daisy's friends made statements that appeared to be supportive but immediately following, they would offer to give her drugs to get high. Daisy's sister followed suit. Her sister attempted to sabotage Daisy's methadone treatment by offering her elicit drugs even though she was aware of Daisy actively working towards recovery. Several of the women

noted that removing yourself from those who are not supportive, or those who you used to use opioids with is critical to staying on methadone treatment and not using illicit drugs.

While some women found a lack of support from family and friends, others were grateful for the support they were receiving from them. Becky's family was no longer present in her life, but she spoke optimistically about the friendships that she had developed by being honest about her experiences with opioid use disorder and treatment.

> My friends, I have a good group of friends. I have some really, really tight knit friends that no matter what time of the night I can call them, and they will be there. So that's a bonus for me. Not everybody has that.

Similarly, one participant, Amanda found that once her parents also entered methadone treatment; it improved their experiential knowledge and hence improved their relationship. Amanda indicated that it gave them insight that she was not using illicit drugs and that methadone had positively influenced her life. As well, Amanda felt her parents understood and empathized with what she had experienced receiving methadone treatment for opioid use disorder contributing to a closer bond between them.

The women unanimously felt that having a significant other, who was also in treatment for opioid use disorder was advantageous. Six of the seven women had partners who were currently receiving treatment. Mary indicated that having both partners in treatment was essential; each partner was able to keep the other accountable. In fact, she felt that being in treatment together actually brought them closer together. Mary identified another advantage to both partners being in treatment together, "you know the

lies so you know when the other one is lying." Another participant, Amanda, began using opioid drugs with her current significant other. Although she felt initially that their relationship was "codependent", she later felt differently.

> But now he's on suboxone and I'm on methadone so it's nice because we know what each other went through and we're there for each other and it's awesome. I wouldn't change it.

Some of the participants had significant others already in treatment for opioid use disorder; when they themselves began treatment. Their presence in treatment had an influence on the women to attend treatment themselves. Jen claims her significant other was already on methadone and was the one who told her about methadone, encouraged her to get treatment and attended her first treatment. "The guy I am with right now said, Jen, you should go on methadone, and I went on methadone and it changed my life."

Community organizations played a significant role in the women's experiences related to supportive others. Some experiences with these organizations was very positive, while others were negative. Either way, participants were emphatic regarding their experiences creating a polarity in responses. The community organizations most mentioned were the Children's Aid Society (CAS), police services, counselling services from various organizations and withdrawal management services (otherwise known as Detox).

Women had very different views of their treatment by CAS. Ella was pregnant when she interacted with the CAS and expressed concern that they were not at all supportive and that she felt judged by her worker. Ella insisted that she understood the

significance of CAS; but recalled a difficult experience when she was in contact with the organization.

> I was on suboxone and they had contact (with her) but it was not helpful because you make one mistake and you are in trouble. They don't understand that relapse is a part of recovery. My worker, she would tell me that she knew nothing about suboxone. And I thought, why are you my worker?

Similarly, another participant, Amanda, recounted a painful experience with CAS where she felt they unnecessarily removed her son from the family home. While Amanda acknowledged that the job of CAS is to protect children who are in danger, she was frustrated because her son was never at risk. Yet he was still removed from the home. Amanda indicated that she should have been taken out of the home and not her son. This was clearly upsetting for Amanda and left her with a negative opinion of this community service.

In contrast, Daisy credits her CAS worker with having a positive influence on her treatment access. The CAS worker supported her getting into treatment and continuing to have access to her son. Yet, CAS did remove her son from her home, but Daisy felt that due to the potential dangers that her lifestyle was posing for him, it was the best decision to remove him.

> When he got taken that was the best time for him to be taken, believe me. That's when I first overdosed on fentanyl. That's when I started doing fentanyl. It was an environment I didn't want to have him in.

Another community organization that was mentioned with opposing views was withdrawal management. While Jen felt that she received caring support that was above and beyond, from the staff at withdrawal management; Becky referred to withdrawal services in the community as “a joke”. She indicated that the organization was turning people away who were trying to access treatment, and this was resulting in unnecessary deaths, in Becky’s opinion. Later in the interview, Becky offered that services are lacking in the community, due to poor funding.

The women unanimously felt that accessing counselling services was positive for women accessing methadone and persisting in treatment. For some, counselling was seen as a tool to deal with past trauma; that potentially led to using opioids. However, some of the women noted that the counselor, at the addiction treatment center they were attending was not working currently, due to a maternity leave and she had not been replaced. Furthermore, the participants felt that the service is not well advertised. Jen indicated that she was accessing counseling services from outside community organizations. She expressed overwhelmingly positive experiences related to the accessibility and compassionate care she received. Jen indicated that “as long as you are willing to work the program, it’ll work with you. Ella observed that from her own experience, counselling was beneficial; but had to be accessed by women on their own accord and not forced upon them. This made the service more effective.

Overall, the desire for more support from the government, community organizations, from healthcare providers and the community at large, was glaringly evident in participant responses. Women expressed the need for empathy, sympathy,

compassion, common decency, removing discrimination and stigma; which women felt could be achieved with broad educational interventions. Statements made by Jen are impassioned and embody the women's experiences. "I feel that like people should talk more to people and care and show more compassion to people… we don't have diseases we're not bad people. You know, there are really good people out there". Additionally, Jen offers that "people can just talk to people and just have some sympathy and just care about them a little bit. It helps so much because half these people feel so alone, all of the time." However, Becky expressed frustration over feeling judged by others due to their lack of knowledge of SUDs.

> I find that people are very judgmental. As soon as you tell them you're on a medication that controls your urges to use drugs, again in their minds they think well, it's a choice, you're choosing to go and use (drugs). Well, what they don't understand is, yeah, it might have been in the beginning but now it's a necessity. People are not nice whatsoever, So, that also makes it that much harder to see the light at the end of the tunnel (treatment).

Mary echoed Becky's frustration over the stigma and discrimination of individuals with SUDs by different groups within the community. She expresses her shock over finding out that a Facebook page shaming individuals who were using addiction treatment services and others who were seen actively using elicit drugs. Mary uses the phrasing 'on the nod' which means to be in a sleep like or an extremely drowsy state; where the person has taken a large dose of a drug.

> A lot of the problem that police have, especially in our downtown area, is that they don't have very much patience. Again, not just them though, it's our nurses, even our local workplaces, fast food restaurants, and the businesses around there like there was actually a Facebook page that had come up…showing people on the nod and coming out of getting their methadone treatment.

Womens' responses that led to the major theme of Reaching Out for Help, varied and were deeply personal. Whether interactions with supportive others were positive or negative, it was clear that women's treatment experiences were affected by them. Women saw the support of others as integral to their treatment. Healthcare professionals, especially those with addiction treatment knowledge were found to be more supportive. Women with significant others and family members in treatment were supportive; while others who were not knowledgeable about methadone treatment were initially not supportive. Education for these individuals led to a change in support. Community organizations were experienced differently according to the women. However, it was clear that increased support from all individuals and organizations was desperately needed to foster successful treatment outcomes. Overall, women felt that education was an essential component to increase support and combat stigma and discrimination, by these supportive others. Elements of the second sub themes were noted in participants responses including: systems of support, referred ignorance and positive emotional engagement.

Finding Your Way to Methadone

In the third major theme, Finding Your Way to Methadone, women in the study indicated that accessibility to methadone treatment had a tremendous effect on their experience of receiving methadone treatment, for opioid use disorder. Travelling to get to daily treatment was a challenge for many. Other issues like housing and additional costs are prevalent in women's responses, especially considering that all the women were unemployed or laid off. Additionally, the inconvenience or inconvenience of treatment factored into women's consistent ability to get to the treatment clinic. The second sub themes included: treatment accessibility, social determinants of health and a Canadian treatment barrier were identified within participant responses. The major theme of Finding Your Way to Methadone factored in each of the other themes that represented women's ability to get treatment and continue to be successful in treatment.

Women in the study identified that getting to the pharmacy to receive treatment was a challenge. The women received rides from others, taxis, walked, biked, and attempted to take the city bus to get to treatment. Because of changes in the bus schedule due to COVID-19, buses in the community were not running as often and had a limited number of passengers at one time. This severely limited access to treatment for women. In fact, Evelyn noted that because of the changes to the bus system due to Covid-19 that she had to find the new bus times and negotiate a ride from her mother halfway to the treatment center. Evelyn felt that this inconvenience upset her mother. If she had not taken the first bus, it would take her mother 30 minutes each way by car so that Evelyn could obtain her methadone treatment. What is more, changes to the bus system also

made getting a spot on the bus more problematic. Only ten people were able to be on the bus at one time and once the bus was full, it would continue past anyone waiting for the bus at any further bus stops. If you were unable to get on the bus, you might not get to the pharmacy on time and therefore not receive your methadone dose. Evelyn noted that this was especially concerning on the weekends when pharmacy hours were so limited.

