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“I was not sick and I didn’t need to recover”: Methadone Maintenance Treatment (MMT) as a refuge from criminalization

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Abstract

Background: Methadone Maintenance Treatment (MMT) in the United States (U.S.) has been undergoing a shift towards conceptualizing the program as recovery-based treatment. Although recovery is seen by some as a means to restore MMT to its rightful position as a medically-based treatment for addiction, it may not represent the experiences, or meet the needs of people who use drugs (PWUD), many of whom who use the program as a pragmatic means of reducing harms associated with criminalization.

Objectives: To examine alternative constructions of MMT in order to produce a richer, more contextualized picture of the program and the reasons PWUD employ its services.

Methods: This paper uses semi-structured interviews with 23 people on MMT (either currently or within the previous two years).

Results: Most participants linked their use of MMT to the structural-legal context of prohibition/criminalization rather than through the narrative of the recovery model. Responses suggested the recovery model functions in part to obscure the role of criminalization in the harms PWUD experience in favor of a model based on individual pathology.

Conclusions/Importance: In contrast to the recovery model, MMT cannot be understood outside of the structural context of criminalization and the War on Drugs which shape illegal drug use as a difficult and dangerous activity, and consequently position MMT as a way to moderate or escape from those harms.

Keywords

Methadone Maintenance Treatment (MMT); recovery; harm reduction; abstinence; disease model; criminalization; medicalization

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[1]It is beyond the scope of this paper to discuss the definitional and taxonomic problems associated with culturally determined and highly unstable categories like “drug” or “abstinence” (see for example Keane, 2002), however, it should be noted that these same difficulties problematize their use in recovery settings too.

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Introduction

For the last 10–15 years, Methadone Maintenance Treatment (MMT) in the United States has been undergoing a cultural and epistemological shift away from an approach that emphasized client stabilization and a reduction of social harms towards one grounded in values associated with the recovery movement (Laszlo_editor, 2016; Substance Abuse and Mental Health Services Association [SAMHSA], 2015; White & Mojer-Torres, 2010). These changes include promoting a view of addiction grounded in the disease model as well as efforts to make abstinence from all substances (as opposed to just illegal opioids) and ancillary services such as recovery coaching/counseling, programs emphasizing proper citizenship, and concern for clients' spirituality as necessary parts of the program (Recovery Oriented Methadone Maintenance [ROM] Client Placement in Phases of Treatment, 2011; White & Mojer-Torres, 2010). Although recovery is seen by some as a means to restore MMT to its rightful position as a medically-based treatment for addiction and a way to remove stigma from individuals on the program, it may not represent the experiences, or meet the needs, of a diverse population of people who use drugs (PWUD) who have very different drug use experiences, and who conceptualize their drug use and treatment goals differently. Moreover, positioning MMT as being 'about recovery' has significant implications for the ways that drug use, drug treatment, and drug control are understood.

This paper uses qualitative data, supported by my own experience as someone who used illegal opioids and as someone currently in MMT, to critically examine the tenets of the recovery model in MMT. It argues that recovery in this setting is based on a decontextualized understanding of illegal drug use that ignores prohibition and the War on Drugs (WOD), both as a source of harm in PWUD's lives and as driving forces in their treatment decisions. Moreover, by constructing PWUD's choice to attend MMT as unrelated to the ways that they are oppressed under criminalization, the recovery discourse depoliticizes drug treatment issues, and, as such, implicitly supports the status quo criminalization of PWUD.

Background

Recovery has been gaining considerable traction within substance use treatment, including MMT for the last 15 years (Humphreys & Lembke, 2014; Laudet, 2007; White & Mojer-Torres, 2010). It has been embraced by leading government agencies in the United States (U.S.) like the Substance Use and Mental Health Service Administration (SAMHSA) (2015) and the Office of National Drug Control Policy (ONDCP) (2012), as well as non-government groups like Medication Assisted Recovery Services (MARS) (2016) and Faces and Voices of Recovery (Faces and Voices of Recovery, 2016; Laszlo_editor, 2016) who advocate for greater incorporation of recovery-based principles into MMT and other substance use treatment modalities.

While the term 'recovery' has always been understood to mean the cessation of a particular illness or ailment, the modern recovery discourse has its roots in the 19th century when temperance societies and related groups began discussing socially unacceptable alcohol use as a disease (Levine, 1978). The concept and language of recovery was later taken up by

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twelve-step groups who formed around a variety of practices including drinking, smoking, and narcotics use (White, Kelly & Roth, 2012). The move towards policies aimed at recovery has been occurring internationally, though efforts in the United Kingdom (UK), Australia, and the U.S. have attracted the most attention (AIVL, 2012; UK Home Office, 2012). One important difference between the U.S.-based approach and those of the UK and Australia has been their stance on MMT; while recovery-based polices in the UK and Australia have focused on reducing use of MMT, seen as allowing individuals to "drift ….into indefinite maintenance, which is a replacement of one dependency with another" (UK Home Office, 2012: p. 3), U.S. agencies have adopted a view of recovery that sees MMT as on par with other legally-prescribed medications and thus, as an acceptable medical treatment for addiction (SAMHSA, 2009).

