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Permalink
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Journal
Journal of Addictive Diseases, 27(4)

ISSN
1055-0887

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Publication Date
2008-09-19

DOI
10.1080/10550880802324499

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Journal of Addictive Diseases

ISSN: 1055-0887 (Print) 1545-0848 (Online) Journal homepage: http://www.tandfonline.com/loi/wjad20

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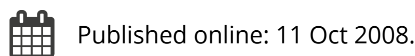
To cite this article: Adeline Nyamathi ANP, PhD, FAAN , Viviane de Castro PhD , Donna McNeese-Smith RN, EdD, CNAA , Kamala Nyamathi BS , Steven Shoptaw PhD , Mary Marfisee MD , Farinaz Khalilifard MFTI & Allan Cohen MA, MFT (2008) Alcohol Use Reduction Program in Methadone Maintained Individuals with Hepatitis C Virus Infection, Journal of Addictive Diseases, 27:4, 27-33

To link to this article: http://dx.doi.org/10.1080/10550880802324499



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Alcohol Use Reduction Program in Methadone Maintained Individuals with Hepatitis C Virus Infection

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ABSTRACT. The purpose of this article was to investigate the personal and social barriers experienced by methadone maintained clients when seeking treatment for alcohol abuse along with strategies for engaging such clients in treatment programs. A qualitative design using semi-structured focus groups was used to obtain the perspectives of 41 methadone-maintained clients in Los Angeles, California. Sessions were recorded, transcribed, and content-analyzed. Attitudes of health care providers were considered critical factors for engaging clients in treatment programs. Other facilitators included incentives and forms of support (emotional, financial, or material aid), whereas barriers consisted of lack of provider knowledge and insensitivity to acquiring needed resources. Clients also discussed the importance of personal attributes in achieving successful behavioral change, such as personal motivation. The findings suggest that healthcare providers' strategies designed to boost motivation, combined with various types of support, may prove successful in alcohol reduction among methadone-maintained clients.

KEYWORDS. Alcohol use reduction, methadone-maintained adults, qualitative methods

INTRODUCTION

Clients enrolled in methadone maintenance programs are engaged in a treatment process that is generally considered a first step toward developing health promoting behaviors. Currently, more than 100,000 clients are enrolled in methadone maintenance programs in the United States.[1] Unfortunately, concomitant with the past history of heroin use is a history of heavy alcohol consumption; those treated in methadone programs drink significantly more alcohol daily than non-methadone maintained heroin users.[2] It is estimated that up to half of all methadone

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Supported by the National Institute of Alcohol Abuse and Alcoholism AA015759.

Journal of Addictive Diseases, Vol. 27(4) 2008
Available online at http://www.haworthpress.com
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doi: 10.1080/10550880802324499

maintained clients are heavy alcohol users.[3] In addition to alcohol, cocaine, and other opiates are commonly used drugs by these clients.[4]

As previous injection drug users, methadone maintained clients are reportedly less healthy and experience a higher mortality rate than the general population.[5] Of greatest concern are infections caused by the hepatitis C virus (HCV) and hepatitis B virus (HBV), and for some, human immunodeficiency virus. It is estimated that 70% of methadone maintained clients in the United States are already infected with HCV.[6] Of these, 60% to 85% progress to a stage of chronicity over a 30-year period.[7–9] Concomitant medical problems have included headaches, gastrointestinal disturbances, fatigue, and sleep problems.[10] Psychological problems in the form of depression, somatization, obsessive-compulsive behavior, and phobias are also prevalent.[4] Aside from social and behavioral activities or consequences of alcohol use and abuse, including ongoing drug use and unprotected sexual activity,[11] another concern is that methadone maintained clients using alcohol who are not engaged in alcohol treatment are at greater risk for terminating methadone maintained programs; these rates are as high as 70% to 80%.[4]

Despite the severity of alcohol use among methadone maintained clients, there is little attention paid to the types of treatment approaches that might work in outpatient settings, such as within methadone maintenance clinics. Over the past several years, it has been discovered that brief behavioral interventions that address alcohol reduction may be feasible and acceptable to methadone maintained clinic administrators and clients.[12] Brief interventions, characterized by their short duration and low intensity, have demonstrated efficacy in reducing risky alcohol drinking.[13] Furthermore, screening accompanied by brief intervention ranks among the seven most cost beneficial prevention services.[14] These findings argue that a brief intervention model for reducing alcohol use among patients receiving chronic opioid agonist therapy should be evaluated.