> Even if you left at ten (to take the bus), you might not make it (to the pharmacy for 12). You should just make it but, you never know, if it (the bus) reaches capacity, you could very well get on one bus and the next one (she has to take two busses to the pharmacy) so you might have to wait for it to come and what if it's the same thing again?

Becky's response echoed Evelyn's. She noted, not only the difficulty in finding a pharmacy located a reasonable distance from her home; but she also pointed out the obstacle of getting to treatment in good and bad conditions.

> So, finding your way to a pharmacy that actually gives out the methadone, that's around you, if you don't have transportation, that becomes a factor, weather becomes a factor. It's a pain in the ass, honestly."

Another participant, Ella, was hoping to move soon to make access to treatment less challenging for her; since she did not have a vehicle or anyone to provide transportation. Ella states "I am looking to move right now. I am looking at a place closer to my methadone clinic". When asked what she thought would help women like her stay in methadone treatment, Ella was insightful and stated that a bus that was dedicated to those receiving methadone could pick them up and drop them back off in a centralized

area. This type of transportation system exists in the city, for patients with renal dialysis. Having a dedicated bus system accessible for those with opioid use disorder accessing methadone treatment; would eliminate the challenges of transportation for many women.

Location of the pharmacy and pharmacy hours played a part in the accessibility of treatment. Many pharmacies do not dispense methadone, and this created an issue with getting to treatment in a timely way. One participant noted that when she was working, attending a pharmacy; that did not have flexible hours led to missing doses.

> With my job it became an issue, because my pharmacy, if you don't go to a 24-hour pharmacy, they closed, and I had a nine to five job at the time. I was going through the treatment when I first started so I had to find a way to go on my lunch. I tried to explain to my employer. And sometimes that's without transportation, so how do you do that? It I was tough.

Jen was also challenged by the pharmacy hours and the absence of transportation. She, like many women, was balancing several commitments that created barriers for her to get to treatment on time. The limited hours of the pharmacy posed great difficulty for her, in getting methadone treatment. At the time of the interview Jen was in a dilemma between her commitment to caring for her son and getting to the pharmacy before it closed.

> I have no transportation. I'm gonna be honest with you, I have to get my methadone by five o'clock. I have to get it today but my fiancé's not back yet. I have a son here that is sick so I can't leave right way. You know what I mean? I

> can't do that. So, it's hard when women don't have transportation or somebody by them to say, I can get you there.

Several women felt that having to receive daily treatment was inconvenient. They indicated that daily treatment prevented them from doing things like having a job, travelling, and making plans unless they revolved around receiving their methadone dose. This was especially difficult for women who did not have full "carries" of methadone; meaning they were required to give urine samples daily, as opposed to weekly. Women who had "carries" were not required to attend the pharmacy each day as they received methadone doses for multiple days. Women felt that they were tethered to getting treatment and had challenges of getting to work and keeping a job and not having to tell their employer. Others found it limited their lives, in that they could not go anywhere because they had to be present at their home pharmacy; to provide urine samples and receive their daily dose. Mary offered this insight into her experiences with making plans while going through methadone treatment.

> Up until you build up daily (carries), you always got to fit it in, especially on the weekends because hours (of the pharmacy) are so limited. So, you only have from eight am until noon. Everything is planned around making sure that you go and you dose. And sometimes if you don't; you might actually start to feel sick, which will make you want to go relapse.

Despite the challenges and inconveniences of daily methadone treatment, women accepted responsibility for attending the pharmacy and did their best to get there. One participant Daisy summed up her acceptance of the challenge of accessing methadone

daily. “Um, it’s okay. I have to go out and get drunk. I still have to go out and gem my methadone, too right? So, it’s basically the same thing.”

The social determinants of health including income, housing, food security, unemployment, health services, social safety nets, social exclusion and gender were all mentioned in participant responses. Of the social determinants of health mentioned, housing was the most pronounced in their responses. The participants described concerns with homelessness, safety in their current living environments, motel living and cohabitating with others. Daisy discussed her situation when she first started on methadone treatment and she was homeless and the difficulty that posed. As Daisy continued to receive treatment, her family noted her progress, and she was able to move in with them.

> At first, I was homeless. I was living in a tent. And so, I would have to ride my bike, hopefully make it on time or wake up during that time. Didn’t know what time it is or nothing. But I still made it to methadone. I ended up moving in with my parents and getting my ‘carries’.

Mary discussed the prevalence of the homeless problem in her community. From her perspective, one of the greatest challenges of being homeless and trying to continue on methadone is that once you choose a pharmacy to get your treatment, you can’t go to other pharmacies; even if you are not living in the same place from day to day. She identified this as a failing of the current system. Mary stated the following regarding the nature of homelessness.

> You may end up on the other end of the city, they might miss a dose because they can't get back, they can't get back, they can't go even if there is a pharmacy that's closer to them or where they're at that day, if it's not the one they agreed to when they went on their weekly appointment. They can't get methadone.

Another participant noted additional challenges when trying to persist in methadone and being homeless. When you are homeless, you are often still living in the same area as you were previously. You are still surrounded by those you may have done drugs with or those who have sold you drugs, making staying in treatment and not using illicit drugs more difficult.

Unanimously, the participants in the study expressed a desire to obtain their methadone treatment as early in the day as possible. Some participants indicated that they would attain their dose as soon as they awoke in the morning. Others chose to eat first or had to wait for childcare. Early access was important to participants because they started to feel "unwell" and "miserable" due to withdrawals from their treatment wearing off by that time. This is what participants often described as being sick or feeling sick. This feeling was avoided at all costs due to the intense pain and discomfort that was felt and was often a stimulus for using other drugs. Amanda describes that she needs to take her methadone treatment as soon as she opens her eyes in the morning and she needs an hour post treatment to begin the tasks of her day. Amanda has "full carries"; meaning she receives doses from the pharmacy for the week and is only required to do a urine test weekly and see the doctor monthly in order the get her weeks' worth of methadone. Amanda illustrates what it is like to take methadone each day.

> By the end of the day, I can start to feel it wear off. So, I'm like achy but I know as soon as I go to bed, I'll be fine, I will make it through the night. And then, but again, like I said as soon as I open my eyes, I need my methadone.

Other participants did not have "carries" and were forced to get to the pharmacy as early as possible every day to avoid feeling unwell. Evelyn illustrates what it is like to have to try to get her methadone dose as early as possible and simultaneously care for her two children.

I wake up, I give my kids food like breakfast and I try to go early, because I've been going early since the second day. I go there and sometimes I feel like, really crappy in the morning at first and then I feel, shortly after I have the drink, I start to feel a lot better and just in a positive mood. You feel a lot better from it (methadone treatment).

The final second sub theme that needs to be addressed, in this major theme, is the Canadian treatment barrier. This finding was surprising considering that Canada has socialized health care called Ontario Health Insurance (Settlement.org, 2017). If you are over the age of 25 and do not qualify for the other programs that are offered in Ontario based on your diagnosis, income or type of drug, you are required to pay for drug treatment. If working, someone with opioid use disorder would not qualify for additional funding unless their drug costs were greater than four percent of their family income. During the third interview, Becky, expressed concern that if you did not qualify for social assistance, or were identified as having a disability, you would have to pay for your own methadone treatment. Unfortunately, this meant that if you were working at a job, you would be forced to pay approximately five dollars per dose every day. This amount is

equal to $1,825 (Canadian) per year for daily methadone treatment. This may be a deterrent from receiving treatment. Becky offered this insight:

> There's no way, you're forced to go on welfare, or you're forced to stay on drugs. You have no other option. There are no other outlets. Everything is so expensive and how do you expect people to pay for treatment even though they want it? How do you expect them to pay for it if there's no government help?

The major theme of Finding Your way to Methadone is evident in participant responses. For women, finding their way to treatment posed unique barriers that affected their ability to get to and consistently receive methadone treatment. Women were challenged with travelling to treatment every day, especially due to bus changes, because of the current pandemic. Issues like housing, employment, convenience or inconvenience, social determinants of health and issues that are specific to Canadians, all contributed to the ability of women with different life circumstances, to access treatment. The second sub themes that were apparent included: treatment accessibility, social determinants of health and a Canadian treatment barrier were identified within participant responses.

