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"That's No Longer Tolerated": Policing Patients' Use of Non-opioid Substances in Methadone Maintenance Treatment

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Abstract

The current overdose crisis in the United States emphasizes the importance of providing substance use treatment programs that are not only effective but tailored to meet the specific needs of the populations they serve. While Methadone Maintenance Treatment (MMT) is considered to be among the best strategies for reducing rates of opioid-involved overdose, its ability to attract and maintain patients may be hindered by a recent focus on policing the non-opioid substance use of people on the program. This paper uses interview data from treatment providers to examine how clinicians conceptualize and organize MMT in regards to patients' use of non-opioid drugs. Responses demonstrate that some treatment providers are increasingly monitoring their patients' use of non-opioid substances and punishing them for infractions, up to and including discharge from treatment. This approach will likely result in increasing rates of patient dropout and a lack of new admissions among people who use non-opioid substances. This article argues that including non-opioid substances in MMT's mandate restricts its ability to improve public health, including by preventing overdoses, and recommends instead that MMT adopt a more individualized approach, shaped by the needs and goals of the patient rather than those of the clinician.

Keywords

Methadone maintenance treatment; abstinence; harm reduction; cannabis; recovery

Introduction

The current opioid-involved overdose crisis in the United States (U.S.: Scholl et al. 2019) emphasizes the importance of providing substance use treatment programs that are not only effective but tailored to meet the needs of the populations they serve. Although research has consistently demonstrated the effectiveness of MMT toward reducing rates of opioid-involved overdose (Degenhardt et al. 2009; Schwartz et al. 2013; Sordo et al. 2017), and other harms linked to illegal opioid use (Bruce 2010; Farrell-MacDonald et al. 2014; Karki et al. 2016), the increasing use of a recovery-based approach to treatment may have led to increased policing by clinicians of their patients' use of non-opioid substances like cannabis

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and alcohol. Since many people in MMT, as well as people who use illegal opioids who are not currently in treatment, use non-opioid substances (Le et al. 2019; McBrien et al. 2019; Scavone et al. 2013) this shift may function as a barrier for individuals who want treatment but are unwilling to abandon their use of all substances.

Opioid-involved overdose rates in the U.S. are currently at dramatically increased levels (Scholl et al. 2019). In 2017, rates of opioid-involved overdose deaths rose from 21,088 in 2010 to 47,600 in 2017 and remained at that level in 2018 with 46,802 deaths (2020).

Although MMT, and Medication Assisted Therapy (MAT) generally, has consistently demonstrated an association with reduced rates of fatal, and non-fatal, overdose (Degenhardt et al. 2009; Sordo et al. 2017), transmission of HIV/HCV (Avants et al. 2004; Karki et al. 2016), and prisoner recidivism (Farrell-MacDonald et al. 2014), it has also been hindered by low rates of use and retention that limit its potential to reduce harm (Saloner and Karthikeyan 2015). Although retention rates vary by location and other factors (Peles et al. 2008), data from the U.S. Treatment Episode Data Set shows that in 2014, 41% of people in MAT dropped out of treatment and that the median length of stay among that group was only 114 days (Substance Abuse and Mental Health Service Administration 2019a). In addition to those that dropped out, a further 11% were terminated from treatment by the facility meaning that less than half of the patient population remained in treatment throughout the year (2019a).

Many argue that MMT's low rates of use and retention are related to its highly regulated, abstinence-based approach to treatment (Frank 2018; Joseph, Stancliff, and Langrod 2000; O'Byrne and Jeske Pearson 2019). For example, research demonstrates that people use MMT for a variety of reasons, including many who use it as a pragmatic means of avoiding the harms of illegal drug use such as arrest, overdose, and withdrawal, rather than to pursue abstinence-based recovery (Frank 2018; Koester, Anderson, and Hoffer 1999; Mateu-Gelabert et al. 2010).