Although the specific meaning of recovery varies and is to some extent contested (Neale, Nettleton & Pickering, 2011), in the U.S., most definitions are based on that of the Betty Ford Institute Consensus Panel which defined recovery as "a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship" (2007: p. 222). SAMHSA uses a similar definition centered on four "major dimensions" including: Health, home, purpose, and community (2016). Thus while abstinence is considered a prerequisite, recovery is based on a holistic conception of personhood that is understood as a lifelong process of growth, change, and reclamation of the self (Laudet, 2007; White, 2007). Recovery advocates William White and Lisa Mojer-Torres contrast recovery with remission, meaning abstinence in this context, stating: "Remission is about the subtraction of pathology; recovery is ultimately about the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and quality of life in the community" (2010: p. 8). Thus, recovery involves a full-fledged change in personhood in accordance with normative ideas about "how bodies should function and about desirable as opposed to undesirable ways of being" (Keane, 2002: p. 16) rather than simply abandoning 'problematic' drug use. This whole-person focus also greatly expands the jurisdictional boundaries of methadone clinics to intervene in multiple aspects of their clients' lives.

The notion of addiction-as-disease is central to recovery in that it establishes the condition one must recover from. Although there is flexibility regarding how the disease is operationalized (usually ranging from views based on the National Institute of Drug Abuse (NIDA)'s chronic brain disease model (Courtwright, 2010) to more mainstream conceptions associated with 12-step groups), recovery rests on the claim that "addiction" is a diagnostic, pathological condition requiring treatment, in this case methadone alongside a battery of psycho-social-spiritual interventions. Yet, despite its current dominance culturally, addiction-as-disease theories are far from universally accepted. Scholars from numerous disciplines point out that they are both scientifically flawed and serve as a means of social control (Lewis, 2015; Conrad & Schneider, 2010; Vrecko, 2010; Peele, 2014; Hart, 2013; Keane, 2002; Reinarman, 2005; Des Jarlais, 1995). Addiction-as-disease theories have also been described as stigmatizing, and as providing support for repressive drug policies, particularly towards poor and marginalized peoples, through their focus on PWUD as pathological (Campbell, 2011; Levy, 2014; Reinarman, 2005). Examining methadone as one of many "technologies of addiction therapeutics", science and technology scholar Nancy Campbell argues that medical and criminal theories of drug use support and co-produce one

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another as well as "the very forms of addicted subjectivity to which they are said to respond." (Campbell, 2011: p. 124).

Moreover, evidence demonstrates that PWUD use, and benefit from MMT outside of the context of the disease/recovery model. Harm reductionists point out that people often utilize MMT for pragmatic reasons including withdrawal avoidance, which in turn reduces the likelihood of risky activity such as syringe sharing; as a temporary means of reducing tolerance and physical wear-and-tear; and as a means for dealing with instabilities of the illegal drug market (Harris & Rhodes, 2013; Mateu-Gelabert, Sandoval, Meylakhs, Wendel & Friedman, 2010; Koester, Anderson & Hoffer, 1999). Although such individuals are often seen as not ready for treatment, or worse, as trying to cheat the system, Koester et al. reject this all-or-nothing interpretation in their qualitative study of what motivates people who use heroin to enter MMT (1999). Instead, they characterize MMT as a pragmatic strategy utilized in multiple ways by a highly criminalized population with limited options. In line with this view, Harris & Rhodes point out that within the context of numerous constraints that restrict people who use illegal drugs and people on MMT, even activities generally understood as rule-breaking or crime, such as diverting methadone to the illegal market, can be understood as "indigenous harm reduction strategies" that help PWUD to "manage their drug use, prevent withdrawal, cement social relationships, and inadvertently protect against hepatitis C transmission." (2013: p. 43)

A review of the early literature suggests that physicians Dole and Nyswander – who did the foundational research leading to MMT in the mid-1960s – valued its potential to reduce structural-legal harm in PWUD lives. They argue that "Methadone maintenance makes possible a first step toward social rehabilitation by stabilizing the pharmacological condition of addicts (sic) who have been living as criminals on the fringe of society" (Dole & Nyswander, 1976: p. 2117). Moreover, in their ten-year review of MMT, they argue against excessive rules and regulations which they cite as the most common reason for "addicts" to reject treatment, and chastise the public at large for their morally-based lack of enthusiasm for substitution treatment, pointing out that "What was not anticipated at the onset was the nearly universal reaction against the concept of substituting one drug for another, even when the second drug enabled the addict (sic) to function normally." (p. 2117)

There has also been resistance to the growing dominance of recovery, both in general, and as it relates to MMT (Australian Injecting and Illicit Drug Users League [AIVL], 2012; International Network of People who Use Drugs [INPUD], 2015; INPUD, 2014). Organizations that support the rights of people who use drugs including the International Network of People who use Drugs (INPUD) and the Australian Injecting & Illicit Drug Users League (AIVL) do not oppose the rights of individuals to identify as "in recovery", or pursue recovery-based goals, but argue against the elevation of such personal choices to the level of policy where it becomes a standard that is forced upon everyone (AIVL, 2012; INPUD, 2014). Such groups argue that rather than a disease, drug use is a "social phenomenon that is characterized by a high level of diversity, not 'sameness' (AIVL, 2012: p. 3). According to this view, recovery functions as a meta-narrative that necessarily implies "that drug use is a disease from which people could or should be cured" (INPUD, 2014, para. 7).