Going Down the Path of Methadone

The second level sub-themes that later were enveloped into the major theme of Going Down the Path of Methadone are experiences with methadone, ebb and flow of treatment, challenges in methadone care, and effects of COVID-19. Women expressed a variety of experiences when going down the path of methadone; some participants expressed positive experiences, while others did not. Becky welcomed the opportunity to start on methadone treatment. She saw methadone as an opportunity to rid herself of the

life she was living when using opioid drugs: “Honestly, it was a relief. I couldn’t wait. I was excited. I was done with this downhill spiral in my life. And I was looking forward to it.” However, now that she has been on methadone, Becky expressed that she felt methadone was a substitution of “one addiction with another”. She stated she does not intend to be on methadone for a very long time. “I’m tired of having that ball and chain around my ankle.” Several women felt that methadone was temporary and expressed a desire to someday be off any drug treatment. Amanda also had mixed feelings about her experience with methadone treatment. Amanda had been in treatment for 15 years and spoke with authority. Her experiences were positive initially and now, after this lengthy period of treatment, it had changed: “So I thought it was the greatest thing in the world. But now I’ve been on it for 15 years and my teeth are falling out. So maybe not the best option.”

Ella had an opposing experience with methadone treatment initially. When asked about when she first received treatment, Ella indicated that she was fearful about the effectiveness of methadone treatment to effectively manage her symptoms: “It was painful because I was still getting withdrawals. It doesn’t last very long the first time. It lasted about four or five hours and I would still be sick.”

This same fear was echoed by Amanda who had unknown treatment expectations; her greatest concerns was experiencing withdrawal as she had in the past:

> It was scary because I didn’t know what to expect. I didn’t know how I was gonna feel. I didn’t know if it was gonna make me not sick. The withdrawal that you go

> through from opiates, it's unbelievable. I was really scared because I didn't want to be sick again. That was my only like, biggest concern.

When participants were asked what they would say to a woman, who was enquiring about going on methadone treatment; the women unanimously indicated that they would encourage her to do so. None of the women indicated that they would discourage her from accessing treatment. However, most of the women offered a disclaimer of warning, to those who were considering methadone treatment. Their warnings were often related to the length of time they could expect to be on treatment. The treatment length was significant to the women; or they warned that it was challenging to wean off treatment, when the women wanted to do so. Ella's response is a prime example of the women's emphatic warning. This is how Ella indicated that she would respond to a woman who was considering methadone treatment.

> I would say that if you want to do it, research it because you are technically replacing it with another drug, whatever drug you are using, but it is more controlled, but it is really really tough. I never realized how long the process was like. Do your homework. Like if you can't get off on your own, know what you are getting into, because it is a long road.

The final participant Jen offered a much more optimistic outlook on treatment. Jen indicated that despite any challenges she faced with withdrawals initially, she would emphatically recommend methadone treatment for any women seeking it. Jen had only been on treatment for a brief period of time compared to some of the other participants.

However, she expressed how being in treatment amplified her senses and gave her, her life back. Jen's statement to women is encouraging and worth noting:

> To all these women, never ever give up. Never! Go to methadone. Even if you're sick that day, even if you can't get a ride. Even if you are desperately sick, your shaking and everything, go to methadone, the one doctor. Call and go to that doctor, he'll put you on methadone and it will change your life. You will feel better 20 minutes later.

When discussing their experiences with methadone treatment, women often referred to receiving carries as something to work towards as they traveled the path of methadone. To women having carries was an achievement, an accomplishment for their dedication to staying in treatment without relapsing. Further, some of the women indicated that getting carries for methadone treatment was even more challenging than getting carries for Suboxone treatment. Once a women relapsed on methadone, one or more of her carries would be removed. This meant that she would have to come to the pharmacy more frequently to receive her methadone dose. Daisy was proud when speaking of her current progress in the methadone program and achieving carries. "Before I was at five carries, but if I'm sober this week, I think next week I'll have another carry." In the following statements, Mary was equally as enthusiastic about receiving carries and described the process of earning carries as effective and one that holds you more accountable.

> It's an accomplishment and a milestone and it gives you that pat on the back to keep going. Like, yeah, I'm doing the right thing, I'm staying clean and I

> accomplished something. And even the doctor is like, good for you! You're doing it, you're doing it right so here you go. You earn your carries.

Women in the study understood that relapse was part of being on methadone or being a part of any type of recovery from addiction for that matter. The women were candid about how they felt telling others about their relapse or having to return to their pharmacy or treatment clinic which made others aware of their relapse. Although the women were not coy about sharing their experiences, they described embarrassment and disappointment. In fact, Amanda admitted her feelings after a relapse that went on for nearly four years after quitting using opioids on her own.

> And then I decided enough was enough. I just called by myself and I had no supports because I didn't want anybody to know that I had relapsed because I felt like a failure. So, I knew nothing about methadone (when she started).

Mary felt that she would defy the odds and be someone who would not relapse and remain in recovery. She felt that this unrealistic expectation set her up to be more frustrated with herself than she might have been otherwise.

> I did have a bit more disappointment with myself because it was exactly what people kind of predicted was going to happen. But then at the same time, as much as I was disappointed in myself, I'm mot a complete failure because I'm not the only failure. A lot of people can relapse even if they are 20 years clean now.

As noted in the major theme, Reaching Out for Help, healthcare providers had a significant influence on women's experiences with methadone treatment. Women expressed admiration and appreciation for those who worked with them in addiction

treatment and described some healthcare providers who worked in non-addiction treatment less favorably. These experiences do bear mention in the major theme of Going Down the Path of Methadone, however, briefly to avoid repetition. Participant Amanda was candid in her appreciation for the addiction care practitioners, as were most of the women. Amanda discussed her community addictions treatment doctor and pharmacy and their no-nonsense approach to her and others receiving treatment. Her community addictions treatment experience stood in stark contrast to her experience in hospital.

> I love my doctor. He is amazing. He cares. He’s not gonna let you slide and if you go and screw up one week, you gotta deal with it like and adult. You know if you’re dirty, they you’re getting a carry removed and that’s it. There is no making him a pushover. He will sit and listen and every week he asks if your dose is okay, and how you’re feeling and if there’s anything you want to talk about; he’s great. My pharmacy, they’re amazing as well. They know me when I go there. But when I go to the hospital, they look at me like I’m a street junkie.

A significant part of staying in recovery for women was finding the right treatment and dosage to adequately treat their opioid use disorder withdrawal symptoms. Women discussed their struggles with changing medications from one to the other and the process of increasing the dosage of methadone after initially starting treatment. Each of these experiences presented challenges for the women but led to the effective dose and treatment they were at currently. In Becky’s response, she discussed her preference of methadone over Suboxone but still indicated that there were issues with methadone that she is dealing with.

> I thought that swapping over to Suboxone was a better choice for me at the time, which was hell in itself. But now I have swapped back over to methadone. It was just better for me. So here I am, going down the path of methadone again. I'm hoping those side effects don't happen. You retain a lot of water (on methadone) and I have swelled out a lot. I'm an athlete so I'm not used to being heavier set. And psychologically that played a big factor.

Comparably, Evelyn experienced challenges on methadone. Even after receiving her first does, she experienced the symptoms of withdrawal. It took time to finally achieve a level of treatment that worked for Evelyn.

> And since my first dose, I've gone up and everything because I still had my headaches, I was still restless., I was still agitated, my hands would shake and my legs, like restlessness. So, he (the doctor) increased it (methadone dose). I've been increasing it, but I think I finally found a number (dose) that helps.

The signs and symptoms described by Evelyn are not unique. All the participants discussed withdrawal in some capacity. They described an intense desire to avoid withdrawal whether they were still using street opioids or in treatment with methadone. Some women stated that even when they were receiving treatment initially with methadone, the dose was low and that caused them to experience withdrawal symptoms. Jen describes her experience with withdrawals while on methadone.

> At first, it was such a low dose that it doesn't help you. When you go to sleep, you can't sleep at night. You fidget your legs are shaky. It's just terrible. They can't put you on a high dose until you've been in methadone for a little while,

then you go up. I missed many days and wasn't able to go up (in dose) and stayed at 25ml for a long time. It didn't help at all. I wanted to use drugs all the time.

Women expressed a strong desire to avoid the symptoms of withdrawal. Daisy explained how experiencing withdrawal acted as a motivator to get into methadone treatment rather than suffering the aforementioned symptoms between illicit drug doses.

> Like you don't want to be sick. That's the last thing you want to be is sick. When your sick, your skin is crawling. It pushes you to get clean and like go on methadone. It doesn't work at first, we got to wait. It always takes time.

A final second sub theme that influenced women's experience with methadone is the COVID-19. How the virus effected women's experiences was surprising. Although COVID-19 had affected the data collection process for this research, making telephone interviews the only option, it was not clear that women's treatment experience was affected in any way. Only when interviewing the women for this research, did these issues come to fruition. As already mentioned in major theme Reaching Out for Help, Evelyn indicated that COVID-19 made accessing treatment easier due to having her boyfriend available to stay home with the children, so she could get methadone treatment without having to take them with her, or to find childcare for them. However, Evelyn also admitted that because parks and other popular places to bring children were closed initially, she was having difficulty finding ways to entertain her children and keep them active. COVID-19 effected each women's experience differently.