Research also suggests that the recent adoption of a recovery-based approach to treatment by institutions like Substance Abuse and Mental Health Services Association (SAMHSA) (Substance Abuse and Mental Health Service Administration 2019b; White and Mojer-Torres 2010), that administer MMT, has led to an increasing focus on monitoring patients' behavior beyond their use of illegal opioids (Frank 2019), the only class of substances that methadone treats from a pharmacological perspective. Since the recovery model is based on the notion of addiction-as-disease – which conceptualizes addiction as a whole-person problem – treatment is organized to affect all aspects of the patients' lives, often including subjective criteria such as community service and spirituality (Substance Abuse and Mental Health Service Administration 2019b; White and Mojer-Torres 2010). Moreover, the disease model positions substance use as something to be inherently avoided/eliminated, and therefore, treatment is generally abstinence-based.

Harm reduction organizations and drug-user-rights groups generally reject such models, arguing instead that substance use is a complex social phenomenon rather than a disease (INPUD 2020b; AVIL 2012). Similarly, they point out that addiction-as-disease narratives

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imply "that drug use is a disease from which people could or should be cured" (INPUD 2020a, para. 7). Instead, harm reductionists argue for lower-threshold approaches to treatment that focus more on reducing the harms of substance use than on the promotion of abstinence and self-transformation.

MMT is already seen as over-regulated and is unpopular with many people who use illegal drugs as evidenced by its low rates of use and retention (Substance Abuse and Mental Health Service Administration 2014). Thus, it is important to avoid the use of policies or treatment models that may further impede peoples' willingness to participate. However, there has been no research that examines if, and how, the growth of the recovery model in MMT has affected the ways that treatment providers conceptualize their patients' non-opioid substance use, or if/how this approach has manifested in practice. This paper uses semi-structured interviews with MMT providers to examine how non-opioid substance use is conceptualized in MMT clinics and how those beliefs manifest as practices in the clinic environment.

Methods

This paper is based on qualitative research consisting of semi-structured interviews and ethnographic observations. Interviews were conducted in New York City with a variety of people involved with MMT but this paper focuses on people who work as treatment providers (individuals working at MMT clinics and government administrative offices that regulate MMT) (n = 10). This group comprised primarily clinic employees such as Program Directors, Clinic Directors, and Counselors, but also included people who work in government agencies such as the SAMHSA and the Office of Addiction Services and Support (OASAS).

Participants were recruited using a purposive sampling strategy. Recruiting and data collection choices were guided by the development of theory and emerging themes within the data. Purposive recircuiting was carried out using my own contacts in substance use and substance use treatment communities, and referrals provided from those initial contacts. Participants had to be at least 18 years old, speak and understand English, and provide informed consent. Interviews were recorded for later transcription using AtlastTi, and all participants are referred to by pseudonyms. This study was given IRB approval by the City University of New York.

Interview questions focused on how well MMT programs aligned with the needs and goals of people on the program and the corresponding willingness of treatment providers to provide them. In particular, patients were asked about how they use and benefit from MMT, what difficulties they had with the program, and how things could be changed to better suit their needs. Correspondingly, treatment providers were asked how they conceptualize substance use treatment in general, and MMT in particular, and how they think people benefit from the program.

This paper is also 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 17 years and received services at two clinics: one in Chicago, IL, and one in The Bronx, NY.

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Although I do not refer to my own experiences directly in this paper, they have structured my own views on this topic and the direction of this study. Moreover, I regularly made notes based on conversations I had with participants both before and after interviews that often spoke to the study's themes. Thus, it incorporates elements of auto-ethnography.

Although auto-ethnographic and insider research has been criticized for its lassie-faire attitude toward 'bias', proponents, often working from postmodernist or post-structuralist theoretical positions, have argued that distinctions between "bias" and "not bias" are artificial and often used to silence the views of marginalized populations (Calley Jones 2010; Frost and Elichaoff 2014). As such, insider research has been particularly useful toward challenging narratives of deviance such as those concerning substance use, sexuality, and race (Ellis, Adams, and Bochner 2011; Frost and Elichaoff 2014; Rooney 2005).

