Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

HHS Public Access

Author manuscript

Int J Drug Policy. Author manuscript; available in PMC 2022 April 10.

Published in final edited form as:

Int J Drug Policy. 2020 September ; 83: 102844. doi:10.1016/j.drugpo.2020.102844.

Methadone maintenance treatment is swapping one drug for another, and that's why it works: Towards a treatment-based critique of the war on drugs

David Frank

New York University, Behavioral Science Training in Drug Abuse Research program, United States

Abstract

The claim that methadone maintenance treatment (MMT) is 'just swapping one drug for another' has typically been used to de-legitimize the treatment and attack those who use it. However, this commentary re-positions that argument as a way of bringing analytic focus to the role of structural forces, like criminalization and the war on drugs, in the treatment decisions of people who use illegal drugs. Specifically, I use my experience as a qualitative sociologist who studies MMT as well as my own experience on MMT to demonstrate how criminalization functions as source of harm in the lives of people who use illegal drugs, that drives them towards the legal, and thus comparatively safer, style of substance use made available by MMT. Moreover, I argue that the dominance of individually-focused theories based on addiction and recovery to understand MMT is related to its punitive organizational structure and lack of popularity among people who use illegal opioids. Ultimately, I argue for a paradigm shift, both in policy and scholarship, that acknowledges the pragmatic value of MMT within the structural context of criminalization.

Keywords

Methadone maintenance treatment (MMT); Recovery; Harm reduction; Criminalization; Addiction

From a recent conversation between the author and others at the methadone maintenance clinic he attends in The Bronx, New York. Individuals' names, except for the author's, are pseudonyms:

Fred Oh yeah, definitely, this clinic is a lot better. Most other clinics are very strict with take-homes, they make you do counseling, all kinds of things.

dfrank40@gmail.com.

Declaration of Competing Interests

The authors report no conflicts of interest. The author alone is responsible for the content and writing of this article.

Similar to MMT, but using buprenorphine – a mixed agonist-antagonist – instead of methadone. However, since TED's data comes from public ally funded treatment programs, that are geared primarily towards methadone maintenance, while the majority of buprenorphine patients receive their medication from private doctors who do not report their "treatment admissions" to the Substance Abuse and Mental Health Services Administration (SAMHSA), it is likely that MMT patients make up the majority of dropouts represented by these figures.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Emilio I hate that, I just want my meds and that's it. I have a job. It's hard enough just coming here every few weeks.

Fred I could see it for people in the beginning [of treatment], you know, but I've been on methadone for 22 years. If I want counseling, I'll see a therapist.

David I just want my meds too. I see this [methadone maintenance treatment] mainly as a way of decriminalizing my opioid use, like switching to a less criminalized version of dope – I have to compromise with it being less euphoric, but…

Emilio Yep, me too, that's exactly how I see it.

David Really?

Emilio Completely, I finally figured out that I just do better with life when I take opioids every day and this is really the only way to do that long-term. If dope was legal, I probably wouldn't have ever quit.

David Same.

Fred Well yeah, I think we all sort of know that, we just can't put it that way to the doctor.

The claim that Methadone Maintenance Treatment (MMT) consists of just swapping one drug for another has historically been used by conservative and anti-MMT voices to de-legitimize the treatment and attack those who use it (Doukas, 2011; Kleber, 2009; Uebelacker, Bailey, Herman, Anderson & Stein, 2016). However, I argue that such a position, when drained of its vitriol, demonstrates an important truth that often gets buried in the United States (U.S.) underneath the addiction treatment administration's need to appear 'Recovery-oriented': that MMT's ability to improve peoples' lives is largely due to the structural-legal change it offers participants by allowing them to continue using opioids outside of the dangerous and unstable conditions imposed by criminalization. In other words, that MMT *is* about switching from an illegal, highly criminalized drug to one that is pharmacologically similar, but legal. Moreover, acknowledging MMT's pragmatic and strategic value within the context of criminalization is not only important from an etiological and explanatory perspective. It is also essential towards understanding the War on Drugs as an oppressive regime that is responsible for much of the problems currently thought of primarily through narratives of "addiction".