Mary offered insight into how COVID-19 was influencing her methadone treatment. She felt that the loss of her routine of getting her methadone dose, going to

work, coming home at night, sleeping, and repeating this cycle, had been taken away. Mary felt that this potentially contributed to her previous relapse. Additionally, she indicated that the overdose prevention organization she volunteered with saw an increase in relapses during the pandemic. Mary discussed how regular life routines ceased during COVID-19 and how this was something she would have looked forward to during her past when using elicit opioids.

> The boring and mundane when you're using drugs, what you actually want is to be able not to have to leave your house. A lot of relapses happened as soon as everything stared to shut down, and it is because our structure and our life went away. Staying in recovery is bout staying in structure and staying or changing what you got to do. And that was all shot out of the window come march (referring to restrictions of COVID-19).

Probably the most surprising and emotional response was how the epidemic had affected Amanda and her ability to see her son. Amanda's son lived with his father who was concerned about exposing the rest of his family to someone who did not live in their household. Not being able to see her son was difficult for Amanda but she expressed that she understood the reasoning and respected her ex-husband's wishes. Prior to COVID-19 Amanda would spend time with her son and provide him with condoms for birth control and advice. Her only contact with him now was to talk to him on the phone. Amanda stated "I'm not allowed to see him. I haven't been able to see him. So, this Covid stuff (brief pause). His dad has younger kids. Yeah. So he was, you know, pretty leery about letting me see him."

The four major themes developed from thoughtful analysis of the data using IPA by Smith et al. (2009) included: learning how to be you again, reaching out for help, finding your way to methadone, and going down the path of methadone. Each of these major themes has been discussed in detail providing ample evidence to support each major theme. The major themes were visually organized using a Venn diagram (Figure 1) to illustrate the relationship between major themes, including the nature of overlap of content, which is evident in participant statements. Participant responses provided insight into what it is like to experience opioid use disorder and receive methadone treatment as a Canadian women. Findings that were most surprising were barriers that were present for participants despite having socialized healthcare in Canada and the effects that COVID-19 on participant experiences.

Summary

The single research question for this study is: What are the lived experiences of Canadian women with opioid use disorder who choose methadone for treatment? The answer to this question can be divided into four major themes. These themes evolved from participant responses. The first major theme of Learning How to be You Again consisted of participant statements that included their role as mothers and how that fit with OUD and treatment. Also included was the motive for change, which consisted of a breaking point for participants, where they felt that they needed to make a change in their lives, which led them to methadone. In their responses, women expressed an understanding of their methadone treatment experiences as women, specifically. Finally, women discussed issues of shame and fear, which often culminated into hiding their

addiction and treatment from others. Each of these second sub themes contributed to learning how to be you again.

The second major theme of Reaching Out for Help included the role of supportive others. This role, whether they were supportive or discouraging in nature, influenced women's experiences with methadone treatment. Referred ignorance was also included here and correlated to the lack of knowledge others had, related to OUD and methadone treatment, which included issues of judgment and stigma. Finally, positive emotional engagement was found to influence participant responses and included the support, compassion, and empathy by others and themselves. These experiences culminated into reaching out for help.

The third major theme was Finding Your Way to Methadone and was focused on accessibility to methadone treatment. Included, was the cost of drug treatment, as a surprising Canadian finding, considering that Canada is a country with socialized healthcare. Finally, specific determinants of health were identified by participants as influencing their experiences of having OUD and choosing methadone treatment. Women's responses produced the theme of finding your way to methadone.

The fourth major theme was Going Down the Path of Methadone. This final theme included women's statements that were specifically about medication assisted treatment with methadone and how that affected their lives. Participants also discussed what is termed as the ebb and flow of treatment, which included experiences of relapse and working towards receiving “carries” of methadone treatment. The challenges of methadone included avoiding withdrawal and the influence of healthcare providers.

Finally, women expressed how Covid-19 influenced their treatment experience; which was an unanticipated finding of the study and was not included initially, in the interview guide. However, each of these participant experiences helped to shape the lived experiences of women with OUD, who chose methadone as treatment during a global pandemic.

Chapter 4 has provided a detailed account of the setting, demographic information, data collection procedures and the data analysis process, that occurred with this research. Evidence of trustworthiness has been explained and the results of the study have been expressed in words, providing participant accounts and visually in the Venn Diagram of Major Themes (Figure 1). In Chapter 5, the findings are explored further in relation to the current knowledge of peer-reviewed literature, found in chapter two. Moreover, the findings will be interpreted and analyzed in the context of the conceptual framework chosen for this study. Finally, limitations of the study, recommendations for future research, and implications for positive social change are illuminated in the fifth and final chapter of this dissertation.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to describe the lived experiences of women with opioid use disorder who were receiving methadone as their treatment of choice. By understanding their experience more fully, from their perspective, nurses and healthcare professionals will be able to provide women with individualized health promotion strategies and treatment (Rubio, 2016). Interpretive phenomenological qualitative methodology was used to conduct this study, which elicited insights and experiences from the participants.

This study filled the identified gap in current research knowledge by shedding light on the topic of Canadian women with opioid use disorder (OUD) who are using methadone treatment—a population that is growing (Marks & Leukefeld, 2017; Public Health Ontario, 2018). No published studies were found that considered opioid use disorder and methadone treatment from the perspective of Canadian women. Yet the numbers of women experiencing opioid use disorder and dying from it are growing (Public Health Ontario, 2018, 2019)

Participant responses from this research were analyzed using the seven steps IPA of Smith et al.(2009). From this analysis and inclusion of field notes, four major themes came to the fore. First, the major theme of learning how to be you again was derived from women's sense of self and statements of self-determination. Second, the major theme of reaching out for help was made clear by women's statements related to supportive others. Some relationships were supportive, while others were discouraging, but all relationships affected women's experiences with methadone treatment. Third, the

major theme of finding your way to methadone included women's statements about accessibility to methadone treatment. Fourth, going down the path of methadone was the final major theme. Both positive and negative experiences with methadone were expressed by women in the interviews. These four major themes represent women's experiences with methadone treatment.

Interpretation of Findings

Findings from this research study confirm, disconfirm, and extend knowledge in the discipline of nursing and addiction studies. The current findings are compared with what has been found in the peer-reviewed literature described in Chapter 2 of this dissertation. The major themes from the research will be used to organize the comparisons from the current research to the peer-reviewed content in the focused literature review.

Learning How to be You Again

In this study, women were unanimously unemployed and experienced many of the barriers and difficulties that come with low socioeconomic status. Furthermore, all but one woman had children, and each of them emphatically identified with the role of mother. But only two of the women had the primary responsibility of caring for their child, children, or grandchild. Other researchers have also supported a struggle with access to MMT and unemployment as well as women having children to care for (Bach et al., 2015; Bawor et al., 2015). Bach et al. (2015 and Bawor et al. (2015) examined gender-specific issues in methadone treatment. The authors found that women reported high unemployment rates and children to care for. This may have challenged women's

ability to access healthcare services and obtain extended healthcare coverage through employment. The findings from the current study confirm those from Bach et al. (2015) and Bawor et al. (2015), in that women with OUD accessing MMT struggle with unemployment. However, although few women in the current study had children to care for, whether women had children or not, they lacked access to healthcare services, which extends the previous research. Whether having children was an additional barrier to accessing services is not known.

The mothering role was significant for all but one participant in the current study. Five of the women in the current study sought treatment with methadone in response to losing custody of children due to their illicit opioid use. Women identified access to their children as motivation for entering MMT. One woman continued to care for her two children and did not express concern about CPS removing her children from the home, though CPS was involved. All the women who had children in the current study expressed sentiments related to the benefits to the mothering role that being on methadone presented. In related but different findings, Secco et al. (2014) found that women attended MMT to retain custody of their children and build relationships with them. The current study findings expand those of Secco et al., as even when children are taken from a women's custody, they are still a primary motivating factor influencing treatment seeking. Further, research confirms the primary importance of the relationships and bonds with children (see Bach et al., 2015; Bawor et al., 2015; Secco et al., 2014). However, in the current study, the findings expand beyond the mother and child relationship to a broader focus of the role of the mother.