Theory

This article adopts a critical theoretical orientation toward the dominant biomedical narratives of treatment that construct and govern MMT. Although institutional discourses conceptualize MMT as a form of treatment for addiction, critical scholars, often Medical Sociologists and/or Medical Anthropologists, have argued that it is better understood as a form of social control (Bourgois 2000; Frank 2018; Fraser, Moore, and Keane 2014; Fraser and Valentine 2008; Keane 2002; Netherland 2012). Such work, which often prioritizes the voices of people in treatment, has focused on the power imbalance between patient and provider, generated in part by addiction-as-disease narratives that position people who use drugs as innately damaged and needing the kinds of strict surveillance that characterizes most methadone clinics (Frank 2019; Fraser, Moore, and Keane 2014; Keane 2002).

Similarly, research that examines how people on MMT conceptualize the program demonstrates that many people on MMT do not see their treatment through the institutional narratives of addiction and recovery, but instead, see MMT as a pragmatic means of avoiding harms liked to criminalization and the War on Drugs (Frank 2018; Harris and Rhodes 2013; Mateu-Gelabert et al. 2010). Thus, clinic policies, such as daily attendance and increased counseling, which are framed by counselors as "treatment" are often experienced by patients as punishment.

Lastly, this article is guided by the anti-essentialist approach that scholars Fraser & Valentine, and others use to understand MMT. In their account of MMT through interconnected spheres of public health, the law and social stigma the authors borrow from feminist science and technology studies to frame methadone as a constantly shifting entity, influenced by its interactions with politics, culture, and institutions (Fraser and Valentine 2008). As they point out, "Instead of viewing it [MMT] as a fixed, pre-defined system that treats similarly preexisting subjects in order to nurture a powerful beneficial change, we analyze it in terms of the powers it exercises and responsibilities it carries in generating particular subjectivities, while constraining or disallowing others." (p. 3)

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Results

Clinic responses to patients' use of non-opioid substances

In line with the institutional focus on recovery as a holistic approach to treatment, treatment providers emphasized that MMT was not just about abstaining from illegal opioids, but from all drugs. They defined "drugs" as any illegal substances as well as cannabis[1] and alcohol. Some treatment providers placed a particular emphasis on cannabis and alcohol, possibly because they are likely the most commonly used substances by patients. For example, the following responses reflect treatment providers' views on non-opioid substance use:

> No [we don't allow any drug use], we're a substance abuse treatment program. We treat all addictions and in fact if patients have additional addictions, we will discharge patients due to illicit substance use: cocaine, benzos, etc. that has ongoing use that interferes significantly with their health or treatment. We do include cannabis as well as alcohol.
>
> (Cliff, Program Director, 2014).

> It's not so much abstinence-only, it's that all illicit substance use has to be addressed. Meaning 'Ok, it's not just that you're not using heroin, we're going to talk about your alcohol use, how you come in here every day smelling of alcohol. We're gonna talk about how that impacts your health.
>
> (Laura, Clinic Director, 2014)

Treatment providers described using a combination of primarily punitive tactics to discourage patients' non-opioid substance use including: increased counseling, an increase or decrease in patients' dose, and the threat of discharge. However, the most common effect of failing a drug-screen (for opioid or non-opioid drugs) was a reduction in, or elimination of, that patients' take-home privileges, the doses of methadone that some patients are given to take on their own, outside of the clinic. Thus, individuals that continue to use such substances are required to attend the clinic on a daily basis to receive their methadone.

Although clinics have always tried to moderate their clients' use of all substances to varying degrees, some treatment providers described an increasing focus on policing patients' use of non-opioid substances. This was seen, in part, as a result of the institutional push toward recovery and its focus on treating addiction holistically. As Laura, an MMT Program Director, explains:

> We have patients that have been here since 1972, so there's patients who've been here [for] years, so they're used to that older modality. And for many years, you could be on a methadone program and as long as you weren't using opiates, it didn't matter if you were using other substances. It was this frame of mind like "Oh, you're using Cocaine, oh, your outpatient will deal with that. Or your using alcohol, 'well someone else will deal with that." So, it was pushed onto other providers or it wasn't the methadone maintenance programs problem. That's no longer acceptable. That's no longer tolerated. … We have to address everything.