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Yet, with important exceptions (Harris & Rhodes, 2013; Fisher, Chin, Kuo, Kirst & Vlahov, 2002; Koester et al., 1999) the majority of scholarship on MMT does not account for how criminalization and the War on Drugs shape the treatment experiences of people on the program. Similarly, there has been a lack of critical engagement with the increasing emphasis on conceptualizing MMT as recovery-based treatment (in the U.S.[2]). By examining alternative constructions that acknowledge its use as a pragmatic strategy to mitigate harms produced structurally by criminalization, this study hopes to produce a richer, more contextualized picture of MMT and the reasons PWUD employ its services. Moreover, a more nuanced understanding of why PWUD use/value/benefit from MMT may open up discursive spaces to examine the etiology of harms they experience as a product of oppression rather than solely from the pharmacological and physiological effects of substances.

Methods

Data collection

This paper is based primarily on two years of qualitative research consisting of semi-structured interviews and ethnographic observations, as well as elements of auto-ethnography. Semi-structured interviews were conducted with three populations: people on MMT (either currently or within the previous two years) (n=23); people who work as treatment providers (individuals working at MMT clinics and government administrative offices that regulate MMT) (n=10); and people who work with advocacy organizations that address the needs of PWUD and people on MMT (n=9). Although the study includes interviews with three populations, this paper only refers to data from the first group: people who are either currently on MMT or have been within the previous two years.

Participants were recruited using a combination of convenience and snowball sampling based initially on contacts I had through my own experience as a PWUD and as someone on MMT. All participants' provided informed consent, and interviews lasted approximately 1 hour and were recorded to be transcribed later. Interview questions addressed participants' experiences with, and views of, illegal drug use and treatment. Data were then coded for themes and analyzed in an iterative process. All participants are referred to by pseudonyms.

Ethnography

Ethnographic observations were carried out primarily at the methadone clinic I attend in The Bronx, NY. I am at the clinic once every four weeks for a period ranging from 1 to 3 hours, and used this time to make field observations and notes. In addition to my regular visits to my own clinic, I was also able to visit approximately 5 other methadone clinics in New York City while conducting interviews with treatment providers. Although the vast majority of my ethnographic data was obtained from my own clinic, visiting other clinics, even if for a short period of time, provided an important context for determining differences and similarities among NYC methadone clinics.

[2]There has been more critique of recovery-based policies in the UK and Australian contexts. For example, see (AIVL, 2012)

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Auto-ethnography

Finally, this paper is informed by my own experiences as an illegal opioid (primarily heroin) user and as someone currently on MMT. I have been on MMT for approximately 11 years and received services at two clinics: one in Chicago, IL and one in The Bronx, NY.

Although I do not refer to my own experiences directly as data in this paper, they have structured my own views on this topic and, correspondingly, the direction of this study. Thus, it incorporates elements of auto-ethnography. My direct experience as a PWUD was, for the most part, highly beneficial throughout the data collection and analysis phases of the project. I not only had access to a hard-to-reach population, but as a fellow PWUD, I was also afforded a much greater level of trust than an outsider would likely have been given. Although I had initially planned to not reveal any personal information with the goal of remaining a "neutral researcher" – a problematic concept to begin with – it quickly became apparent that the benefits of disclosing my status, in terms of richness and quality of data, as well as the increased honesty and comfort of the study participants, outweighed the benefits I might gain in terms of not "biasing" my data. For example, participants often visibly relaxed or verbally expressed relief upon my disclosing my own history and status as someone on MMT. Similarly, my familiarity with the terminology, common culture, and shared experiences, also helped to position me as part of the community rather than an outsider, who are often (and with good reason) viewed with suspicion. I am confident that my insider status enabled me to gather data that would have been very difficult, if not impossible for someone without direct experience in this community.

Conducting social research as an insider also involves a number of challenges, some that are specific to the researchers' insider status (Simmons, 2007; Kanuha, 2000), yet it is an accepted form of investigation and has been shown to reveal aspects of communities that may not be possible using more traditional forms of research (Contreras, 2012).