Initially, women in the current study did not identify gender-specific issues in their methadone treatment. In fact, most of the women indicated that they did not see any difference at all and used statements like “we are all people.” However, after some hesitation and consideration, the women indicated that children were a major difference between men and women who were receiving methadone treatment. They noted that caring for children and carrying children were women-specific issues that have a bearing on treatment. Other research like Bach et al.’s (2015) study has shown many differences between the sexes when comparing them. Bach et al. found that for women, pregnancy was a factor that was strongly associated with MMT. In fact, men did not identify parenthood as a factor influencing their treatment whatsoever. As noted, women in the current study also identified children as motivation for receiving MMT. Children, for almost all the women in the current study, contributed to the breaking point where they experienced critical factors that led them to receive treatment. Children are a critical consideration when attracting and retaining women in MMT. However, the results did not show enough about the motivating factors for women who are not mothers.

Further, the participants described how they began using opioids and how it led to a climax that was described as a breaking point. Each woman depicted a unique experience of their introduction to using opioids, including losing custody of a child, pressure from an abusive partner, injury, and chronic pain. They described using opioids until events led to the feeling that they must make a change because they were desperate, or they were going to die. Women described this as having nothing left or losing everything. These findings echoed those from Rubio (2016). In Rubio’s study, women

described contributions to using opioids, including stressors, peer pressure, and other triggers. But there was a tipping point at which they made a change to stop using opioids as “rock bottom.” Both Rubio’s findings and the findings of this current study indicate a similar decisive point at which they recognized changing their opioid use as critical, which can act as a reminder to persevere in treatment. However, there are differences between the current study and Rubio’s study such as one woman being brought to treatment against her will, whereas the women in the current study unanimously expressed that getting treatment was their decision. The findings of the current study were described as the sub-theme of self-determination. Another difference is that women in Rubio’s study unanimously described their initial drug experiences positively, and some of the women in the current study described their first experience with opioids negatively. For example, one participant described this event as being pressured by an abusive partner. This difference can be due to individual circumstances and should be considered individually when entering treatment. Additionally, the finding of self-determination that exists among most of the women in both studies confirms that women feel empowered to enter treatment by their own accord.

Self-determination was another finding in the current study. Women made a variety of statements related to their ability to be themselves and independently make decisions. Further, women discussed their decision making related to treatment and returning to treatment after relapse. Marks and Leukfeld (2017) offer a similar finding. These researchers indicated that strength-based factors, including resilience and positive perceptions of life, can positively influence women’s recovery from OUD. These positive

perceptions can include perceptions of the self and the ability to make one's own decisions, self-determination. Additionally, resilience in difficult life circumstances or experiencing a relapse can be a function of a women's self-determination. Future interventions to support women in MMT should include methods to empower women and foster control over their own decision making.

Reaching Out for Help

Systems of support were identified by women in the current study as being an essential part of their MMT, whether the interactions were supportive or discouraging. Women provided many statements that indicated that the relationships with friends, family, children, and significant others were influential to their treatment and recovery. All but one of the participants identified having a partner who influenced her in treatment. All participants discussed relationships with friends and family and their impact on their recovery. Similarly, Letourneau et al. (2013) found that women in their study relied predominately on family and friends for support and secondarily on community resources. In a related finding, Polenick et al. (2019) found that women who reported severe loneliness were three times more likely to use illicit opioids while in MMT compared to those with moderate, mild, or no loneliness. Though the findings are not exact to what was found in this current study, they speak to the importance of significant relationships and their influence on sustaining recovery. Loneliness can be the absence of close relationships that are supportive, and this connection warrants further consideration. To be most effective, future initiatives to support women in recovery may need to be inclusive of significant others, family, and friends.

In contrast to supportive relationships, stigma from others was a barrier to receiving methadone treatment. In fact, in the current study, some women reported stigma and judgment by healthcare professionals as a detriment to their treatment. Mattocks et al. (2017) reported similar findings in their study of women's perceptions of their experiences and challenges with MMT and obstetrical care during pregnancy and the postpartum period. One of the five themes that emerged from the study included finding an obstetrician that was knowledgeable of care for women receiving MMT. Stigma among the care providers was noted among women and acted as a challenge and barrier for women receiving MMT during this period. The stigma needs to be addressed within the healthcare system to better support women in receiving MMT during all stages of life.

Despite potential barriers to treatment, women in the current study also identified a variety of resources that they considered helpful in supporting women in methadone treatment. Community resources, including healthcare services like pharmacies and addiction treatment services, were among those identified by participants. Other community agencies mentioned by women were employment and life skills training and counseling services. Other researchers have also recounted a variety of community services identified by women as helpful in addiction recovery, including healthcare, counseling, and employment assistance (Falletta et al., 2018). For instance, social support and parenting assistance support mothers into early engagement with MMT (Sicco et al., 2014).

Counseling services were also a support identified by women in the current study. Women indicated that having the opportunity to receive counseling when they determined they were ready was a resource that would help women enter and be retained in treatment. Some women felt that their OUD, and that of others, was precipitated by traumatic events that led them to abuse opioids. Others felt that receiving counseling could help them learn how to achieve their goals and transition back into society. It is important to address the psychological impact of victimization experienced by women to promote treatment retention (Levine et al., 2015; Zielinski et al., 2017). Counseling is a vehicle to address psychological issues, such as those raised by women in this current study and those in Levine et al. (2013). Women in Letourneau et al.'s study reported service preferences, including individual counseling to address more sensitive issues, followed by group sessions. Likewise, Zielinski et al. (2017) suggested counseling to promote better treatment outcomes. Initiating addiction counseling for cannabis use, OUD, and psychological issues, facilitates recovery for women experiencing SUDs. Sicco et al. (2014), offer similar findings from their study, stating that social support and parenting assistance support mothers into early engagement with MMT. Counseling is an effective measure to support women in substance use disorder SUD treatment.

Finally, relationships with CPS workers were conflicting in this current study. Regardless of whether women felt that CPS involvement was positive or negative, women were forthright about their feelings. Some women felt that CPS was supportive and did what was best for their child at the time, whereas others felt CPS workers were uniformed and unsupportive. These findings confirm those of Letourneau et al. (2013),

which showed mixed but strong feelings about CPS. When the outcome of CPS involvement ended favorably, women felt supported by CPS, even if children were removed from the home. But when the attitudes of CPS workers were negative and insincere, women felt that CPS was completely unsupportive. These inconsistent feelings about CPS were echoed in the current research findings. These findings suggest that relationships between women and CPS employees needs to be better understood.

Finding Your Way to Methadone

Women experience barriers to accessing methadone treatment in many forms. Some of the issues related to accessibility for the participants in this study included transportation, pharmacy hours, location, addiction treatment services, and limited pharmacies dispensing methadone. Many women discussed their concern with transportation by bus being a challenge during the current COVID-19 pandemic. Women in the United States, especially those with low income, have reported access to healthcare services as a barrier such as difficulty with accessing health insurance, a clinic, a health center, or a physician (Marks & Leukefeld, 2017). Women in a Canada have expressed similar concerns over accessibility to healthcare acting as a barrier to mothers participating in MMT. Women's concerns included a lack of daycare services, convenient and affordable transportation, the distance, and frequency of travel between home and MMT services (Letourneau et al., 2013). Overall, similarities in these findings suggest that women experience barriers to services that need to be addressed collectively and individually. Differences in accessibility concerns between women in the U.S. study and the Canadian studies exist. Women in both Canadian studies discuss transportation,

including cost, inconvenience, and location of treatment center as barriers in access. Whereas, in the U.S. study, women identified health insurance, access to a clinic, health center or physician. These differences may exist due to rural versus urban locations of the Canadian studies and differences in healthcare systems between the two countries.

Marks and Leukefeld (2017) also found that the healthier women were and the less pain they reported, the more likely they were to engage in health-related behavior change, while participating in MMT. Women in this current study expressed a variety of physical illnesses. One participant reported lifelong issues with chronic pain dating back to childhood. One woman reported being an athlete prior to experiencing OUD. Despite the illnesses women experienced while receiving MMT, they may be more likely to participate in behavior change if they have less pain and see themselves as healthy.

Going Down the Path of Methadone

Women in the current study described both positive and negative experiences with methadone treatment. Women described methadone and addiction treatment services as lifesaving, and their statements were positive. In fact, all the women stated that they would encourage other women to receive methadone treatment if they were considering it. At the same time, some of the women in the current study had negative outlooks on methadone, describing the side effects of treatment that were initially unknown to them and the difficulties in getting off methadone treatment when they wanted to. Moreover, two participants described methadone treatment as swapping one addiction for another. Participants in previous research have voiced similar experiences. Findings in Rubio's (2016) study were mixed. Nine of the 13 participants in this study expressed positive

sentiments about methadone treatment, expressing that it was a positive experience to get back to "normal life." Conversely, two of the participants had mixed feelings about methadone treatment, and two others had completely negative views. The findings, of the current study, confirm what is known from Rubio's study (Rubio, 2016). Women receiving MMT indicate both positive and negative views, yet they still choose to access this treatment. This could indicate that the positives outweigh the negatives when it comes to MMT.