The central problem with how MMT is most often conceptualized is that it ignores the political nature of substance use treatment. MMT is generally understood through a "Recovery" model that views addiction as a whole-person sickness and sees abstinence and holistic self-transformation as the primary goals of treatment (SAMHSA, 2016; White & Mojer-Torres, 2010 Panel T.B.F.I.C., 2007). According to this narrative, people, described as "addicts", are seen to experience difficulties because of their disease/disorder, addiction, and to pursue treatment as a response to it (Barnett, Hall, Fry, Dilkes-Frayne & Carter, 2018; SMAHSA, 2019). Both the harms of substance use and the benefits of treatment are positioned on an individual-level with no relationship to larger structural forces.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

While many individuals do conceptualize their substance use and treatment in this manner, there are also many who see their use of MMT in more pragmatic terms (Frank, 2018; Koester, Anderson & Hoffer, 1999; Mateu-Gelabert, Sandoval, Meylakhs, Wendel & Friedman, 2010). For example, the majority of those I interviewed for a recent study examining patients' treatment goals were involved with MMT primarily as a way of avoiding, or eliminating, harms linked to criminalization rather than from a desire to 'recover from addiction' (Frank, 2018). They used it to avoid things like overdose, withdrawal, arrest, and most of all, to escape the constant hustle and hassle of dependence on an illegal drug. Even those who used the language of Recovery described the benefits of MMT in primarily pragmatic terms related to not having to constantly procure illegal drugs or experience withdrawal when their efforts were unsuccessful. As I wrote, "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" (2018, p. 8).

By obscuring the fact that people benefit from MMT by continuing to use opioids (methadone) outside of the dangerous and unstable conditions of criminalization, the Recovery discourse describes MMT apolitically. Thus, it provides cover and implicit support to policies that criminalize people who use illegal drugs.

This fundamental misunderstanding as to how people use and benefit from MMT is partially responsible for many of the problems that programs continue to deal with. Since people using MMT in the U.S. are often constructed as both "bad" and "sick" (Conrad & Schneider, 2010), responsible for their own problems and needing strict regulations, treatment is punitive and prescriptive, aimed at transforming rather than protecting their charges. For example, people who continue to use substances, even cannabis and alcohol, are often required to attend their clinic on an everyday basis, in perpetuity. This can dramatically reduce their ability to maintain a job, attend school, or otherwise adopt a more stable lifestyle. In some cases, people are even discharged for using substances or otherwise deviating from the focus on Recovery.

Programs also encourage (sometimes require) individuals to participate in a variety of self-help initiatives, such as Narcotics Anonymous or community service organizations. However, such groups often run counter to participants' goals and beliefs, can further prevent them from achieving stability, and sometimes lead to arguments and poor relationships between participants and clinic staff (Joseph, Stancliff & Langrod, 2000; Strike, Millson, Hopkins & Smith, 2013). Not surprisingly, rates of use and retention in the U.S. have historically been, and remain, terribly low (Peterson et al., 2010). The U.S. Treatment Episode Data Set (TEDs), which measures average length of time in treatment, shows that in 2014, 41% of people dropped out of Medication Assisted Treatment and that the median length of stay among that group was only 114 days (2014) .[1] In addition to those that dropped out, a further 11% were terminated from treatment by the facility meaning that less than half remained in treatment for even one year (SAMHSA, Treatment Episode Data Set, 2014).

[1]These figures also include people on buprenorphine maintenance, a substitution-based treatment

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

I propose instead that MMT should be conceptualized in a way that acknowledges its practical use as a refuge from criminalization, and similarly, positions people who use illegal opioids as operating within a context of oppression. Such an approach would have far better explanatory power for understanding the treatment decisions, and everyday lives, of people using criminalized opioids. For example, although I have been successfully on MMT for 15+ years, earning my PhD in the process, my experience has very little in common with the narrative of self-transformation and redemption associated with Recovery. Like those I interviewed, I became involved with MMT because of external pressures linked to heroin's illegality. Within a few years of everyday use, I had already been arrested twice, beat up and robbed many times, and suffered through too many nights to count sick in withdrawal. MMT allowed me to trade in the 26-hours a day, every day hustle of illegal heroin use, for the highly imperfect and overly-difficult, but crucially-legal and therefore stable, strategy of obtaining my opioids through a methadone clinic. I also never pursued complete abstinence, even from heroin (though I certainly use/d less), or any type of self-improvement. Thus, rather than transforming from an addict into an addict-in-recovery, it would be more accurate to say that I was re-classified from someone who is dependent on illegal opioids to someone dependent on legal ones.