Theoretical position

This paper adopts Fraser and Valentine's theoretical framework based on challenging narratives that conceptualize MMT through reductive and essentialist lenses (2008). Fraser and Valentine borrow from feminist science and technology studies, in particular the work of Karen Barad, by framing methadone as a *phenomenon*, described as "an assemblage of human and non-human actors made in its encounter with politics, culture and research" (2008: p. 3). This approach allows for an analysis of MMT that acknowledges both the material and the social/cultural/discursive, and sees the two as co-constitutive. In Barad's model, the phenomenon replaces the notion of bounded and distinct objects with definite properties, thereby problematizing standard notions of causality that imagine a linear chain of objects, each one produced by its predecessor (Barad, 2003; Fraser & Valentine, 2008). Here methadone the substance, treatment regulations, and the political climate they exist within are all seen as related to, and co-constructing one another. This position is particularly useful in regards to studying drug use and treatment which have typically been conceptualized through overly deterministic narratives that focus primarily on individual bodies using substances at the expense of the (political, social, structural) context that drug use and treatment occur within.

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Results:

PWUDs’ problems and MMT’s role in reducing them

> “Implementing models of Recovery Oriented Methadone Maintenance (ROMM) will involve key staffing changes within Opioid Treatment Programs (OTP), including a greater role of addiction medicine specialists in patient/family/community education, increased involvement of primary care physicians, co-location of OTPs and primary health care clinics, greater inclusion of family/child therapists, increased use of current and former patients in medications-assisted recovery as staff and volunteers, and the use of indigenous healers drawn from diverse cultural communities, e.g., leaders of recovery-focused religious and cultural revitalization movements.”
>
> (White & Mojer-Torres, 2010)

As the above quotation illustrates, recovery in MMT is firmly based on a medical model of addiction that positions PWUD not only as individuals with a disease, but as wholly problematic selves requiring a variety of psycho-social-spiritual interventions. As such, it is a model that focuses on the individual, both as the source of harms and difficulties PWUD experience, and as the proper site of intervention. More specifically, the etiology of PWUD problems are their own untreated ailments, understood through the discourse of “addiction”.

Yet, most study participants did not describe their experiences in this way. Instead of using medicalized language, discourses of addiction, or expressing their problems as individually derived, participants framed their drug use difficulties as directly related to external factors associated with the structural-legal context of prohibition/criminalization. Specifically they focused on the practical difficulties of having to regularly acquire illegal drugs, and related problems when their efforts were unsuccessful. These difficulties were seen as having a synergistic quality that made dependence on an illegal substance an unsustainable lifestyle.

They described MMT as alleviating those problems by providing a means to safely, affordably, and reliably acquire opioids outside of their criminalized context. This not only eliminated the dangers associated with police/criminal justice, and the unreliability and inflated prices of the illegal market, but allowed them the time and stability to build a life free of the need to constantly seek out drugs. Thus, participants contrasted the constant hustle, dangers, and chaos of illegal drug use with the relative ease and stability of MMT. The following comments are typical of participants’ responses:

> “[As someone who uses heroin, you] Gotta hustle to get that money and I wasn’t taking care of my girl or me, and it’s just rough. It was rough…. [I got on MMT to] stop that hustling, that was the main reason. That everyday, three times and four times, trying [to get] money to supply me and my girl, it was too much. Too much.” (Grace, interview, 2016)
>
> “I think it’s [heroin] the healthiest drug you can possibly take. The drawbacks are the cost and the system you have to go through to get it. It’s all the imposed stigma that creates the detrimental aspects.” (Pauline, interview, 2014)

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> "I can just do this [take methadone] and I won't have to worry about anything… The illegality and the cost, and then dealing with knuckleheads in the street that try to rip you off. It was just easier and it was stable too." (Tom, interview, 2014).

Participants focused in particular on using MMT to minimize withdrawal or to avoid it completely. Withdrawal was seen as problematic not only because of its extremely unpleasant effects, but because of the inability to work, stay in school, or pursue non-drug related activities when periodic sickness was a regular occurrence. Some participants, who continued to use illegal opioids (and other substances), saw MMT as a "backup", or a way of reducing the instability of illegal drug use by ensuring against withdrawal when illegal opiates were unavailable. They often remained on programs temporarily, usually when obtaining illegal opiates was particularly difficult, dangerous, or expensive. Others saw MMT as a permanent substitute for illegal opioids, and tended to use them rarely if at all.

> "It was hard to get the money to get heroin everyday…….When I didn't get the money, I was getting sick… [I got on MMT] because I didn't have to worry about getting sick or nothing. I could just go to the methadone clinic, drink [my dose of methadone] everyday, and not have to worry about withdrawal or nothing like that….. It worked out great for me. At the time [before getting on MMT] I didn't have no place to stay. Once I got on the methadone program everything started to fall into place" (Sofia, interview, 2016)

> "[I got on MMT] because I was waking up sick too much and, you know, have to steal to support my habit. You know, we have to do things to support our habit." (Spencer, interview, 2016)

> "The dope [heroin] was the worst because if you don't have it, you get sick – that was the purpose of the methadone. That was the purpose of the methadone…. In other words, if I couldn't get that [heroin], the meth[adone] was a total backup" (Donald, interview, 2016)

When asked directly, participants were mixed in their views of addiction as a "disease" or "medical condition". Some argued that it is a disease or disease-like by referencing genetics and/or language suggesting neurological models of addiction. The following participants characterized addiction in this way:

> "I don't know if 'disease' is the right term but I think of it as an illness. I think my brain forever changed, since I started early, when I was a kid…. I feel like I'm forever damaged in some way." (Marshall, interview, 2014)

> David: When you think about addiction, do you think of it as a disease?

