

# Perspectives on the Moral Qualities of Methadone and Buprenorphine in the Rural Midwest

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Like many rural and suburban counties in the Midwestern United States, George County, Indiana was facing increased rates of heroin use, drug-related overdose, and hepatitis C in 2016 and 2017 when this research was conducted. This paper examines local moral perspectives toward medication assisted treatment (MAT) in the rural context of George County. In interviews with community members who use and do not use opiates, methadone treatment was found to be a highly criticized and morally suspicious way to address addiction, while buprenorphine treatment was a preferred and normalized approach. Both are forms of MAT, yet methadone and buprenorphine are offered in different clinical settings. Lacking moral capital, methadone treatment was equated to continued heroin use while buprenorphine treatment was perceived as a truer form of treatment due to a perceived shorter treatment duration.

Negative opinions among methadone treatment recipients toward methadone treatment have been linked to early treatment termination (Kayman et al. 2006) and stigma against substance abuse treatment in rural Indiana is a recognized barrier to receiving treatment (Kooreman and Green 2017). People who inject drugs have cited larger scale public stigma towards methadone as discouraging their participation in methadone treatment. This stigma is buttressed by the exclusion of methadone patients from participation in many recovery support services such as Narcotics Anonymous (Paquette, Syvertsen, and Pollini 2018). Stigma with regard to buprenorphine treatment (with Suboxone, for example) is experienced differently based

on the patient's position within social structures of race and socioeconomic class where management of the stigma associated with medically assisted treatment may be more accessible for white middle class patient (Hatcher, Mendoza, and Hansen 2018).

### **Study methods**

As part of a sociological exploratory study of heroin use and community response in George County, Indiana, 29 qualitative semi-structured interviews were conducted between June 2016 and September 2017 with 20 individuals, who have experience using heroin and/or prescription opioid painkillers, and 13 individuals, who are involved in local organizations or efforts to address heroin use in the county. The interviewees were recruited through outreach to several community organizations—a food pantry, two behavioral health centers, a faith-based addiction support group, and the county department of health. A flier advertising the study to those with experience using heroin or opioid painkillers was distributed to the behavioral health centers and food pantry.

Written informed consent was secured prior to all 29 interviews. The interviews were conducted by the author and typically lasted 45 minutes to 1 hour. Free meals were offered to all participants and thus, 14 interviews took place in a restaurant. Other interviews occurred in offices, public parks, and outside a drop-in center for a local behavioral health center. Two participants were interviewed twice. The interviews were digitally recorded and transcribed in full by a professional transcription service, except for one transcript, which was transcribed by the author's student intern. This research was approved by the institutional review board at the author's former institution.

The interview transcripts were initially coded for their relevance to medication-assisted treatment, and then further coded based on the type of treatment and the qualities of the

perspective toward that modality of treatment. The qualitative data analysis software, HyperRESEARCH, was used for data organization, coding, and storage. The interview extracts presented were selected for their representativeness, as well as their clear articulation of perspectives.

Demographic information was collected from interviewees with experience using heroin or prescription opioid painkillers. These interviewees ranged in age from 22 to 59. Sixteen were white, three were African-American, and one was bi-racial (African-American and white). Eighteen had experience using heroin, while two primarily used prescription opioid painkillers. Other drugs mentioned were marijuana, crack, and methamphetamine. Four interviewees with experience using opiates were receiving some form of drug treatment at the time of the interview. Both interviewees with experience using prescription painkillers were receiving treatment with buprenorphine. Sixteen of the interviewees with experience using heroin were not receiving any form of drug treatment.

The interviewees who were involved in formal and informal efforts to address local opiate use ranged in their institutional affiliations, and for some their efforts were not linked to their employment. Interviewees, whose jobs involved interacting with people who had experience using opiates, worked at behavioral health centers, a methadone clinic, the county department of health, and a HIV resource center. Other interviewees were involved in grassroots efforts to address the epidemic.

With a population of around 66,000 George County is one of the more populated counties within Indiana, though it is considered a rural county (Ayres et al. 2013). Its education levels are comparatively low within the state and its median household income is one of the lowest. It's poverty rate and number of unemployed are correspondingly high as compared to other counties

(Indiana Business Research Center 2017). In the years 2011 to 2015 the county was consistently well above the state average for emergency room visits for non-fatal overdoses, soft tissue infections associated with drug use, deaths from opioid poisonings, and levels of acute hepatitis C viral infection (Clayton et al. 2017). By early November 2017 the county coroner had confirmed sixty-six drug-related deaths. In 2016 there were fifty-six and only sixteen in 2012 (Emery, 2017).