It is important to point out that it has only been through a combination of luck, privilege, and careful planning, that I have been able to remain a patient-in-good-standing without accepting the tenets or practices of Recovery and there is no guarantee that my luck will continue. I have specifically sought out clinics with a comparative focus on harm-reduction and lived in big cities where they exist. Yet, despite everything I have achieved while on MMT, all it would take is moving somewhere without access to a harm reduction-oriented clinic and I could easily be discharged and back to scoring on the (more dangerous than when I was around because of the increasing presence of fentanyl) streets. Moreover, my experience is far from unique. Scholars have demonstrated that lots of people who benefit from MMT are forced to enact a wide variety of strategies to maintain their access to treatment ranging from living in places with better clinics to buying black-market urine in order to pass drug tests (Harris & Rhodes, 2013; Koester et al., 1999; Mateu-Gelabert et al., 2010). Many also opt to use buprenorphine, despite a preference for methadone, because of its availability through office-based treatment – some have told me that it does not really 'hold' them (compared to methadone) but that MMT's strict regulations (particularly the need for daily attendance) make it impossible as a long-term solution.

Yet, perhaps even more important than understanding (and improving) MMT programs, are the discursive and political implications of conceptualizing MMT's benefits as related to the legal status it confers. By acknowledging that MMT protects people from harms linked to criminalization and the War on Drugs, those harms can be better understood as resulting, at least in part, from the effects of policy rather than addiction. In other words, that people benefit by switching from highly criminalized opioids to a substance that is pharmacologically similar but available outside of the context of criminalization, suggests that the problems people using illegal drugs experience are much more a product of drugs' illegality than acknowledged by discourses of addiction which focus almost entirely on their pharmacological properties and/or the biological properties of people who use them.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

This commentary aligns in particular with the work of Harris & Rhodes who describe peoples' reasons for illegally diverting methadone by acknowledging the larger context of constraint that people who use drugs exist within (2013). Rather than as a form of deviance or rule-breaking, their analysis re-positions diversion as an "indigenous harm reduction strategy" used pragmatically, by a criminalized population with limited options (2013). I argue that MMT itself can be described as a similar strategy, used by the same population and often in a similar manner. It also fits in with, and supports, the many critiques of addiction as the near-ubiquitous model for understanding problematic substance use. Scholars have noted its lack of conceptual clarity and rigor (Campbell, 2012; Davies, 2013; Fraser & Valentine, 2008; Keane, 2002); its political utility through a focus on the individual rather than structure (Clark, 2011; Levy, 2014; Reinarman, 2005); its basis in normativity and use as a means of social control (Conrad, 1992; Fraser, Moore & Keane, 2014; Smith, 2012); and its general inability to either accurately describe the lives of many people who use substances or help to improve their situations (Lewis, 2015; Peele, 1985; Smye, Browne, Varcoe & Josewski, 2011). These issues are all plainly on display in MMT where clinics try to wrench peoples' highly diverse, and often pragmatic treatment goals into a punitive model based strictly on the moral-ideological constructs of addiction and Recovery.

It is important to emphasize that this commentary addresses MMT in the U.S. context and that the meanings attached to certain terms like "recovery" as well as how they are used politically, differ in various contexts. In the U.K., for example, recovery rhetoric has been used to justify a move away from methadone provision, seen as preventing people from successfully re-integrating into society (Duke, 2013). Similarly, while a full discussion of these issues is beyond the scope of this commentary, it is also important to acknowledge that the naming of methadone provision is part of its construction, and that terms, like "OST", "MMT", "MAT", "OAT" each refer to different understandings of methadone and buprenorphine provision that can themselves differ according to context.

Lastly, it is important to be clear that I am not trying to deny or reject the lived experience of people who do see their drug use and treatment through the narrative of Recovery. Many have found this to be a useful way of understanding their experiences. Rather, this commentary aims to point out MMT's material basis in pharmacological substitution in order to demonstrate the substantial role of structure, in particular criminalization and the War on Drugs, as a source of harm in the lives of people who use illegal drugs.