One strategy employed in alcohol use reduction is Motivational Interviewing, an approach that incorporates reflective listening, elicits motivational statements from clients, examines the positive and negative sides of the client's ambivalent statements, and reduces resistance by monitoring clients' readiness while not pushing change prematurely.[15] Findings of more than 30 clinical trials have reported brief Motivational Interviewing sessions as being beneficial for alcohol and drug addiction, with an effect greater among heavier users of alcohol and drugs than among cigarette smokers.[15,16] In addition, Motivational Interviewing was found to be effective with both substance-dependent and substance-abusing people.[15] Still, little is know about the importance of motivation and the barriers methadone maintained clients experience in seeking alcohol reduction programs.

In a recent qualitative study assessing 41 methadone maintained clients, findings revealed that major barriers were experienced in seeking access to basic health care.[17] Discrimination by health care providers was pervasive when clients' methadone status was revealed, a stigma exacerbated by the clients' abuse of alcohol and other drugs. Lack of primary care providers and limited access to health care facilities both contributed to an inability to receive adequate health care.

The purpose of this study was to further investigate, through qualitative research, the personal and social barriers methadone maintained clients faced in seeking alcohol treatment and strategies (such as the use of motivation) that might successfully engage methadone maintained clients using alcohol in treatment.

METHODS

Design

A qualitative focus group approach was conducted with clients of a Los Angeles methadone maintained clinic, the Bay Area Addiction Research and Treatment, Inc. (BAART), to determine their interest in having such an on-site program available to them. Quantitative data were also collected on demographics and alcohol use of clients. The UCLA Human Subjects Protection Committee provided oversight of all study activities.

Subjects and Setting

The research team recruited a convenience sample of 41 methadone maintained adults for focus group discussions about treatment for substance abuse. Current methadone maintained clients of the Los Angeles BAART clinic were considered eligible for participation in this study if they were over the age of 18 and had been enrolled in the methadone maintained program for at least 3 months. Out of 400 clients attending the clinic, a total of four focus groups were conducted in September 2006, with 8 to 11 participants per session.

Procedure

This community-based study engaged key leadership and clinic staff to help design and plan the study. The researchers met with the administration and staff of the BAART program and reviewed the questionnaire guide for leading the focus groups. Assistance was also provided by the Director and staff, posting recruitment flyers at the BAART site. The researchers, including the focus group facilitators, recruited participants on-site prior to the scheduled focus groups, and administered informed consents, socio-demographic questionnaires, and an alcohol screener with each eligible client interested in participating in the study. Focus groups were conducted in a private area within the BAART facility and data were collected through audio recordings. Non-verbal communication and other evidence were noted by one of the co-facilitators. Participants all received a nominal cash payment for their participation after the sessions ended.

Socio-Demographic Data

Socio-demographic assessment included the items of age, gender, ethnicity, and quantity and frequency of alcohol use.

Semi-Structured Interview Guide

A semi-structured interview guide (SSIG) was used to facilitate each session, and revised in a linguistically appropriate manner with our community partners.

Data Analysis

Tape recordings of each focus group were transcribed after all the sessions were completed and observational notes were incorporated as appropriate. Content analysis was conducted directly from the transcripts using Glaser's[18] constant comparative method: a line-by-line analysis of data that is coded into relevant sentences and phrases that constituted "themes." Saturation was reached after concurrent coding no longer yielded unique categories.

