Article

'We're Gonna be Addressing your Pepsi Use'

How Recovery Limits Methadone Maintenance Treatment's Ability to Help People in the Era of Overdose

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Abstract

Methadone Maintenance Treatment (MMT) in the United States has recently adopted an approach based on the principles of the Recovery movement — a view of treatment informed by addiction-as-disease models but also incorporating social, psychological, and spiritual components. Although organizations that administer drug treatment services claim that the shift represents a more client-centered, individualistic approach, it may not meet the needs of the many individuals who use MMT to reduce the harms of drug use, like overdose, rather than as a way to become abstinent. In this article, I use interview data from treatment providers to argue against institutional claims of Recovery as an individualistic model. My research demonstrates how — despite the wide variety of treatment goals among people on MMT — the Recovery discourse positions and organizes treatment strictly as abstinence-based, self-help. Moreover, I show how the Recovery model serves as the justification for an expansion of clinics' ability to surveil and intervene in aspects of people's lives which had previously been seen as outside of MMT's purview, including nutrition, public service, and spirituality. In conclusion, I argue that Recovery restricts MMT's ability to reduce harms, like overdose, in the lives of people who use drugs, and recommend that MMT adopt a more open-ended, low-threshold approach to treatment.

Keywords

Methadone Maintenance Treatment, recovery, addiction, overdose, harm reduction, abstinence

‘Recovery encompasses an individual’s whole life, including
mind, body, spirit, and community.’

(SAMHSA 2012, 5)

Introduction

Opioid-involved overdose rates in the United States are currently at unprecedented levels (NIDA 2018; Rudd 2016; Peterson 2016). According to the National Institute of Drug Abuse, overdose rates for heroin, natural and semi-synthetic opioids, and synthetic opioids (other than methadone) have all increased every year for the past five years (2018). Substantial research also demonstrates that Methadone Maintenance Treatment (MMT) is among the most effective means of reducing risk of overdose as well as many other harms associated with illegal opioid use (Sordo et al. 2017; Schwartz et al. 2013). Despite this, MMT in the United States recently adopted an approach to treatment informed by the Recovery movement that could potentially make accessing treatment more difficult for those not pursuing Recovery as defined by the discourse.

People on MMT conceptualize their treatment goals in a variety of ways, including many who use it as a strategy for reducing the harms of illegal drug use, such as overdose and arrest, rather than as a means to become abstinent (Frank 2018; Harris and Rhodes 2013; Mateu-Gelebert et al. 2010). Yet, the Recovery model is based on an abstinence-only approach that often results in increased surveillance and punishment for such individuals, potentially leading to cessation of treatment (Frank 2018). Moreover, Recovery is based on a holistic conception of addiction that includes hard-to-define aspects such as spirituality and community involvement (SAMHSA 2012; White et al. 2012; White and Mojer-Torres 2010). This more comprehensive view significantly expands clinics’ ability to surveil and intervene in patients’¹ lives beyond their use of illegal drugs. Thus, Recovery could increase rates of patient dropout and discharge as well as discourage people not currently in treatment from signing up (Frank 2018). MMT in the U.S. is already criticized for its strict rules and time-consuming, intrusive approach (Parpouchi et al. 2017; Callon et al. 2006) as evidenced by its consistently low rates of use and retention, particularly when compared to other countries using less-regulated approaches (Saloner and Karthikeyan 2015). Thus, the use of Recovery in MMT may make an already over-regulated and overly-cumbersome treatment even more so precisely when it is most needed.

¹ It is important to point out that the term ‘patients’ is considered problematic by many people and has been criticized for its tendency to medicalize individuals on MMT, many of whom do not conceptualize themselves as sick (Frank 2018; INPUD 2014). Although I considered using less specific language, I felt it was important to describe the population within the discursive context of Recovery-based treatment. Thus, my use of the term, ‘patients’ throughout the paper, is as a socially-constructed label that is often resisted by people on MMT.

This article uses semi-structured interview data from treatment providers that administer MMT in the U.S. to argue that Recovery restricts MMT’s ability to reduce harms, like overdose, in the lives of people who use drugs, and recommends that MMT adopt a more open-ended, low-threshold approach to treatment that acknowledges the diversity of treatment goals among people on the program.