The implications of this issue are particularly timely because of the dramatically increased rates of opioid-involved overdoses in the U.S. Although MMT is widely recognized as one of the best means of reducing risk of overdose (Schwartz et al., 2013; Sordo et al., 2017), in order to meet its tremendous potential, we must recognize that its use and benefits are intrinsically linked to the larger context of criminalization. As many have pointed out, it is this context that drives the presence of adulterants, like illicitly manufactured fentanyl (and fentanyl analogs), in the illicit drug supply (Beletsky & Davis, 2017; Socías & Wood, 2017). With this in mind, treatment should be as low-threshold as possible. Such models, which are used in parts of Europe and Canada and prioritize harm reduction over abstinence, demonstrate lower rates of overdose mortality and all-cause mortality, as well as higher

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

rates of patient satisfaction, retention, and stability than the U.S.'s highly regulated and more restrictive model (Ahamad et al., 2015; Millson et al., 2007; Strike et al., 2013). Similarly, clinics' policies regarding the ability of participants to obtain take-home doses must be significantly liberalized. It is simply not possible to build and maintain a stable life while forced to attend a methadone clinic on a daily basis, sometimes for hours at a time, indefinitely, and a treatment model where a significant portion of patients must do so will always have low rates of use and retention. Moreover, that such policies are used as punishment for cannabis use while in the midst of an overdose crisis, represents a terrible mis-valuation of potential risk.

In short, MMT in the U.S. needs to undergo a paradigm shift whereby its pragmatic benefits are recognized and considered legitimate. Although such discourses do exist here and can be seen in the work of drug user unions, harm reduction organizations, and critically-minded advocates and scholars, they are often overshadowed by SAMHSA's institutional focus on Recovery. Thus, an important shift would involve a re-assessment of SAMHSA's focus on Recovery-based treatment, and particularly, the importance placed on abstinence (2016). Moreover, this should be accompanied by a critical examination of what the success of substitution-based treatments means within a context of criminalized drug use. Hence, the claim that MMT's benefits are derived from the substitution it enables – to swap an illegal drug for its legal alternative – should be re-claimed from those who would use it as an attack on MMT, and re-fashioned towards a treatment-based critique of the War on Drugs.

Acknowledgments

The author was supported as a postdoctoral fellow in the Behavioral Science Training in Drug Abuse Research program sponsored by New York University Rory Meyers College of Nursing with funding from the National Institute of Drug Abuse (T32 DA007233B). Points of view, opinions, and conclusions in this article do not necessarily represent the official position of the U.S. government or New York University.

References

Ahamad K, Hayashi K, Nguyen P, Dobrer S, Kerr T, & Schütz CG (2015). Effect of low-threshold methadone maintenance therapy for people who inject drugs on HIV incidence in Vancouver, BC, Canada: An observational cohort study. The Lancet HIV, 2(10), e445–e450. [PubMed: 26423652]

Barnett AI, Hall W, Fry CL, Dilkes-Frayne E, & Carter A (2018). Drug and alcohol treatment providers' views about the disease model of addiction and its impact on clinical practice: A systematic review. Drug and Alcohol Review, 37(6), 697–720. [PubMed: 29239048]

Beletsky L, & Davis CS (2017). Today's fentanyl crisis: Prohibition's Iron Law, revisited. International Journal of Drug Policy, 46, 156–159. [PubMed: 28735773]

Campbell ND (2012). Medicalization and biomedicalization: Does the diseasing of addiction fit the frame? Critical Perspectives on Addiction. Emerald Group Publishing Limited3–25.

Clark M (2011). Conceptualising addiction: How useful is the construct. International Journal of Humanities and Social Science, 1(13), 55–64.

Conrad P (1992). Medicalization and social control. Annual Review of Sociology, 18(1), 209–232.

Conrad P, & Schneider JW (2010). Deviance and medicalization: From badness to sickness. Temple University Press.

Davies JB (2013). Myth of addiction. Routledge.

Doukas N (2011). Perceived barriers to identity transformation for people who are prescribed methadone. Addiction Research & Theory, 19(5), 408–415.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Duke K (2013). From crime to recovery: The reframing of British drugs policy? Journal of Drug Issues, 43(1), 39–55.

Frank D (2018). “I Was Not Sick and I Didn’t Need to Recover”: Methadone maintenance treatment (MMT) as a refuge from criminalization. Substance Use & Misuse, 53(2), 311–322. [PubMed: 28704148]

Fraser S, Moore D, & Keane H (2014). Habits: Remaking addiction. London, UK: Springer.

Fraser S, & Valentine K (2008). Substance and substitution: Methadone subjects in liberal societies. UK: Palgrave Macmillan.