> Nadine: Yes! Yes, it is a disease! It is. It is a disease.

> David: Ok, tell me more.

> Nadine: It's a disease because, like I said, my father was an alcoholic. And I think it's because different people, like their mother or father, or somebody in their family has had this disease before. And that's why I feel that it's a disease.

> David: Because of genetics?

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> Nadine: Yes, genetics. It could be to alcohol or pills or whatever. (Nadine, interview, 2014)

One participant, who identified as being in recovery and who also worked with recovery-based organizations, was particularly forceful in his insistence that drug use and treatment should be conceptualized through the disease model of addiction. When asked about people who understand their drug use experience and/or treatment needs in other ways, he positioned their views as being in opposition to "science" and thus, inherently incorrect:

> "Every credible academic, medical, and research organization in the world does agree [that addiction is a disease]. What I say to them [people who do not see drug use as a disease] is: there is no 'disease model', there is no 'disease theory'. If we are people that believe in science, it's a fact." (Chad, interview, 2014)

But others directly challenged the view that their drug use was (or was caused by) a disease. Participants criticized the disease model as deterministic using discourses of personal responsibility and by rejecting the assertion that drug users are devoid of agency in regards to their drug use decisions. Moreover, some were suspicious of medicalized conceptions of drug use and argued that they function as a means of shifting blame. For example, participants stated:

> "I don't feel comfortable with everything that goes with that title [the disease model of addiction]….. My hand never shot me up against my will" (Melissa, interview, 2014)

> "I really don't [think it's a disease]. I remember being in rehab when they said 'Oh they found out it's a disease, that there's this chemical THIQ [Tetrahydroisoquinolone] and I'm like 'what the fuck ever man', I said 'I don't really think so'. Cause you know, really addiction – sex addiction, food addiction, this and that, money, power, fame - I said 'come on', you know. I guess for me, it's like a scapegoat, like giving up a little responsibility. To me personally, I don't consider it a disease, I guess it's behavioral." (Dale, interview, 2014)

Some participants also rejected the fundamental premise of recovery that positions drug use as inherently pathological. For example, when asked if she identified as being in, or pursuing recovery, Pauline, who does not currently use illegal drugs, emphatically stated:

> "I was not sick and I didn't need to recover." (Pauline, interview, 2014)

Recovery's relationship to non-opioid drug use

Not surprisingly, most participants reported a recent increase in their clinic's focus on non-opioid substance use. Yet, in line with their view of MMT as a means to reduce or eliminate the problems associated with illegal opioid use (the only class of substances that methadone treats from a pharmacological perspective), many were not interested in abandoning substance use completely. Some wanted to use illegal opioids less often without quitting entirely, while others wanted to quit using illegal opioids but continue using other substances (most often alcohol or marijuana). Most participants found the focus on addiction generally, and the ability to police a wider range of substances that it enabled, to be counterproductive,

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demoralizing, and a barrier to others not currently involved in treatment. The following responses are typical:

> "You're going to the clinic for treatment for opiate addiction. That's what methadone's for. It's not a treatment for cocaine addiction. It's not a treatment for alcohol addiction." (Karen, interview, 2014)

> "In my opinion using other drugs is a whole different topic. I was trying to get off my heroin habit, that's all I saw methadone as useful for. (Pauline, interview, 2014)

The focus on non-opioid substance use had a negative impact on at least one of the participants who was not pursuing abstinence-based recovery. Barry specifically identified stability and a change in lifestyle as his primary motivations for utilizing MMT. He states:

> "I didn't want abstinence from all illicit drugs by any means. I definitely wanted to stop the lifestyle that I was going to go back down. I don't think that the methadone community has the idea that abstinence as being the total goal of recovery for MAT. [It's] to get your life together. I mean you can't be fucking going to the West side [of Chicago], shooting dope, shooting dope in the bathroom at work, you've got to get high every six to eight hours. There's no way to live a life like that." (Barry, interview, 2014)

Barry's life improved dramatically at his initial clinic, one that did not test for alcohol and marijuana use; he maintained a job, took classes, and described his life as the most stable it had been since he began using heroin. However, when he moved to Cape Cod, and began receiving services at a new, recovery-oriented clinic, he quickly began experiencing problems, and left treatment shortly thereafter. He explains:

> "I was able to do the things that normal people do [at my old clinic]. Normal people go to bars… Normal people smoke weed. Normal people do those things when they want to do them. Now if you're gonna tell me because when I was between the age of 16 and 22, I shot dope and I was a heroin addict, fine, you can say that, but don't let that define the rest of my life. Don't tell me I can't go to a pub and have some beers. Don't tell me I can't smoke a joint with my buddies, cause that is bullshit….. You just want to live a regular life and they try to impede on you living a regular life, then that's where it bothers me, and that's where I say 'you know what, fuck it' and that's why I said fuck it in Massachusetts." (Barry, interview, 2014).