Access to MMT

MMT is a form of substitution-based treatment for opioid addiction whereby individuals are maintained on methadone, a synthetic opioid similar to, but less euphoric than heroin (and other illegal opioids). Methadone reduces the cravings and withdrawal that accompany cessation of opioid use and has proved to be an effective form of treatment (Ball and Ross 2012; Joseph et al. 2000). Its use is associated with reduced rates of illegal opioid use, overdose, transmission of blood-borne viruses, and recidivism as well as generally improving the stability of people on the program (Sordo et al. 2017; Schwartz et al. 2013; Brugal et al. 2005). Conversely, leaving treatment – either voluntarily or involuntarily – is associated with an increased risk of overdose (Cousins et al. 2011; Brugal et al. 2005; Magura and Rosenblum 2001). Despite its benefits, MMT in the U.S. has consistently maintained low rates of use and retention (Joseph et al. 2000). Data from the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that in 2014, 41% of people in Medication Assisted Treatment dropped out of treatment and that the median length of stay among that group was only 114 days (2014). 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 (SAMHSA, Treatment Episode Data Set 2014).

Research that examines patients’ perspectives on treatment demonstrates that strict regulations, an abstinence-only approach, and the time consuming, intrusive character of MMT in the U.S. is inconstant with the needs and treatment goals of much of the patient population (Strike et al. 2013; Peterson et al. 2010; Joseph et al., 2000). For example, Mateu-Gelebert and collaborators found that instead of pursuing abstinence, many people use MMT as a pragmatic strategy for avoiding withdrawal, which in turn reduces the likelihood of risky activity such as syringe sharing or committing crimes in order to obtain money for buying drugs (2010). Similarly, many use MMT as a temporary means of reducing tolerance and physical wear-and-tear; as a way of dealing with instabilities of the illegal drug market; and as a strategy to avoid overdose and transmission of blood-borne viruses such as HIV/AIDS or Hepatitis C (Harris and Rhodes, 2013; Mateu-Gelebert et al. 2010; McKeganey et al. 2004; Drucker et al. 1998). Scholars have also pointed out that many people use, and conceptualize MMT as way of moderating risks more associated with criminalized drug use than with drug use itself (Frank 2018; Harris and Rhodes 2013; Koester et al. 1999).

Comparatively, low-threshold models, that are used in parts of Canada and Europe and prioritize easy access to methadone over the promotion of abstinence,

attract a greater diversity of clients, have higher retention rates, and are associated with a reduction in injection-related HIV risk behaviors, overdose, and mortality in general (Nolan et al. 2015; Strike et al. 2013; Millson et al. 2007; Langendam et al. 2001).

Emergence of Recovery

Recovery has recently gained strength in the U.S., both culturally, and as a bedrock principle meant to undergird the creation of policy in substance use treatment, including MMT (SAMHSA 2018; NYS OASAS 2018; White and Mojer-Torres 2010). As SAMHSA notes in the Recovery and Recovery Support section of their website: ‘The adoption of recovery by behavioral health systems in recent years has signaled a dramatic shift in the expectation for positive outcomes for individuals who experience mental and/or substance use conditions’ (2018). Recovery has its roots in the 19th century when temperance societies and related groups began discussing socially unacceptable alcohol use as a disease (Levine 1978). However, research – particularly in Australia and the UK – has linked the current recovery discourse to the emergence of twelve-step groups (e.g. Alcoholics Anonymous, Narcotics Anonymous) that formed in the late 20th century around a variety of practices including drinking, smoking, and narcotics use as well as to the context of neoliberalism that emphasizes practices of individual governance and surveillance (Fraser et al. 2017; Neale et al. 2015; Fraser et al. 2014).

Although the term ‘recovery’ can mean different things to different people, ‘Recovery’ is a specific, and institutionally-proscribed, discourse that refers to a commitment to abstinence as well as a focus on more general notions of health and well-being, including community involvement, spirituality, and nutrition (Duke, 2013; Best and Lubman 2012; White 2007). The Betty Ford Consensus Panel — on which most modern definitions of Recovery are based — defined it as ‘a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship’ (The Betty Ford Consensus Panel 2007). SAMHSA uses a similar definition, based on abstinence and including ‘a voluntary, self-directed, ongoing process where patients access formal and informal resources; manage their care and their addiction; and rebuild their lives, relationships, and health to lead full meaningful lives’ (2010).

Recovery is also positioned institutionally as a more inclusive approach to MMT. Government organizations like SAMHSA specifically describe Recovery as a more patient-centric model that empowers individuals to structure treatment according to their own goals. For example, SAMHSA’s Second Principle of Recovery, that ‘Recovery is person-centric’ states that:

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by

leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives (The Second Principle of Recovery, SAMHSA’s Updated Working Principles of Recovery 2012).