RESULTS

Socio-Demographics

Participants ranged in age from 24 to 73 years, with a median of 44 years. The majority of the methadone maintained clients were white (n = 17; 41.5%), followed by Hispanic-Americans (n = 9; 22.0%), and African-Americans (n = 8; 19.5%), six were of mixed ethnicity (14.2%), and 1 (2.8%) was "Other." Most participants were male (n = 28; 68.3%). Participants reported drinking between 0 to 10 drinks per week or more. Others consumed 12 or more drinks per day (n = 12; 29.3%), followed by 4 to 5 drinks per day (n = 7; 17.1%), 2 to 3 drinks per day (n = 8; 19.5%), or 1 drink per day (n = 6; 14.6%). Eight people reported no alcohol use in the past 6 months (19.5%).

Major Themes

The participants verbalized several themes that related to developing a successful alcohol reduction program within a methadone maintenance setting. These themes centered on the use and significance of alcohol use for methadone maintained clients and strategies these clients perceived might help providers in designing culturally sensitive programs. Table 1 provides a summary of the major themes and sample illustrative quotes of the participants.

Use and Significance of Alcohol and Other Drugs

The clients recollected the role of alcohol in the lives of several addicts maintained on

TABLE 1. Major Themes of Focus Group Participants and Their Comments

Theme	Comment
Use and Significance of Alcohol and Other Drugs	"I have found that people that are on methadone are also on alcohol. . . . But, it's not enough of a euphoric for us. So we end up taking . . . pills. . . . We combine 'em, because we wanna intensify the euphoria of taking the methadone and . . . . So when we're combining all those drugs together, the hardest one I feel is alcohol to drop, because . . . you know, it's cooling . . . you're high on it . . . [it] gives you the highest euphoria. . . ."
Attitude of Health Care Provider	"You don't have to be thrown. . . well, you know. . . with the guilt. . . . The guilt is what keeps us down . . . . The guilt is what keeps us on alcohol . . . on drugs . . . to escape. . . . So we don't need guilt thrown at us. . . . We wanna know how can we be helped today. . . ."
Importance of Motivation	"If I know that I done seen her down, and I done seen her layin' in the streets. . . . I done seen her pee on herself in the streets. . . . And I looked at her today: she's clean, she's got a new job. . . . I mean she's just a whole totally different person! I figure myself, 'Well, if she can do it, I can do it too!'. . . . You cannot depend on somebody else to take care of you all the time!"
Support in Many Forms Is Critical	" . . . . So, along with getting the person off alcohol, you oughtta have somethin' for them to be able to do once they get off this alcohol, as far as. . . . These people have jobs, and you can go here for jobs . . . and you can go here for this, and you can go here for that . . . . " "But when you can't depend on the other people, you know what you do? you get on your knees and you start prayin'. You get your Bible, and you start readin'. That's what you do! You pick yourself up . . . "
Ways to Engage Clients	"I think the fear factor doesn't work, because the majority of people that use drugs or alcohol. . . . I mean, my personal experience . . . is because you're running from some tragic thing in your life, and you're trying to escape it through the use of drugs or alcohol. . . "

methadone. Many reported alcohol as a common substitute for heroin amongst addicts seeking to discontinue heroin use, whereas alcohol was commonly used to increase euphoria for those maintained on methadone. In fact, as expressed by a man and woman in the group, alcohol and pills are combined with methadone to intensify the euphoria of taking the methadone. However, alcohol was considered the hardest to stop because it provided the highest euphoria. Despite the candor relating to why alcohol and other drugs are consumed by these clients, the participants of the focus groups were thoughtful about strategies they considered to be helpful in reducing alcohol use among their peers. These factors included attitudes of health care providers, personal attributes such as motivation of the client themselves, and support strategies health care providers could offer.