The preference for methadone over other medication assisted treatment was another consistent finding between the current study and previous research (Mattocks et al., 2017). In the current study, some of the women had previously been on suboxone, a combination of buprenorphine and naloxone, and experienced withdrawal symptoms. This led to them switching over to methadone treatment, which they found to be more effective. One participant had been on suboxone previously and relapsed. After returning to treatment, she found that suboxone was no longer effective in controlling her withdrawal symptoms and had to begin treatment with methadone, which effectively managed her symptoms. Participants in a study by Mattocks et al. (2017) also expressed their preference for methadone because it prevented the sickness associated with withdrawal. Prior to taking methadone, participants were taking buprenorphine, a component of suboxone and continued to experience withdrawal symptoms. In that same study, physicians were essential in finding the right dose of their methadone to treat women during pregnancy. Correspondingly, women in this current study expressed concern about receiving an appropriate dose that would prevent withdrawal, something

they emphasized as being paramount. Finding effective treatment and dosing is a critical consideration for women seeking methadone treatment.

A final confirming finding was related to the cost of MMT in Canada. This finding was surprising. Women in the current study indicated that the cost of treatment was a factor that challenged women's ability to receive MMT. One woman expressed frustration in her comment that a woman may have to make a choice between going on social services, otherwise known as welfare, or continuing to use illicit opioids. Canadian women have access to free healthcare services through the Ontario Health Insurance Plan; however, they do not always have access to free medications (Ministry of Health and Long-Term Care, 2018). Only in specific circumstances do Ontarians have access to free prescriptions; for example, those who receive social services in the form of Ontario Works, Ontario Disability Support Program have access to free medications or those under the age of 24 years old. In an American study, Marks and Leukefeld (2017) indicated that women in their study who received additional financial support through various government services were more likely to participate in substance-related behavior changes such as methadone treatment. In this US study, women with OUD experienced limited healthcare service access, including prescriptions. While women in the current study had healthcare access from socialized healthcare found in Canada, they too did not have access to methadone universally. Additional financial support is needed for women entering MMT.

Interpretation of Findings and the Conceptual Framework

The conceptual framework for this study is derived from the middle range theory, self-care of chronic illness (Riegel et al., 2012). Self-care is defined as a process of maintaining health through health-promoting practices and managing illness (Riegel et al., 2004). Self-care is an essential element in chronic illness. Addiction is considered a chronic illness that requires ongoing treatment and intervention (Morse, 2018). Self-care of chronic illness theory includes three concepts: self-care maintenance, self-care monitoring, and self-care management (Riegel et al., 2012). Assumptions, propositions, and a variety of barriers and facilitators influence the process of self-care. The current research findings can be viewed through the lens of this theory.

Changes that occur due to chronic illness require adaptation. Participants accessed methadone treatment and other interventions to maintain recovery, self-care maintenance. Participants expressed both positive and negative experiences with methadone treatment. Treatment was required daily, and participants needed to find ways to access treatment. Supportive systems such as friends, family, counselors, healthcare providers, and other community support provided much-needed assistance to persevere in treatment. Moreover, women expressed self-determination in their ability to maintain treatment despite all the barriers that might have been experienced. Women expressed many sentiments that exhibited how they were the decision-makers in their treatment and recovery. Women coped with withdrawal symptoms by continuing to attend their methadone treatment and physician visits to adjust their dose as needed. They also found that staying home and disconnecting from those who were not supportive in their

treatment was an effective measure to remain in recovery. Healthcare provider supported women in treatment by providing regular medical follow up appointments and supervision. Daily, women avoided withdrawal symptoms by accessing treatment as early as possible and one participant managed by using other illicit drugs. Women performed self-care maintenance by accessing medication and using illicit drugs, distancing from some, receiving support from others, and expressing self-determination to continue in treatment and maintain recovery.

The second concept in Self-Care Chronic Illness theory is self-care monitoring. As change in their chronic condition occurred, women had to self-assess and determine when they needed to reach out to others for assistance or make changes. For example, when one participant was using Suboxone, body listening led to her accessing the addiction treatment physician to adjust her treatment. The participant was experiencing withdrawal symptoms that were causing her to relapse. Women in the study performed other forms of self-care monitoring, including urinalysis. Supervised urinalysis was completed by participants to determine if other drugs were in the women's system. If drugs were found, women could have a carry removed or otherwise be set back in treatment. Other assessments were performed to monitor for changes by the physician, nurses, and pharmacy staff. These included medical exams and assessments. Women attempted to be vigilant in self-care monitoring to prevent relapse but recognized this was not always perfect, as relapse was part of their recovery journey. Self-care monitoring was ongoing and required body listening for signs and symptoms of a change in condition. Women expressed that sometimes they would experience cravings and

withdrawals, a change in their condition. Once the participant recognized a change in their condition, the action required was the next step in self-care of chronic illness theory, self-care management.

Self-care management occurred when women accessed a healthcare provider in response to changes in their conditions. These conditions included withdrawals or cravings. Treatment from the addiction treatment physician and other healthcare providers included adjusting the methadone dose, helping to find community supports, and making suggestions for behavior change. Other women acted on this change in their condition by accessing illicit drugs. No matter their choice, women acted by self-determination to initiate the course of action. When women identified triggers to using opioids, they altered their behavior accordingly. For example, some women identified individuals who were not supportive of their treatment. When they did, women chose to distance themselves and disconnect from them. Other responses to changes included talking to a counselor or a community support person, friend, or family member who would provide assistance or a listening ear. Their responses were often positive and helped to maintain their recovery. Women made decisions to act on changes in their condition to seek help, use illicit drugs, or change their behavior.

Essential components to the three concepts of self-care of chronic illness include the processes of decision making and reflection. The first process, decision making, was reflected in the response by women in the current study. As discussed, women expressed self-determination in their actions to enter and maintain recovery. However, some decisions made were not always appropriate. In the past, when the women experienced

withdrawal, some returned to using opioids or other drugs to relieve their discomforts. The second process is evident in women's decision to change that behavior and not return to opioids at other times. Of the women who relapsed, some experienced shame and were embarrassed to return to treatment. Other women chose to hide their relapse or treatment with MMT. Their decisions were based on their reflection of previous behavior and decisions. Both processes of decision making, and reflection are evident in women's experiences in this study.

Limitations of the Study

There are several limitations to the current study. The smaller sample size and purposive sampling method limit the generalizability of the findings. However, the purpose of the study to develop a deeper understanding of women's experiences, which was achieved. The descriptive nature of the research enables readers to determine transferability to other contexts, in part or whole. To mitigate the issue of smaller sample size, snowball sampling was used as planned, and seven participants were included in the research.

Further limitations exist in the data collection method. The COVID-19 pandemic also posed challenges that led to limitations in this study. Due to requirements to limit contact, all interviews were conducted by phone rather than face to face, as initially planned. Using voice to text software and a recording device limited clarity of some responses, which led to reviewing the recording and transcripts multiple times to ensure accuracy. This occurred despite the exemplary quality of software and the recording device. The inability to have face to face interviews posed additional limitations. Having

to use a phone for the interview required participants to have access to a cellular phone, with 30 minutes to an hour of time available on their phone plan or purchased minutes for 'pay as you go' phone cards. This would be an additional cost for participants. In addition, keeping a phone charged for 30 to 60 minutes presented a challenge due to transient living conditions. Although the addiction treatment centers offered for participants to use their landline phone, none of the participants felt that it was an option they would agree to. This may be due to not wanting to be seen spending any more time than necessary at the clinic, transportation issues or concerns related to COVID-19. Lastly, face to face interviews allow the interviewer to see expressions and emotions that were otherwise lost with phone interviews. The initial plan of face to face interviews would have alleviated these limitations.

Recommendations

A variety of recommendations for further research exist that are grounded in the strengths and limitations of this study; as well as the literature reviewed in Chapter 2 and the findings of this research. First, additional phenomenological studies need to be conducted to examine the experiences of Canadian women with opioid use disorder who choose methadone for treatment. As indicated in Chapter 2, this is a significant gap in the qualitative literature. Expanding our knowledge of women's experiences can help add to what is now known by confirming the emergent themes of self-determination, improving care experiences, fostering support of others, and promoting accessibility of care for women in these circumstances found in this study.

At the present time, methadone continues to be the most widely used ORT for those with OUD; and the number of women being treated continues to rise (Public Health Ontario, 2018). Women from this and other studies indicated mixed perceptions of methadone (Rubio, 2016). To have a clearer understanding of this phenomenon, future studies, including replication of this study, should be accomplished using other groups of women. Results from this finding may help healthcare professionals collaborate with women; to emphasize the positive and mitigate the negative effects of treatment. For example, women expressed that knowing how difficult it would be to transition off of methadone treatment completely would have influenced their decision to accept treatment or at least they would have been prepared for their future on methadone.