Harris M, & Rhodes T (2013). Methadone diversion as a protective strategy: The harm reduction potential of ‘generous constraints’. International Journal of Drug Policy, 24(6), e43–e50. [PubMed: 23199896]

Joseph H, Stancliff S, & Langrod J (2000). Methadone maintenance treatment (MMT). The Mount Sinai Journal of Medicine, 67(5), 6. [PubMed: 10677773]

Keane H (2002). What’s wrong with addiction? Victoria, Australia: Melbourne University Publish.

Kleber HD (2009). Methadone: The drug, the treatment, the controversy. The Praeger International Collection on Addictions, 1, 305.

Koester S, Anderson K, & Hoffer L (1999). Active heroin injectors’ perceptions and use of methadone maintenance treatment: Cynical performance or self-prescribed risk reduction? Substance Use & Misuse, 34(14), 2135–2153. [PubMed: 10573308]

Levy J (2014). The harms of drug use: Criminalisation, misinformation and stigma. International Network of People that Use Drugs (INPUD).

Lewis M (2015). The biology of desire: Why addiction is not a disease. UK: Scribe PublicationHachette.

Mateu-Gelabert P, Sandoval M, Meylakhs P, Wendel T, & Friedman SR (2010). Strategies to avoid opiate withdrawal: Implications for HCV and HIV risks. International Journal of Drug Policy, 21(3), 179–185. [PubMed: 19786343]

Millson P, Challacombe L, Villeneuve PJ, Strike CJ, Fischer B, Myers T, et al. (2007). Reduction in injection–related hiv risk after 6 months in a low-threshold methadone treatment program. AIDS Education & Prevention, 19(2), 124–136. [PubMed: 17411415]

Panel TBFIC (2007). What is recovery? A working definition from the Betty Ford Institute. Journal of Substance Abuse Treatment, 33(3), 221–228. [PubMed: 17889294]

Peele S (1985). The meaning of addiction: Compulsive experience and its interpretation. San Francisco, CA, USA: Lexington Books/DC Heath and Com.

Peterson JA, Schwartz RP, Mitchell SG, Reisinger HS, Kelly SM, & O’Grady KE (2010). Why don’t out-of-treatment individuals enter methadone treatment programmes? International Journal of Drug Policy, 21(1), 36–42. [PubMed: 18805686]

Reinarman C (2005). Addiction as accomplishment: The discursive construction of disease. Addiction Research & Theory, 13(4), 307–320.

Schwartz RP, Gryczynski J, O’Grady KE, Sharfstein JM, Warren G, Olsen Y, et al. (2013). Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995–2009. American Journal of Public Health, 103(5), 917–922. [PubMed: 23488511]

Smith CB (2012). Harm reduction as anarchist practice: A user’s guide to capitalism and addiction in North America. Critical Public Health, 22(2), 209–221.

Smye V, Browne AJ, Varcoe C, & Josewski V (2011). Harm reduction, methadone maintenance treatment and the root causes of health and social inequities: An intersectional lens in the Canadian context. Harm Reduction Journal, 8(1), 17. [PubMed: 21718531]

Socías ME, .& Wood E. (2017). Epidemic of deaths from fentanyl overdose.

Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, et al. (2017). Mortality risk during and after opioid substitution treatment: Systematic review and meta-analysis of cohort studies. BMJ (Clinical research ed.), 357, j1550.

Strike C, Millson M, Hopkins S, & Smith C (2013). What is low threshold methadone maintenance treatment? International Journal of Drug Policy, 24(6), e51–e56. [PubMed: 23743178]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Substance Use and Mental Health Service Administration (SAMHSA). (2016). SAMHSA's working definition of recovery: ten guiding principles of recovery. Retrieved fromhttp://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf.

Substance Use and Mental Health Service Administration (SAMHSA). (2019). Mental health and substance use disorders. retrieved ondecember 6th from:https://www.samhsa.gov/find-help/disorders.

Uebelacker LA, Bailey G, Herman D, Anderson B, & Stein M (2016). Patients' beliefs about medications are associated with stated preference for methadone, buprenorphine, naltrexone, or no medication-assisted therapy following inpatient opioid detoxification. Journal of substance abuse treatment, 66, 48–53. [PubMed: 27211996]

White WL, & Mojer-Torres L (2010). Recovery-oriented methadone maintenance. Chicago, IL: Great Lakes Addiction Technology Transfer Center.