Some of the participants on MMT did believe in recovery and supported the clinics' focus on abstinence. They generally described individuals who were not pursuing abstinence/ recovery in a negative light, framing MMT as a privilege that must be earned. Similarly, they worried about the potential negative effects of such individuals on public opinion. For example, Francine stated:

> "I think that's [using methadone to moderate drug use or for other non-abstinence reasons] absolutely ridiculous and it pisses me off when I see people that are doing that. Because it gives us such a bad name. Cause it [MMT] does work and you get these assholes who are still getting high… It pisses me off because you have these people who would get on it because they figure well they can't afford to get high anymore so they get on 'meth', and they're not doing it for the reason of they want

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> to clean up their lives and that really irritates me… Why be on it? Why do that? You have such a chance of getting yourself together. Why are you gonna take it and then still go and screw around? It just makes no sense to me." (Francine, interview, 2014)

However, many in this group relied upon subjective and culturally specific interpretations of "abstinence" and "drug" that problematized recovery's use of discreet and universal categories to delineate between people in recovery versus those who are not. For example, participants who occasionally drank alcohol (like Francine) tended to view that as within the bounds of recovery but rejected recreational marijuana use. Others smoked marijuana and argued for its acceptability while dismissing the claims of those who drink. Since the recovery discourse is involved in expanding the jurisdictional boundaries of addiction-causing substances and behaviors, one can imagine how debates over substances like cigarettes, chewing gum, and sugar, or behaviors such as playing the lottery can further complicate the already tenuous boundaries between recovery and active addiction.

Establishing a discursive difference between heroin and methadone

Because methadone, like heroin, is an opioid, the recovery discourse in MMT depends upon establishing a discursive distinction between heroin (and other illegal opioids) seen as a "drug" and methadone, seen as "medication". This construction not only renders the treatment more politically acceptable, but also enables positive treatment outcomes to be seen as the result of switching from a drug to a medication while obscuring the important differences between using a legal versus illegal substance. While many participants adopted this rhetorical strategy when describing their treatment experience (an unsurprising outcome considering the institutional dominance of the disease model in MMT), others challenged this view by emphasizing the similarities between the two substances. For example, Casey, who describes herself as being in long-term recovery, argues that similar results could be achieved with either heroin or methadone:

> Casey: I think that this was something I was born with and then through environmental traumas and use [it was made worse]…. Methadone just took care of all that. It just took away the crave. It helps me tolerate pain both emotionally, mentally, physically.
>
> David: Did heroin do that for you too? Casey: Oh yes! Day one, day one! I would tell you that heroin, in some ways, I know this is gonna sound weird, but it saved my life.
>
> David: That doesn't sound weird at all.
>
> Casey: Well, you know, some people would say…. my parents would tell you that it destroyed my life but I'd tell you that I probably would have suicided if I hadn't found something.David: So both heroin and methadone had that same effect of treating the mental and physical anguishes, but heroin was probably tougher to maintain.

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> Casey: Yeah, you can't maintain it. You can't lead a healthy lifestyle. You know, I bet if I could get heroin from a medical doctor I think one or the other would work just as well. I'm convinced. (Casey, interview, 2014)

Thus Casey locates the difficulties of opioid use not in their pharmacology - in fact she states that opiates have always helped her to the point of saving her life – but in their structural position as an illegal drug and the lifestyle that illegality engenders. In contrast to recovery's attempts to discursively separate the two substances, Casey's account suggests that MMT's ability to improve lives is not related to methadone's 'medicineness' as compared to heroin's 'drugness', but because of the quasi-legal environment of opioid use that MMT allows - a view supported by the recent success of Heroin Assisted Treatment (HAT) in Switzerland and elsewhere (Ferri, Davoli & Perucci, 2011; Uchtenhagen, 2010).

Casey's response also illustrates pressure to describe her drug use through the dominant recovery-based narrative. She clearly hesitates before stating her belief that heroin functioned as a positive in her life, first by qualifying her response as "weird" and then by pointing out that her parents would probably subscribe to the opposite position. Thus her response demonstrates the social and institutional pressure among people on MMT to view their positive treatment outcomes as the result of a medical intervention rather than from the ability of opioid-dependent individuals to continue using opioids in a decriminalized manner – a narrative far more likely to lead to critiques of criminalization.

Sarah, who has not used illegal drugs in almost seven years, also describes both internal and external forms of pressure to accept the dominant narrative, despite its inability to describe her drug use experiences. Although she articulates a complex, nuanced, and multi-factorial view of drug use problems, which seems to fall outside of the boundaries of the recovery model, after taking half an Adderall obtained from a friend while sick at work, she describes significant stress based on the categories established by recovery discourse. The interview portion begins with her critique of recovery-based policies – which included pressure to attend 12-step meetings - at her clinic.