Second, while some quantitative studies have been conducted on OUD and MMT, few phenomenological studies have been conducted on just women and no studies on just Canadian women. Based on the findings of the current study, future studies should consider women's self-determination in treatment and motivation for perseverance. Overall, studies should explore how women's self-determination is a key factor in treatment perseverance. Knowing this information may foster future interventions that strengthen women's self-determination, which may influence women's participation in MMT.

Third, future research should focus on accessibility of treatment for women and include a variety of factors that influence women entering and continuing in treatment. Past research studies have found accessibility to be a barrier for low-income women with no health insurance and for women with children in tow (Letourneau et al., 2013; Marks

& Leukefeld, 2017). Based on the findings of the current study, the specific aspects of accessibility including transportation, availability, and cost need to be investigated as they relate to women's MMT. Specifically, in Canada, studies that consider medication cost in socialized healthcare should be conducted. Other countries with socialized healthcare, which have paid medication costs, may not experience the same barriers. Knowing this information can assist in policy development that focuses on supporting women into treatment.

Fourth, the effects of COVID-19 are another surprising finding of this research. Women experienced mostly negative effects on their care due to COVID-19, while one participant experienced the positive effect of having a significant other unemployed due to COVID-19. The significant other's unemployment allowed him to stay at home with the children while the participant received methadone, rather than having to take the children with her. To more fully support women who are currently accessing methadone treatment or may be in the future, a deeper understanding of the effects of COVID-19 on MMT needs to be investigated further.

Fifth, women in the current study, identified children and mothering as motivating factors to treatment; but also discussed mixed experiences with CPS. Similarly, other studies examined the effects of MMT on parenting and the relationship between mother and child (Letourneau et al., 2013; Secco et al., 2014). Another examined women's perceptions of CPS with mixed results, similar to the current study. The mother's relationship with children, as well as CPS, was complex and requires further investigation to better understand the factors that influence these experiences. Concerns with removing

children from home; and judgment from CPS workers worried women in MMT (Secco et al., 2014). The focus of future studies should be on how access to children, parenting, and relationships can be fostered to support and retain women into treatment. Studies regarding the effects of child separation from the parent during treatment on the parent-child relationship may help provide evidence to encourage women into treatment. Additionally, motivating factors for women who do not have children may also prove fruitful determining factors that can promote treatment motivation and persistence.

Finally, significant relationships in a woman's life who is receiving MMT is another area that requires further research. Fostering these relationships for women in MMT can potentially improve women's addiction care. Women noted the importance of these relationships in getting into treatment and providing much needed support like transportation and emotional support. Support systems can also include healthcare providers. Supportive relationships between healthcare providers and patients have been found to be essential for patient in MMT (Mattocks et al., 2017). Studies that focus on this supportive relationship must be investigated further to gain knowledge of how healthcare providers can improve treatment retention by their personal interactions with women. Studies that investigate the nature of these relationships and how to foster them fully can contribute to successful recovery for women with OUD accessing MMT.

Implications for Positive Social Change

The potential impact for positive social change at the individual, family, organizational, and societal levels can be noted. Here, tangible improvements are described, and the implications are discussed. Finally, recommendations for practice are

explained. This study presents many opportunities for positive social change and practice changes in nursing and healthcare.

Outcomes of this study can influence positive social change for individuals. Women who have had the opportunity to tell their experiences felt as though they were helping other women by sharing their insights. This may have empowered women to feel more positively about treatment and their contribution to the understanding of OUD. Additionally, the findings support improvements for gender-specific care for women. By receiving more individualized care, each woman can be supported to improve their quality of life by remaining in treatment. Other women may be attracted to treatment; if they are aware of the practices that have been implemented to support them. For example, if women have resources that support their mental health, like counseling, at the place where they receive MMT, women may be more likely to experience positive outcomes. Practices that facilitate women's self-determination may improve their ability to enter and remain in treatment. As well, women may benefit from having their treatment facility implement more family-centered treatment. Including family and close friends in treatment may facilitate better understanding and support from them. This action may broaden the much-needed support system of women with OUD, who choose methadone as treatment.

Individual healthcare providers, healthcare organizations, and CPS will benefit from positive social change based on the findings of this research. By reading and understanding the implications of their behaviors towards women with OUD; these individuals can self-reflect and provide appropriate support to women with OUD who are

experiencing OUD. These individuals and organizations can review the findings of the research and implement practice changes that support women with OUD, who have children, and are accessing MMT. These changes can reduce stigma and fear of healthcare providers and members of CPS. For example, providing reassurance and a non-judgmental attitude towards women can foster a more collaborative relationship and help women to continue on in treatment.

Organizations may benefit from positive social change related to the findings of this research study. Organizations that care for individuals with OUD may benefit by reviewing their policies and procedures that may create barriers for women with OUD. Influencing change in organizations' policies like hours of operation on weekends, access to additional services on-site, and attitudes of staff may help to improve accessibility to services. City organizations may benefit by understanding the importance of frequent and reliable public transportation for individuals with OUD receiving MMT, even during times of pandemics. The current COVID-19 pandemic continues, and access to care should be a primary consideration for healthcare organizations and communities.

The impact of positive social change at the societal level can be incurred when considering the improved outcomes of a healthier society. Society may be improved when knowledge is gained regarding a highly stigmatized group. By presenting insights from women themselves, knowledge can be gleaned of the struggles and barriers women face; when trying to get into and succeed in recovery. Educating the public may help to reduce the stigma experienced by women who have OUD and accessing MMT. As well, the findings of this study shine a light on the barrier of cost of methadone treatment.

Although Canada has socialized healthcare, the lack of access to free medication as part of healthcare presents barriers to women getting help. This finding exposes a barrier to health. It is a lack of access to medications based on income and private insurance. A final societal implication for positive social change is the need to provide access and support to women with OUD during a pandemic. The findings expose the need to change the response to pandemics, specifically for women with OUD. The current study findings can influence positive social change for societies and policies.

The findings of this study add to the body of qualitative researcher overall. It also adds to the limited qualitative research on women with OUD who choose methadone as their treatment of choice. This current research study is the only Canadian phenomenological study on women's experience with OUD accessing MMT. The study adds to Canada's body of knowledge on this growing epidemic. Although research in this area is expanding, most of the research studies that were found on this topic were quantitative. It can be difficult to gain access to vulnerable groups to participate in research. Moreover, due to the personal nature of the phenomenological inquiry, participation in research studies such as this can pose additional challenges. To access women with OUD using MMT, who will discuss their sometimes painful and difficult experiences is challenging; and makes the insights of this research that much more poignant.

This study extends the use of self-care of chronic illness theory by Riegel et al. (2012) to addiction studies. The conceptual model has been applied in other chronic conditions, including heart failure (Jaarsma et al., 2013), diabetes (Ausili et al., 2017),

and, more recently, eating disorders (Sitarz, 2020). However, this is the first study of its kind to apply this theory to addiction, OUD. In the future, other types of SUD studies may utilize this theory in their investigations.

Based on the findings from this study, practice recommendations can be made. Nurses and other healthcare professionals need to be aware of the impact their attitudes and interactions on women with OUD who are accessing treatment. Since negative attitudes deter women from accessing treatment and positive interactions made women feel supported, nurses need to ensure a positive approach to these women. By improving attitudes and interactions, nurses can help to improve women's methadone treatment experiences. Nursing assessments should include such areas as self-determination and accessibility to facilitate women receiving treatment. Practice changes should also involve the inclusion of the women's support systems in treatment interventions. By including supportive others in women's OUD care, families and friends can develop knowledge to adequately support them. Knowledge can also be supported by nursing student education. Nursing education should include a robust mental health and addictions curriculum. More knowledgeable nursing students will eventually become nurses who understand OUD and can act as future advocates for women's OUD care.

Conclusions

This phenomenological study focused on women's experiences with treatment for OUD in a Canadian context. Seven women provided their thoughts and experiences on accessing methadone treatment for OUD and how this affected them and those around them. The influence of their families, friends, significant others, and children have been

discussed in detail, exposing personal feelings. Women offered their thoughts on how to support women in treatment and their experiences, both positive and negative, with MMT, including interactions with healthcare professionals. Perceptions of community organizations, healthcare providers, and accessing treatment were exposed. Woman's' path to methadone treatment, including the breaking point at which women were faced with treatment, as the best or only option, was revealed. Finally, women expressed a strong personal conviction leading them to make the decision of treatment and continue the path of methadone, which I termed self-determination.