Attitude of Health Care Provider

To the clients, it was critical that health care providers show compassion for methadone clients and that providers not "look down upon" the clients. The perception of being stigmatized because of drug use was noted as a major deterrent for most clients who sought change and a need for communication and understanding. For one woman, frustration with use of the word "guilt/guilty" only provided a deterrent for herself and others in making positive changes. Moreover, it was thought to promote avoidance and negative behaviors. Another women noted that promotion of self-esteem or self-value was considered to be an important factor in providing assistance. By being positive, health care providers can enable participants to make positive decisions about the need to gather more information and "see that you need help." For many other participants, a desire to be helped with troubling aspects of their lives that led to negative feelings or insecurities was strongly felt need.

Importance of Motivation

There was general consensus among the participants that motivation was critical before positive behavioral changes could occur. The need

for motivational interviewing as a strategy was further discussed by the participants. The determination of clients' goals and personal outlook on their current situation was deemed an important step to engage clients in thinking about change. For some participants, support and inspiration originating from others was a helpful way to initiate their desire to make positive behavioral changes. Participants, however, recognized readiness to change as an important factor in help seeking behavior and in bringing about change. These sentiments were clearly portrayed by two women who recalled their disappointment at watching addicts, who had been lying on the street, being transported by ambulance to the emergency room and quickly leaving as soon as they were registered. Another women was inspired by the positive turnaround of a female addict who was strung out on drugs for a long time. Positive examples of life changes by people like themselves are often a powerful motivator for change.

Participants expressed the sentiment that making a commitment to take small steps was the most effective way to change negative behaviors. Group sessions were particularly motivating for several clients and imbued one women with a sense of hope and solidarity. An awareness of the damage that alcohol had and could continue to have on the body was another motivator for some clients, and for others, religion and the use of monetary incentives were important incentives.

Support in Many Forms Is Critical

For some clients, becoming motivated to change meant forgiving themselves for all the harm that they caused to others and, by doing so, would make them more open to advice. However, clients were realistic in recognizing that motivation was not always apparent within the individual and that health care providers could play an important role in promoting motivation through supportive activities. The participants discussed the helpfulness of support in several ways, ranging from financial and material aid to emotional support. Programs and resources to assist recovering alcoholics reintegrate into society were of most interest. This included assisting participants with housing needs, job skills, and even food and shelter for the night.

Ways to Engage Clients

The focus group participants were thoughtful in how health care providers could successfully engage people like themselves into making positive health choices. For many, overcoming major barriers was critical before successfully engaging the client to consider behavioral change. The personality of the addict was one major barrier mentioned. To many, the sense of being "told what to do" was unhelpful and even worked to deter many from seeking help. Participants did, however, see incentives as helpful in attracting those interested in attaining assistance. Comforting foods as simple as coffee and donuts were enough to get people "in the door."

Alternatively, the use of fear as a way of motivating methadone maintained clients to enroll in alcohol reduction programs was perceived to be a controversial strategy. Although one participant noted that the fear of death was particularly motivating in bringing about change, other participants reported that fear could elevate avoidance behaviors and high-risk activities because an individual may perceive that he or she cannot do anything to change a negative prognosis and that he or she has nothing left to lose. Additionally, fear tactics were thought to be of little use in situations in which an individual is attempting to escape from emotional pain or trauma.

DISCUSSION

Qualitative findings collected from the four focus groups with these clients, all participants in methadone maintenance and many of whom reported drinking alcohol, revealed several facilitators and barriers that would engage them in entering an alcohol treatment program. These factors included the attitudes and behaviors of the heath care providers, methods used to engage clients into the alcohol treatment program, the importance of motivation, support and its forms (financial, material and emotional), and the use of fear to persuade change.