> "It was all centered on the idea that you had done something wrong, that you were in the wrong, that you were this drug addict and you could be making amends for all these things you've done. There was no sense of a drug user being a person. They didn't look at anyone's story, situation, or struggle, which is the reality of any person, and every person's story, situation, and struggle is different. And that plays a part. It plays a part in whether or not a person can be able to go do stuff [drugs] again, and that be ok. I'm not opposed, I wish I could do that, and I don't think there's anything wrong if I did take a morphine vacation. I know because of myself and the way that my brain works that I can't take that chance cause I'm way happier now. But do I think that's wrong? God no. You know, this bothered me so much, cause you know, I haven't done drugs in, it'll be almost 7 years, and I found myself, when I took this half an Adderall and failed this drug test, I'm like 'Have I relapsed?!' Like in reality, I haven't done anything wrong, I was just sick and took half of my friend's medication. But I was like, I found myself asking these questions: 'Now can I not say that I'm clean?' and it's ridiculous and that's been so drilled into my head. I have great guilt, I feel bad about it. In the reality I know I

> didn't do anything wrong, I didn't jeopardize my livelihood or whatever, and had I not gone through all this drug shit, I would've never thought that." (Sarah, interview, 2014).

Since Sarah, who has two young children, worried about the ability of the clinic to contact Child Protective Services (CPS) if they believed she was not "in recovery", after numerous clashes with her clinic counselor, she eventually decided to simply pretend that she had accepted their focus on recovery. As she states:

> "I finally learned that I just had to lie. I hate having to do that, but I filled the lady's head with all the shit she wanted to hear. Used all the buzz phrases she wanted to hear. Plus I have had to, to protect myself, still stay in ongoing therapy. [I] Learned real quick it is best to have someone who can attest to your sobriety." (Sarah, interview, 2016)

Discussion

This paper critically examines the conceptualization of MMT as recovery-based treatment. It argues that, in contrast to recovery, MMT cannot be understood outside of the structural context of criminalization and the War on Drugs which shape illegal drug use as a difficult and dangerous activity, and consequently position MMT as a way to moderate or escape from those harms.

Participant responses demonstrated this by focusing on the difficulties and dangers of illegal drug use as the primary forces driving them to participate in MMT. Similarly, MMT was seen as beneficial by reducing or eliminating these problems. Rather than describing it as a medically-based treatment for addiction or a route to achieving recovery, most participants emphasized the pragmatic advantages of MMT, such as stability, legality, and the elimination of withdrawal. Similarly, most were not interested in cessation of all substance use but saw MMT as related only to their use of opioids. Thus, participants conceptualized, and utilized MMT, primarily as a way to moderate or potentially eliminate the harms and difficulties of illegal opioid use and not as an abstinence-based program of self-change.

These results align, to some extent, with those of McKeganey et al. (2004)'s examination of whether drug users in treatment are seeking abstinence or harm reduction. Although that study is framed as demonstrating their preference for abstinence, the results show that individuals in MMT, as opposed to other types of drug treatment, were the least focused on achieving abstinence – only 42.5% reported seeking only abstinence (as opposed to harm reduction only or a mix of abstinence and harm reduction). It is likely that the percentage is even lower due to social desirability bias. Similarly, Fisher et al.'s examination of drug users' perceptions of MMT emphasizes the pragmatic benefits PWUD accrue through not having to participate in the illegal market (2002). Some of the participants' responses sound remarkably similar to those in this study. For example, one stated "As long as I don't have to find or chase heroin, I would be able to function. Methadone is the solution for me." (2002: p. 507) Similarly, many participants in that study were not pursuing abstinence but used MMT as a way of minimizing (sometimes temporarily) the harms associated with illegal opioid use such as withdrawal and having to steal to avoid withdrawal (2002).

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Because people on MMT continue using, and are physically dependent on opioids (methadone), there has always been a tension between understanding MMT as a form of drug treatment, and understanding it as a means of using opioids legally i.e. the common charge that people on MMT are 'just swapping one drug for another' (Doukas, 2011; Kleber, 2009; Fraser & Valentine, 2008). Unfortunately, most discourses that emphasize the similarities between methadone and illegal opioids are framed by conservative and anti-drug ideologies, and used to de-legitimize the treatment. However, the same comparison also challenges criminalization by positioning a substances' legality as directly related to its capacity to produce positive treatment outcomes. Thus, if opioid dependent individuals' lives dramatically improve by switching from an illegal opioid to a legal one, then criminalization itself may be a larger part of the difficulties PWUD encounter than acknowledged by medical models of addiction like recovery.

The results of this study should be considered in light of some important limitations. My own position as someone in MMT is the most notable source of bias. Although I believe my insider status was primarily an advantage in this study, it clearly influenced my relationships with participants, and thus the data I collected. I attempted to control for this both through transparency, and by including multiple participants' responses when addressing the study's major themes. This was done to mitigate concerns of 'cherry-picking' only the data that supported my own views. Additionally, since this study is not based on a representative sample, the results cannot be generalized to the larger population of individuals on MMT.