[1]. This study was conducted in New York State where recreational cannabis use is currently illegal.

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> So these patients who have been doing this for years are now like "What are you talking about?!".
>
> (Laura, Clinic Director, 2014).

As Laura's comments demonstrate, the changes in clinic policy were experienced as stressful by some patients, particularly those who had been in treatment, successfully, for years, and whose access to methadone was now in jeopardy. It is important to point out that since people on MMT are physiologically dependent on opioids and will experience severe physical and psychological distress without them, there is significant fear associated with the threat of missing one's dose or losing access to their medication.

The most serious consequence of patients' non-opioid substance use was discharge from the program. Although participants from SAMHSA stated that they preferred clinics to avoid dismissing clients, and to do so only as a last resort, they admitted that individual clinics have significant latitude in such matters. For example, when asked if she believed that clinics were following that procedure, Karla, a SAMHSA Program Administrator, replied: "Some. Some. And I think it varies, to be quite honest with you, state by state." (Karla, Program Administrator, 2014)

Some treatment providers did describe discharging patients as uncommon and used only after numerous less severe strategies had been tried unsuccessfully. For example, as Kelly, an MMT Program Director, explained:

> Yeah. You know, a lot of programs, a lot of methadone programs do do that [discharge patients for non-opioid substance use]. That's really for us an absolute last course of action. I can say that I have discharged, I believe at the nine years that I've been here, two patients … … for continued use. But that's because we had exhausted every intervention that we could possibly do. The patient was not putting forth any effort and we're talking about three plus years in treatment, but there have only been two cases here thus far like that. You know what I mean? We really will work with the patient as much as we possibly can. The only reason we would discharge them for continued use is if they are not putting forth any effort and it's a significant amount of time.
>
> (Kelly, Program Director, 2014)

Yet, as the following comment reveals, others were much more willing to discharge patients for non-opioid substance use:

> We don't buy it [people who want to stop using opioids but not other substances] anymore. The reality is we can't buy it anymore. We have regulations, we have to account for this. I told them how … I'm like, we no longer can accept this because at the end we all get audited. We all are accountable to a higher level, a higher agency and they're going to tell us, "How are we keeping patients in here that are still using X, Y, and Z and you're not helping them?" That's the mentality. We have to help them. If not, they can't stay here.
>
> (Grace, Counselor, 2014)

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Treatment providers responses also demonstrate how recovery's emphasis on complete abstinence can become institutionalized within the clinic system. Thus, while patients may not be discharged for substance use, per se, their use of non-opioid substances can lead to a poor relationship between patient and clinic, which can escalate, ultimately resulting in that patients discharge or quitting of their own accord. For example, Laura, a Program Director, stated:

> They're not getting kicked out of this clinic, dependent upon, so solely that they are using either opiates or secondary drugs. Really either would not be a criteria for getting kicked out of this clinic. Why people may be terminated from treatment is based upon the consequences of using, right? So, in terms of their behavior, if they're threatening, if they're noncompliant with treatment in terms of they're not coming here, they refuse to meet with their counselor, they refuse to whatever, fill in the blank, whatever the expectations are of the program. If they're unwilling to comply with those, being abstinent is not a regulation of this program, right?
>
> (Laura, Program Director, 2014)

Clinicians views of the legitimacy of non-opioid substance use while on MMT

There was substantial diversity among treatment providers regarding the legitimacy of their patients' use of non-opioid substances while on MMT. Although most agreed that it was something that programs should address, they differed on whether or not it was ultimately reasonable for PWUD to use MMT as a form of harm reduction rather than in pursuit of abstinence. Some argued that since MMT was still helpful to such individuals, they should be accommodated by programs. For example, Janice, a Program Director described her clinics' process as follows:

> We are very harm reduction. We have met in team meetings … where we also meet with a patient where we will really struggle and kind of go, 'How are we really helping this guy or gal?' Right? And we will have those honest conversations, however we're harm reduction and if someone is using less, which again, may be difficult to gauge if they're always positive for opiates, how do I know they're not using once a week and one once a day? We get a sense based on their clinical presentation, definitely if people are stopping to use from IV and now they're just intranasally, that's a great benefit for us. Or if there they were, they didn't care about needles and now they're going to needle exchange. That's a … … So, we really do, we really are harm reduction. Any positive change. Maybe someone comes in, they're homeless and now they, with being in treatment, having some stability here, they're able to gain an SRO. Great. How much their life improved, right? So, family relationships, anything, we sort of look at the whole person.
>
> (Janice, Program Director, 2014)

Yet others explicitly rejected the use of MMT for reasons that did not position complete abstinence from all substances as the goal of treatment. For this group, harm reduction was sometimes seen as a useful means of reaching illegal opioid users or retaining them in treatment, but complete abstinence from all substances was always conceptualized as MMT's true purpose. Moreover, this belief was often expressed in punitive terms that

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positioned MMT, and treatment generally, as something that must be earned through adherence to the tenets of recovery. The following comments demonstrate this view:

> If that's what you're here for [to use MMT to reduce harm rather than for complete abstinence], then understand that if you're still using, the consequences are still there. [If] you don't want the consequences, then stop using and just use your methadone.
>
> (Wilma, OASAS, 2014)

> I don't think it's [recovery-based treatment] stigmatizing for the folks who aren't recovery-oriented, I think it raises the bar for people, that they can be recovery-oriented in the context of a methadone clinic. So it opens up light and hope for folks there because it raises expectations in a general way, as opposed to folks that are just, who have more limited reasons [for using MMT]. 'Well tough, while you're here notice these folks, they're responding to a different calling.
>
> (Cliff, Clinic Director, 2014)

> There's old school and new school. For myself, our goal is returning people to a level of functioning in various life environments, where they are not just surviving or at a sort of tolerable level, but actually are succeeding and exceeding what I think [were] previous expectations for opiate addicted persons to have.
>
> (Jerry, Program Director, 2014)

Although participants from this group rejected claims that recovery-based treatment might discriminate against individuals not seeking recovery as defined by the institutional discourse, their responses demonstrated a clear hierarchy that positioned such patients negatively. Treatment providers contrasted recovery with lower-threshold models by framing the latter as a form of low expectations. Similarly, they described those using MMT, either to reduce but not discontinue their drug use, or as a way of avoiding harms associated with illegal drug use, as being there for the wrong reasons and as unwilling to see the truth of their addiction.

Moreover, patients' requests for different kinds of treatment, such as harm reduction, rather than abstinence-based, were often interpreted through addiction-as-disease narratives that positioned PWUD as having an innate tendency toward lying and bad behavior. For example, when asked about people who want to use MMT as a way of reducing but not eliminating their use, or as a strategy for reducing the harms of their substance use, clinicians replied in the following ways:

> That's just a lie you want to tell yourself, 'that you just want to get it [drug use] under control' because as an addict, and I know people don't like the saying 'once and addict, always an addict' but as an addict, that's the issue, the control, you can't keep it at that [safer or more controlled drug use]. As an addict, the minute that you have that problem at work or your boss reprimands you, what you're using is gonna double. That's just the way it is.
>
> (Grace, Program Director, 2014)

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> I don't find many people who chip [use drugs without developing a problematic relationship with them]. Eventually, it catches up to you, and they're gonna start using more, and then it's going to interfere with those things [job, work, school, etc.]. …Those people need to be dealt with in terms of what's really going on in their lives
>
> (Sandy, Program DIrector, 2014)

Thus, such requests were seen as attempts to manipulate the system, that further justified treatment providers' focus on surveillance.

Discussion

Study findings demonstrate that, in accordance with recovery's focus on treating addiction holistically, some treatment providers are increasingly policing patients' use of non-opioid substances and punishing them for infractions up to and including discharge from treatment.

Although many treatment providers reported discharging patients only as a last resort, their responses also problematized this claim by demonstrating how recovery is built into some programs, structurally, and may discriminate against those not seeking abstinence in less direct ways. For example, testing positive for non-opioid drug use nearly always affects patients' ability to earn take-home doses, thereby forcing individuals who continue to use non-opioid substances to attend the clinic on an everyday basis. Research shows that the need for daily attendance is a significant barrier that often forces people to discontinue treatment of their own accord (Gerra et al. 2011; Pani et al. 1996).