However, drug-user rights and harm reduction organizations have been critical of Recovery (AIVL 2012; INPUD 2014). Although such groups do not oppose the rights of individuals to identify as ‘in recovery’, or pursue recovery-based goals, they argue that by elevating such personal choices to the level of policy, it becomes a standard that is forced upon everyone rather than a choice. Moreover, they are critical of addiction-as-disease narratives, and argue that rather than a disease, drug use is a social phenomenon, characterized by a high level of diversity, not ‘sameness’ (AIVL 2012, 3). From this perspective, the Recovery discourse necessarily implies ‘that drug use is a disease from which people could or should be cured’ (INPUD 2014).

Methods

This article is based on two years of qualitative research, conducted as part of my doctoral dissertation in sociology, from 2014 through 2016. Data collection involved conducting semi-structured interviews with stakeholders and ethnographic observations in New York City methadone clinics, as well as elements of auto-ethnography. My interest in this issue and the development of research questions were based initially on my own experience as an illegal opioid user and someone who has been in MMT for 15+ years. Research questions were further developed in the context of relevant literature. This article focuses primarily on data from 10 interviews with treatment providers, which refers to individuals working either in government organizations that administer MMT such as SAMHSA or the New York State Office of Alcoholism and Substance Abuse Services (OASAS), or in methadone clinic settings. Participants were recruited using a combination of convenience and snowball sampling based initially on contacts I had through my own experience as a person who uses drugs and as someone on MMT. All participants provided informed consent, and interviews lasted approximately one hour and were recorded and later transcribed. Data were then coded for themes and analyzed in a process informed by Critical Discourse Analysis (Weiss and Wodak 2007; Fairclough 2013). All participants are referred to by pseudonyms.

Theoretical Position

This article is informed by a social constructionist perspective that sees knowledge production as an inherently political act that carries with it a set of fixed identities, power relationships, and codes of behavior (Conrad and Schneider 2010; Berger and Luckmann 1971; Foucault 2003; Bourgois 2000). Thus, terms like ‘drugs’,

‘addiction’ and ‘recovery’ are seen as socially-contingent categories that reflect, and re-produce, existing power structures rather than as universal truths. Scholars have used this position to deconstruct medical and cultural knowledge about addiction, such as the disease model of addiction, often pointing out how such concepts function as forms of social control (Tiger 2013; Campbell 2011; Keane 2002). As Fraser and colleagues point out, ‘addiction operates as a powerful therapeutic and political discourse which classifies, normalizes, and disciplines subjects’ (Fraser et al. 2014, 5).

Recovery as Self-evident

Responses from treatment providers closely aligned with the institutional position by describing Recovery as patient-centered, individually-focused and empowering. In every case, Recovery was seen not only as an improvement in how treatment was organized but specifically as one that would increase the ability of patients to affect, and make choices about their treatment. They referred to it as ‘less of a cookie-cutter approach’ and a move away from a model where patients ‘were not partners in the process’. For example, Sandy, an administrator for the OASAS emphasized that:

number one is that the person is center and everything to do with [their treatment] is person-centered. They’re included in all major decisions about their treatment, the direction of their recovery, and all of that is explained. It’s about what *they* want to do (Sandy, OASAS 2014; emphasis in original).

The patient-centric character of Recovery was seen by treatment providers to be demonstrated most notably by the fact that the Recovery model accepted MMT (and other forms of Medication Assisted Treatment (MAT)) as a legitimate form of treatment for addiction. Treatment providers explained that programs using medication, like MMT, have historically been seen as fundamentally distinct from those using ‘abstinence-based’ treatment, defined here as programs not using medication (Hunt et al. 1985). As a result, people in MMT have often been stigmatized and denied access to many recovery spaces because of their use of methadone, seen as a drug and not a medicine (Earnshaw et al. 2013). Thus, part of the current Recovery discourse involves the institutional re-construction of methadone as a ‘medicine’ and an effort to frame all treatment choices as different ‘paths to Recovery’, which were seen as equally legitimate. The following responses reflect this shift:

In a lot of the ‘drug-free’ programs, they don’t consider someone in recovery if they’re taking medication, methadone being one of them. But we certainly are a Recovery-based program, and if somebody is being maintained on methadone and they’re not using any illicit substances or abusing any prescription sub-

stances [then] that is recovery (Michele, Clinic Administrator 2014).