Methadone maintained clients readily admitted that alcohol use, and the occasional use of other drugs, was a strategy they engaged in to intensify euphoric sensations. The literature supports the fact that about half of methadone maintained clients use alcohol excessively; methadone maintained clients drink alcohol to relax, escape boredom, and improve their mood and as a booster to increase the effects generated by methadone.[19] This occurs despite the fact that approximately 70% are HCV positive and express awareness that alcohol causes further damage to the liver. In a study conducted among opiate users in methadone maintained treatment, more than one-third of the clients with HCV did not change their alcohol pattern after receiving advice regarding this harmful condition.[6]

Clients in these discussion groups referenced the attitudes of the health care providers as a critical factor to engage clients in alcohol treatment and concurred that health care providers should show respect, be committed to the clients' progress, and demonstrate empathy. These themes converge with findings showing that better drug treatment success rates are correlated with the number of counseling sessions received and, particularly, to the therapeutic relationship between client and therapist.[12]

Methadone maintained clients in this study emphasized the importance of psychological and material support to bolster low self-esteem, overcome difficulties related to guilt, and provide, at times, food and shelter. The addiction and its consequences have often disrupted the internal and external environments of the addicts so that material and emotional supports were important incentives to motivate them to rebuild their lives. Significant material barriers to engage clients into drug and alcohol treatment programs were related to lack of insurance, transportation, and limited access to treatment.[20] Although fear was presented as a strategy that could motivate some people to reconstruct a better life, it was also perceived as a strategy that might intensify clients' desire to drink due to the lack of interpersonal skills needed to change life's direction.

As disclosed in our findings, the role that motivation plays in the lives of methadone maintained clients is fundamental to support their commitment to change. Methadone maintained clients were clear that willingness to change was a required first step to move toward behavioral change. According to seminal authors, Ajzen and Fishbein,[21] the immediate determinant of changing an alcohol use pattern is the behavioral intention to do so. As a formulated conscious plan to take a real action toward reaching the goal, the strength of the individual's intention is particularly connected with his or her commitment to put the plan in practice. Thus, readiness to change seems to be a strong predictor of alcohol drinking reduction.[22]

These results are limited in that they are collected from a relatively small sample of methadone maintained clients in the Los Angeles, California, area but they are offered for their heuristic value in illustrating the importance of recognizing alcohol use, especially in HCV infected clients in methadone maintenance. It is also possible that the provision of incentives for the clients may have produced biases in their reports. Ongoing investigation should continue to assess how the motivations of methadone maintained clients' influence their alcohol consumption.[19]

CONCLUSIONS

The findings in this study raise an awareness to the range of barriers and facilitators to alcohol reduction that methadone maintained clients face in starting and maintaining sobriety. As indicated by these client's self-reports, a combination of emotional and material support along with motivational-oriented health care providers and strategies are most likely to engage methadone maintained clients to initiate and maintain alcohol reduction strategies. There is a need to continue to investigate ways to reduce barriers and improve the facilitators experienced by methadone maintained clients in terms of promoting alcohol-related health-seeking and treatment completion in methadone maintenance settings, so that population-specific intervention strategies can be developed. Critical to this list is the awareness of the importance of negative attitude and stigmatizing behaviors of health

care providers on change potential of methadone maintained participants.

With approximately one-half of clients in methadone maintenance also using large amounts of alcohol, and alcohol posing a strong risk to successful outcomes for methadone treatment, support for increased treatment is more than a localized problem; it is a public health threat because 70% of methadone maintained clients in the United States are also positive for HCV. Research indicates that alcohol abuse treatment can be effective among methadone clients,[12] and in an environment of shrinking resources, the needs of this high-risk group of substance dependent clients must remain a priority for funding. The alternative is increased costs of care in emergency rooms, increased crime of those using opiates, and continued transmission of life-threatening diseases including HCV.