However, the results of this study demonstrate some of the problems with conceptualizing MMT as recovery-based treatment. First, while many individuals on MMT are undoubtedly seeking recovery, many clearly are not – these already marginalized individuals become increasingly marginalized by having to conform to its tenets. In some cases this can lead to cessation of treatment (either voluntarily or involuntarily), an outcome associated with increased risk of overdose (Magura & Rosenblum, 2001; Joseph, 1994; Seal et al., 2001). Moreover, the presentation of MMT as essentially recovery-based can also serve as a barrier to PWUD not currently in treatment who would benefit from MMT but are not pursuing recovery. This is particularly important in light of the long history of silencing, and ignoring the voices of PWUD in regards to their own perceptions of, and needs for treatment (Chen, 2011; Friedman et al., 2007; White, 2001).

Although some treatment providers emphasized that their clinics' focus on recovery was non-coercive, this is not only substantively untrue since recovery-oriented goals and principles are often built institutionally into programs (SAMHSA, 2015; SAMHSA, 2009) as well as conveyed through the "patient"/counselor relationship, but also misunderstands the highly unequal power dynamic between individuals on MMT and treatment providers. People on MMT are often terrified of being discharged from programs, which makes any official doctrine on how to conceptualize drug use and treatment, coercive. Moreover, other treatment providers maintained that people in their programs were encouraged to adopt the disease model and describe their drug use through that language.

Participant responses also suggest that the recovery discourse in MMT functions, in part, to obscure the role of criminalization and the War on Drugs in the problems PWUD

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experience, in favor of a view based on individual pathology. Although the notion that MMT protects people who use illegal opioids from structural-legal harm was an important part of how the treatment was originally conceptualized (Dole & Nyswander, 1976), it is absent from the recovery discourse, which positions PWUD problems as caused by "addiction". Thus, while medical approaches to drug use, like recovery, are often touted as progressive alternatives to more overtly punitive models, both positions locate drug use as a monolithic, and wholly negative activity that must be controlled.

Some participants even directly rejected the pharmacological distinction between heroin and methadone, and saw them instead as *legal* versus *illegal* opioids. However, most were reticent to express that view and admitted to social pressure from family and others to position methadone as a medicine, separate and distinct from illegal opioids like heroin. Public health initiatives like recovery have often been criticized for their tendency to focus on individual behavioral change at the expense of structural analyses (Salas, 2015; Walls, Peeters, Proietto & McNeil, 2011; Merzel & D'afflitti, 2003; Reinarman & Levine, 1997). For example, sociologist Deborah Lupton argues that public health discourses often mobilize concepts of risk in order to "blame the victim, to displace the real reasons for ill-health upon the individual, and to express outrage at behavior deemed socially unacceptable" (1993: p. 425).

Thus, the results of this study demonstrate the need for a paradigmatic shift in how MMT is conceptualized. Specifically, there needs to be discursive space for understanding MMT's function as related to dealing with the effects of criminalization. This does not mean disallowing or rejecting individuals' rights to understand their drug use and treatment through the recovery model. Rather, it means adopting a less positivistic ontology for MMT that rejects easy binaries and reductive narratives as a means of conceptualizing the 'treatment'.

Increasing focus should be given to 'low-threshold clinics' that "seek to break down barriers to the treatment of opioid dependence by reducing entry and retention criteria and by accepting individuals who continue to use drugs without threat of expulsion from the program" (Millson, Challacombe, Villeneuve & Strike, 2007: p. 125). Although treatment providers may object to such clinics on the basis that individuals on MMT who use other substances may be at increased risk of overdose, studies have found that low-threshold clinics reduce the risk of overdose (Van Ameijden, Langendam & Coutinho, 1999) as well as injection-related HIV risk (Millson, Challacombe, Villeneuve & Strike, 2007) and health related quality of life among participants (Millson et al. 2006). Moreover, like many critiques of harm reduction-focused treatment, such claims are based on the falsehood that individuals who wish to continue using drugs while in MMT will be dissuaded by the possibility of punishment and comply with the rules. In actuality (and like one participant in this study) many simply abandon treatment and return to illegal and unregulated – and thus, more risk-involved - opioid use.

Similarly, the culture and institutions involved with MMT must allow for alternative discourses that position criminalization as oppressive to PWUD and acknowledge the role of treatment (particularly MMT because clients are not required to discontinue opioid use) as a

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refuge. By acknowledging MMT's use as a protective factor, treatment decisions can be understood not simply as medical choices but political ones (Smith, 2012). This provides a more productive framework from which to address criminalization as an oppressive regime. As Koester et al. rightly conclude: we should consider "drug users' own models of drug use and treatment" and that "these addict-led adaptations of methadone maintenance treatment may encourage us to rethink what we mean by 'successful' treatment" (1999: p. 2151).

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