To date, researchers have not adequately examined the experiences of this population in terms of perceptions of their experiences in methadone treatment in Canada. These insights can support healthcare providers, organizations, and society; to improve care for Canadian women who are accessing methadone treatment. Nurses and other healthcare providers can use the findings of this research to positively influence the experiences of women with OUD who are in MMT, and support them to continue their lifelong recovery process.

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Appendix: Interview Guide

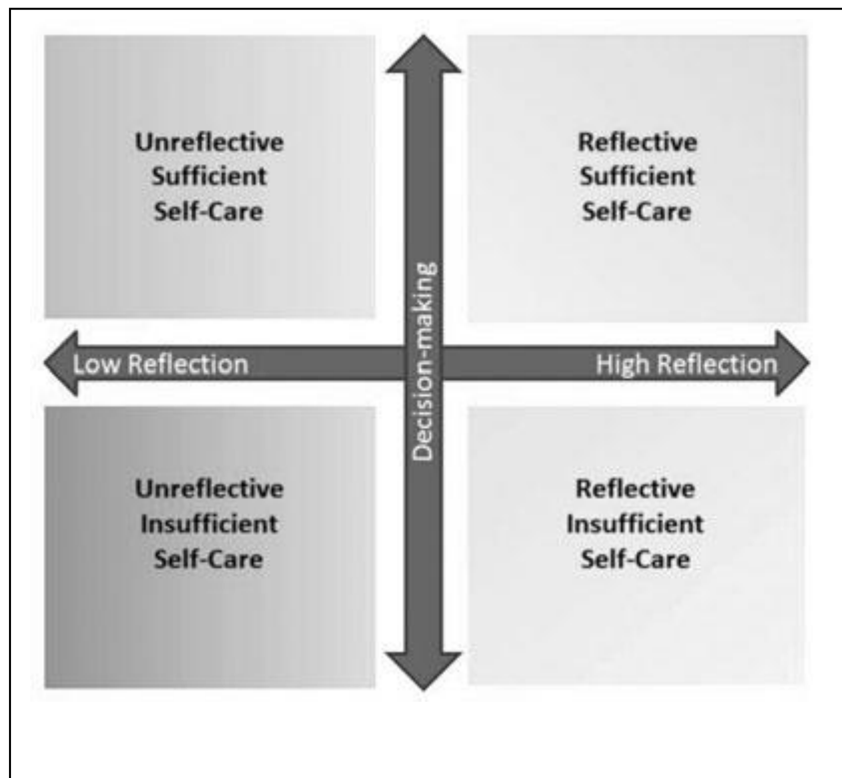
Central Research Question: What are the lived experiences of Canadian women with opioid use disorder who choose methadone for treatment?			
Main Questions	Potential Follow Up/Focus Questions	Conceptual Framework Element Alignment	Research Question Purpose Alignment
Demographic Questions: How old are you? Do you work? What type of work do you do? Where do you live? Do you have anyone living with you? Do you have a significant other? Are you married, divorced, common-law, widower? Do you have any children living with you? Do you have any children who don't?			Establishing demographic data to compare other populations or samples.
Please tell me about yourself.		Reflection is an essential aspect of all concepts within the Self-Care of Chronic Illness Theory (Riegel, Jaarsma & Stromberg, 2012).	Open dialogue for participant to begin sharing personal information related to the phenomenon.
Please tell me about your experience of first using opioids.		Reflection is an essential component to the definition of self-care and is also an important element in the concepts of self-care maintenance, monitoring and management (Riegel, Jaarsma & Stromberg, 2012)	Contributes to our understanding of the participants individual lived experience of this phenomenon. Contributes to CRQ
Can you describe a typical day in your life when you were struggling with using opioids?	What did that experience mean to you? Were there others who influenced your experience? What life events if any influenced your decision to use opioids?	Self-care is a daily activity that involves maintenance, monitoring and management with chronic illness (Riegel, Jaarsma & Stromberg, 2012).	Provides greater depth of understanding of the individuals lived experience. Contributes to CRQ
What led you to methadone treatment?		Decision making in response to signs and symptoms is an essential aspect of self-care in chronic illness. Self-care monitoring of physical and cognitive changes leads to the response of decision making about taking action (Riegel, Jaarsma & Stromberg, 2012).	Establishes understanding of the development of chronicity of addiction in this context. Contributes to CRQ

What was the experience like receiving methadone treatment for the first time?	Was there a specific event or series of events? Can you tell me more about that? In what way, if any, do your relationships impact treatment? Was there anyone/anything who encouraged you to get help? Prevented you from getting help?	Self-care management involves treatment decisions in response to signs and symptoms. It also requires attention to the effectiveness of the treatment and determination of the success of the approach and if it should be repeated. Support from others is factor affecting self-care of chronic illness (Riegel, Jaarsma & Stromberg, 2012).	Establishes understanding of the unique experience of the phenomenon. Contributes to CRQ
Please describe your experiences in the healthcare system.	Were there any factors that influenced your experience? Please describe your experiences in the healthcare system.	Access to healthcare influences self-care in chronic. Lack of access leads individuals to seek guidance from less qualified others including friends, neighbors and parented. This can lead to poor health (Riegel, Jaarsma & Stromberg, 2012).	Establishes our understanding of the experience of receiving care in a Canadian context. Contributes to CRQ
How does methadone treatment affect your life?	What was it like to access methadone? How has this affected you and your family/relationships? How did healthcare professionals influence your experience?	Adherence to therapy is influenced by healthcare providers and is associated with evidenced based care and therefore, the best outcomes (Riegel, Jaarsma & Stromberg, 2012)	Establishes chronic illness and/or nursing contexts Contributes to CRQ
What was it like to receive a diagnosis of opioid use disorder (opioid addiction)?	How did it affect you positively and/or negatively?	Self-care management involves evaluation of changes and how to respond. In self-care monitoring, recognizing an emotional change occurs with personal insight and interpersonal awareness (Riegel, Jaarsma & Stromberg, 2012)	
What is it like being a woman on methadone?	What did it mean to you? What should people know about being a woman on methadone?	Self-reflection involving awareness and insight influences all concepts within the framework (Riegel, Jaarsma & Stromberg, 2012).	Establishes understanding of the unique experience of women with OUD. Contributes to the CRQ
How would you describe a typical day for you when you receive treatment?		Establishing the context of chronic illness self-care involves daily processes of self-care monitoring maintenance and management (Riegel, Jaarsma & Stromberg, 2012).	Contributes to our understanding of the lived experience of receiving daily treatment in the community for OUD. Contributes to CRQ

Do the attitudes of other affect your experience when receiving treatment?	Is there anyone who helps you? In what way do they help you? In your opinion, what needs to be added or changed to help women in treatment?	Support from others directly influences all concepts within self-care including monitoring, management and maintenance (Riegel, Jaarsma & Stromberg, 2012).	Contributes to our understanding of contributing factors associated with experiences of treatment. Contributes to CRQ
What supports are in place to help you stay in treatment? What supports do you need to stay in treatment?	What makes receiving treatment more difficult? What makes receiving treatment easier? Some people find that issues like: Food, finance, travel, childcare can make getting treatment difficult. Do you find that?	In self-care management, treatment implementation and evaluation occur. Treatment often involves consultation with a healthcare provider. Evaluation of the treatment approach can lead to repetition and adherence to the treatment. A personal cost-benefit analysis can influence an individual's decision related to treatment (Riegel, Jaarsma & Stromberg, 2012)	Establishes the concepts of nursing care and chronic illness care within the community. Contributes to CRQ
What supports do you see that other people need to get into/ keep coming to treatment? In a perfect situation, what would be in place to help women get methadone treatment?	If yes, what are their attitudes and how do they affect you?	Support from others directly influences all concepts within self-care including monitoring, management and maintenance (Riegel, Jaarsma & Stromberg, 2012).	Establishes the concepts of nursing care and chronic illness care within the community. Contributes to CRQ
Is there anything that I have not asked that you think that I should know?		Reflection is an essential component to self-care of chronic illness (Riegel, Jaarsma & Stromberg, 2012).	Providing the opportunity for participants to address any thoughts or ideas related to the experience that have not been addressed in the questions asked. Contributes to CRQ

Figure A1

Reflection Sufficiency and Decision-Making Self-Care



The relationship of decision-making and reflection on self-care. Reflection promotes knowledge development and helps to determine the quality and effectiveness of self-care. when individuals make decisions, they can be sufficient or insufficient, purposeful or unintentional, reasoned and reflective, or automatic and unobservant. The goal is reflective sufficient self-care.

Combinations of self-care and reflection are illustrated by Riegel, Jaarsma and Stromberg, 2012 A middle-range theory of self-care of chronic illness. *Advances in Nursing Science, 35*(3), 194-204. doi: 10.1097/ANS.0b013e318261b1ba.