REFERENCES

1. American Methadone Treatment Association. 1998 Methadone Maintenance Program and Patient Census in the U.S. New York: Haworth Press.
2. Backmund M, Shutz CG, Meyer K, Eichenlaub D, Soyka M. Alcohol consumption in heroin users, methadone-substituted and codeine-substituted patients—frequency and correlates of use. Eur Addict Res. 2003;9:45–50.
3. Kreek MJ. Using methadone effectively: achieving goals by application of laboratory, clinical, and evaluation research and by developing of innovative programs. In: Pickens RW, Leukefeld CG, Schuster CR, eds. Improving drug abuse treatment. NIDA Research Monograph Series 196. Maryland: National Institute on Drug Abuse, 1991;245–66.
4. Rowan-Szal GA, Chatham LR, Simpson DD. Importance of identifying cocaine and alcohol dependent methadone clients. Am J Addict. 2000;9:38–50.
5. Best D, Gossop M, Lehmann P, Harris J, Strang, J. The relationship between overdose and alcohol consumption among methadone maintenance patients. J Subst Use. 1999;4:41–4.
6. McCusker M. Influence of hepatitis C status on alcohol consumption in opiate users in treatment. Addiction. 2001;96:1007–14.
7. Estrada, AL. Epidemiology of HIV/AIDS, hepatitis B, hepatitis C, and tuberculosis among minority injection drug users. Public Health Rep. 2002;117:S126–34.
8. National Institutes of Health (NIH). Management of hepatitis C: 2002;2002 June 10–12; Rockville, Maryland. National Institutes of Health (NIH consensus statement); 2002 Aug 26. 3 p.
9. Alter MJ. The epidemiology of acute and chronic hepatitis C. Clin Liver Dis. 1997;1:559–68.
10. Sheridan J, Wheeler A, Walters C. Health problems and help-seeking activities of methadone maintained clients at Auckland Methadone Service (AMS): Potential for community pharmacy service expansion? Harm Reduct J. 2005;2:25.
11. McKirnan DJ, Vanable PA, Ostrow DG, Hope B. Expectancies of sexual "escape" and sexual risk among drug- and alcohol-involved gay and bisexual men. J Subst Abuse. 2001;13:137–54.
12. Gossop M, Stewart D, Marsden J. Effectiveness of drug and alcohol counseling during methadone treatment: content, frequency, and duration of counseling and association with substance use outcomes. Addiction. 2006;101:404–12.
13. Babor TF, Higgins-Biddle JC. Alcohol screening and brief intervention: Dissemination strategies for medical practice and public health. Addiction. 2000;95:677–86.
14. Coffield AB, Maciosek MV, McGinnis JM, et al. Priorities among recommended clinical preventive services. Am J Prev Med. 2001;21:1–9.
15. Dunn C, Deroo L, Rivara FP. The use of brief interventions adapted from motivational interviewing across behavioral domains: a systematic review. Addiction. 2001;96:1725–42.
16. Noonan WC, Moyers TB. Motivational interviewing. Journal of Substance Misuse. 1997;2:8–16.
17. Nyamathi A, McNeese-Smith D, Shoptaw S, et al. Perceptions of Methadone Maintained Clients about Barriers and Facilitators to Help-Seeking Behavior. Progress in Community Health Partnerships: Research, Education, and Action. 2007;1(4):301–9.
18. Glaser K. The treatment of depressed and suicidal adolescents. Am J Psycho. 1978;32:252–69.
19. Hillebrand J, Marsden J, Finch E, Strang J. Excessive alcohol consumption and drinking expectations among clients in methadone maintenance. J Subst Abuse Treat. 2001;21:155–60.
20. Appel PW, Ellison AA, Jansky HK, Oldak R. Barriers to enrollment in drug abuse treatment and suggestions for street outreach clients and other system stakeholders. Am J Drug Alcohol Abuse. 2004;30:129–53.
21. Ajzen L, Fishbein M. Understanding attitudes and predicting social behavior. London: Prentice-Hall International.
22. Freyer J, Tonigan JS, Keller S, et al. Readiness for change and readiness for self-helping: a composite assessment of client motivation. Alcohol Alcohol. 2005;40: 540–4.