## **Findings**

Sitting near the edge of town behind Springville's dying mall, the low-lying brick building of the local MAT clinic often featured a busy parking lot with cars zipping in and out. It was a for-profit endeavor that according to interviewees asked patients to pay out of pocket for methadone or Suboxone accompanied by counseling. There was the justification that patients found ways to afford heroin, so they could find ways to pay for their treatment for opioid dependence. As Debra, a 59 year old white woman on buprenorphine treatment for her use of opioid painkillers, stated: "If you have money for pills, you have money for treatment." The expense of MAT treatment at the Springville Treatment Center also worked as an incentive encouraging patients to seek a shorter duration of treatment, contrary to the recommendations of treatment center staff. Will, a physician employed by the county who often provided care for people with opioid use issues stated:

They usually want to withdraw quicker than they're supposed to. It's an expensive – suboxone and methadone are quite expensive. And I think that they don't want to spend that kind of money – of course, I don't know how much they were spending before for whatever they were using – heroin or whatever. But yeah, they want to get off of it as quickly as possible, and some of them move pretty quickly, and I'm sure that they're

going to have withdrawal symptoms.

Time spent in treatment was a salient issue throughout the interviews and became linked with morality in commentary about methadone treatment in particular. Narratives of bad experiences with the local MAT clinic and the treatment it offered were abundant among interviewees and though attitudes towards buprenorphine-based treatment with Suboxone or Subutex were more positive, there were criticisms as well. While mention of and experience with MAT was common among interviewees with opioid use experience, interviewees with no opioid use experience, who were involved in local efforts to address drug use, expressed criticism of substitution-based therapies. After a continued discussion with Will, the local physician employed by the county, about the monetary incentives to the clinic of keeping patients on methadone for a lengthy period of time and reports from his patients that clinic staff were discouraging its patients from decreasing their methadone dose levels, he concluded: “I'd rather they not be on anything. I don't know.” Another local physician, Linda, who had limited, experience with patients with opioid use issues, also expressed criticism of MAT:

I have a problem with those because they're also made of the same substance. The evidence that they're providing is not convincing enough. And there is too much money and political pressure in promoting these treatments. If you put that same money into deaddiction programs, you pay these people a living wage...”

Interviewees with experience using opioids shared similar concerns though their criticisms of substitution therapy were aimed more specifically at methadone and often involved likening it to heroin and likening methadone patients to people that regularly use heroin. Blake, a 27 year old man recovering from opioid painkiller usage and currently on buprenorphine, stated:

And I can say – I don't know if I'm being a hypocrite but it seems like the people on methadone are just like the heroin addicts. I would just – if I was in charge of it, whatever, making the decisions, I would put everybody on Suboxone – not Subutex either but actually Suboxone, naltrexone – yeah. Makes it to where you can't – you have a negative interaction with the opiates.

His emphasis on the inclusion of naltrexone found in Suboxone aligns with his concern over the continuation of an addict identity while receiving MAT. According to him, methadone allows this to happen, while Suboxone does not.

Multiple interviewees, including Blake, felt that the MAT clinic's practice of allowing patients to request methadone dose increases triggered an addictive sensibility and maintained patients in a drug using habitus. This clinical practice seemed suspect to interviewees and linked to concerns over connections between corporate profit motives and the lengthening of treatment duration. Nathan, a 28 year old man in recovery from heroin use who had experience receiving methadone treatment, offered his perspective:

Nathan: I mean I think there could be a better way, because they'll [the MAT clinic] just let you go as high as you want, basically. You can go 5 milligrams up a week, as long as you're not failing for benzos or anything else, marijuana or whatever. As long as you're clean, you can just keep going up, up, up, up, up, so 5 milligrams a week.

Kelly: Do you have to request that or do they just –

Nathan: Yeah, you just put it on paper, but it's not hard. You just fill out the paper and they'll give you 5 more milligrams every week. But I don't know. I think it's a lot about money for the state, you know what I mean? They're

not really worried about getting anybody better. If anything, they're worried about getting you higher up so you're stuck. But, if it wasn't there, I would be doing a whole lot worse than I am right now.