Moreover, while treatment providers justified their expanded jurisdictional boundaries through narratives of addiction that position problematic drug use as a whole-person sickness, research demonstrates that many PWUD do not see their drug use or treatment in that way (Frank 2018). For example, many describe MMT in more pragmatic terms that emphasize the benefits of withdrawal-avoidance and the freedom from having to purchase illegal substances on a daily basis, more so than as a "treatment for addiction" (Mateu-Gelabert et al. 2010).

These results align with related research that demonstrates how treatment providers conceptualize treatment through narratives that position MMT as a medical and psychosocial treatment focused on promoting abstinence (Ekendahl 2011; Frank 2019; Peterson et al. 2010). Yet, previous research also demonstrates important differences between the way treatment is understood in the U.S. compared to some locations in Western Europe. For example, treatment providers in Copenhagen and Ireland demonstrated a much greater acceptance of harm reduction as opposed to abstinence as a treatment goal (Järvinen 2008; Van Hout and Bingham 2014). Results also align with previous studies that demonstrate substantial divisions between how treatment providers and people in treatment conceptualize MMT (Frank 2019; Harris and Rhodes 2013; Lilly, Tim Rhodes, and Stimson 2000).

This issue is particularly important in the current context of dramatically increased risk of overdose (Scholl et al. 2019). Even before the overdose crisis, leaving or being dismissed from MMT was associated with an increased risk of overdose, and rates are particularly high

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among people who have been on MMT before but are not currently (Brugal et al. 2005; Cousins et al. 2011; Magura and Rosenblum 2001). Thus, discharging people for non-opioid substance use, or adopting policies that will increase their likelihood of quitting, will put many PWUD at increased risk. Moreover, as recovery has been become more accepted within MMT since the interviews for this study were conducted (2014), clinics may have become even more restrictive (White and Mojer-Torres 2010).

This article should be read in the context of study limitations. First, my own position as someone in MMT can be seen as a limitation in that it may 'bias' results. Since I am using a social constructionist approach, that sees all knowledge as situated, this may be considered less of a problem. However, to mitigate concerns of bias, I am being transparent in my position as someone on MMT and that the article's analysis and findings should be read in that context. Second, because of this study's small sample size, qualitative methodology, and purposive sampling strategy, the findings cannot be generalized to a larger population of MMT treatment providers.

However, these findings demonstrate some of the potential problems with expanding the jurisdictional boundaries of methadone clinics to include the surveillance and policing of non-opioid substances. It argues that since many people on MMT use non-opioid substances (Le et al. 2019; McBrien et al. 2019; Scavone et al. 2013), and see that as unrelated to their use of MMT, this approach will likely function as a barrier for people currently in treatment as well as discourage people who would benefit from MMT but are not interested in abandoning their use of all drugs, from signing up.

Thus, policing the non-opioid substance use of people on MMT makes an already over-regulated program even more so. Moreover, since methadone has no therapeutic effect on non-opioid substance use, there is no reason to incorporate it into MMT, particularly as a policy to be enforced universally.

Clinics should instead pursue an approach to treatment modeled on patients' rather than clinicians' needs and goals. For example, low-threshold clinics, that prioritize easy access to methadone over the promotion of abstinence, demonstrate greater diversity of clients, higher retention rates, and are associated with a reduction in injection-related HIV risk behaviors, overdose, and mortality in general (Millson et al. 2007; Nolan et al. 2015; Strike et al. 2013).

Moreover, clinicians should be cognizant of PWUD's status as a marginalized group, whose views are often silenced by more powerful 'experts', and thus, be cautious of imposing their own views onto people in MMT. Clinics could address this power imbalance by instituting more robust training for counselors and staff that includes reference to harm-reduction and substance user rights perspectives (INPUD, 2020b). Moreover, greater inclusion of patients, including those who continue using drugs, in administrative and policy decisions would help clinicians better understand the needs of their patients.

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