Perspectives towards the temporalities associated with methadone and buprenorphine treatment fused with moral discernments in determinations of affinity for one or the other medication. The moral quality affixed to the duration of medication assisted treatment found connection to concerns over the ethics of for-profit drug treatment enterprises. This excerpt from an interview with Samantha and Tom, a couple who had experience using opioids and were in very recent recovery, laid several issues bear—concerns with substitution treatment, conflicted monetary interests, and the duration of treatment:

Samantha:\_ We tried the Methadone clinic and it made us sick.

Kelly:\_ Oh, after you took the Methadone, it made you sick?

Samantha:\_ Mm-hmm.

Kelly:\_ Huh.

Tom:\_ At least with the one here in [Springville], the way I take it, I believe that it's not like it's – they don't set you up with a treatment plan. They don't treat you like, "We want you to do this for so long, and then we're gonna wean you down, and you'll get better." This doctor tells me, because I have scoliosis, he straight tells me, "This is the best medicine you'll ever have."

Samantha:\_ You'll never be in pain again.

Tom:\_ They want people to stay on it. They like that money. That's what I believe. They don't set it up and design it for people to use it, get better,

and then come off of it. It's like they want you to just stay on it. I know people that's been on it for years.

[some text removed]

Tom: It's just a legal high is what it is.

Samantha: It's legal heroin.

Tom: Yeah, I don't believe in that at all. Tried it, it made me sick.

Kelly: It made you go into withdrawal?

Tom: Physically sick.

Kelly: You were still in withdrawal or you –

Tom: I don't know. I don't know. It just didn't work well with me at all.

Samantha: Neither one of us. We went, what, one week, and that was it. It's all about the money.

Tom: That's what I believe.

Kelly: Did you have to pay out of pocket or [did your] insurance [cover it]?

Tom: No, you had to pay that one time deal. Insurance don't cover it. You pay one time deal when you first go, and then \$15.00 every day you go.

Samantha: It's \$16.00 every day.

Tom: Yeah, every day.

Samantha: The first time through was \$65.00 a person.

Kelly: So that HIP [Medicaid provider in Indiana] won't cover it?

Samantha: Medicaid, nothing will cover it. They don't accept insurance.

Tom: Now, what I'm doing now with Suboxone, and to me, that's well worth the money. I'll pay it any day of the week. It really works well, and it is

designed to go. It's like a six month program. It's designed to –

Samantha: A year.

Tom: A year? Whatever. It's designed to go, and then they'll taper you down and bring you off.

Samantha: After six months it gets lowered, and then after a year he's off.

Tom: They have me going to meetings, and it's like an actual treatment rather than just give you the medicine. It's working really well right now.

## **Discussion**

In a rural context with limited MAT options local clinical practices become affixed to the medications and come to define their use in treatment among the local community of people with experience using opioids. In George County methadone was understood as medication without end while buprenorphine uplifts its moral image as it is considered a limited duration treatment. Rural areas in the Midwest with higher amounts of opioid use are places where corporate behavioral health care providers find customers and profit. The practices of those clinics and their business models come to define methadone treatment among locals just as the buprenorphine-based treatment provided by local physicians come to define that modality of care for locals. When local physicians criticize substitution therapy, it limits the space for counter-narratives beyond those emanating from the treatment providers themselves. Powerful attributions of morality are at play in the local MAT field where length of the treatment plan becomes linked with a drug using habitus and monetary conflicts of interest. Following Sherman (2006) moral capital is an essential resource in rural contexts since it may link residents with economic capital via access to employment opportunities. Thus, associating oneself with a morally suspect form of drug treatment may threaten one's livelihood.

Considerations of treatment planning which offer patients a vision of themselves as opioid free may be helpful in encouraging individuals dependent on opioids to consider medication-assisted treatment. Considerations for treatment planning must also include attention to evidence related to post-MAT overdose and relapse rates, as well as emerging concerns over patient autonomy and coercive factors at play in “voluntary” treatment settings, such that patients’ concerns over being “stuck” on a high dose of methadone are addressed (Damon et al. 2016). Overall, treatment with buprenorphine-based medications was more morally palatable in the rural context of George County, but with adjustments to treatment planning methadone therapy, which may be more accessible and applicable for some, might shift its moral qualities in the minds of residents.

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