I think there’s been a lot of gains over the years of people talking about their recovery from addiction. But not as often do we hear about peoples’ recovery using medications and utilizing methadone specifically. So, when you listen to peoples’ recovery stories, oftentimes there is no medication element at all to treat the addiction. Or you may hear ‘Oh I was in a methadone program but now I’m no longer in a methadone program, now I’m drug free’... There shouldn’t be that kind of thinking where one person’s pathway to recovery is better than others. The path to recovery is unique and all paths are acceptable. It doesn’t matter if you haven’t even been in treatment and you’ve recovered through a faith-based intervention or on your own (Karen, OASAS employee 2014).

Our patients become very stigmatized. They’re looked at as drug seekers whether or not they are. Their families continue to have difficulty accepting that people are on methadone or ‘why aren’t you getting off this?’... As a treatment community we really empower that [seeing MMT as Recovery] and every year [we] do more things and get more education [out to the community] (Marguerite, Clinic Program Director 2014).

However, by positioning MMT in this way, treatment providers’ responses reflected a view of Recovery as the universal and proper goal of treatment. Although people were seen as increasingly able to choose from different types of treatment — including MMT — they were all conceptualized as strategies toward the singular goal of Recovery (see also Fraser and Valentine 2008). This contrasts with many harm reduction and drug-user rights narratives that justify MMT through pragmatic benefits, such as the elimination of withdrawal and reducing harms, that are not necessarily linked to an over-arching concept of self-improvement.

Moreover, the Recovery discourse obscures important differences between medication versus non-medication using treatment models as well as the often-different reasons that lead people to choose either option. For example, the many people that use MMT as a way of managing harms associated with criminalization are erased by the Recovery discourse. Thus, by flattening distinctions between different kinds of treatment — and particularly the differences between medication versus non-medication using models — the utility of MMT as a pragmatic form of resistance to criminalization becomes invisible.

How is Addiction Conceptualized?

In line with constructing MMT as a means to achieve to Recovery, treatment providers maintained a view of addiction that focused almost entirely on the behavioral, psychological and spiritual. Although most stated that they saw addiction as a disease, they downplayed its material or biological aspects such as dependence and withdrawal in favor of a more value-based view that emphasized character flaws and moral shortcomings. Thus, patients were seen as both bad and sick (Fraser et al. 2017; Fomiatti et al. 2017; Tiger 2013). Treatment providers conceptualized treatment in a similar manner by stressing its ability to shape behavior seen as problematic rather than as providing a pharmacological substitute for illegal opioids. As one Clinic Director explained:

We accept that there is a brain disease, but we’re not intervening in the brain. We’re intervening at the level of behaviors, of attitudes, of spirit. Of course, all of that’s the brain, but... we discourage talk of neurotransmitters.... Really what you have to do is people, places, and things, and triggers to relapse, and anger management, and that kind of stuff (John, Clinic Director 2014).

Similarly, treatment providers avoided describing patients through their physiological dependence on opioids. They rarely mentioned the material role of methadone as a substitute for illegal opioids and often de-valued the notion that people use MMT for that reason. Patients were described instead using discourses of trauma and disorder that positioned them as a monolithic and universally damaged population (Fomiatti et al. 2017). For example, treatment providers stated:

We’re also looking to focus much more on trauma. It’s no secret that most people that have an issue with addiction have experienced trauma of some sort in their lives, whether it be what led them to use or the trauma of the lifestyle of addiction... but I would say, with pretty clear confidence, that 99% of our clientele has experienced trauma of some sort or another (Michele, Clinic Administrator 2014).

Recovery is going deeper into something that’s beyond your narcissism, tapping into something. I say for folks that are kind of atheistic or not open to that I say ‘We’re your higher power’... It’s investing in a community instead of your narcissistic drug taking behavior. If you can buy into that as a higher power, trust our rules and regulations, trust our staff, like being here or can tolerate being here, well maybe that’s a higher power than the arrogance of your addiction (John, Clinic Director 2014).

By conceptualizing addiction as a whole-person sickness Recovery provided discursive support for the production of MMT as a comprehensive intervention that included treatment for behavioral, psychological, and spiritual maladies, all conceptualized as ‘addiction’. Similarly, because Recovery situated patients within a more comprehensive and clearly articulated therapeutic relationship (than previous approaches to MMT), it restricted rather than promoted their agency. Clinicians were the experts on addiction and patients were advised to, as John states (above): ‘trust our rules and regulations, trust our staff’. In some cases, this was framed in harsh and punitive language that positioned patients as requiring constant surveillance. For example, when asked about the need to monitor patients’ behavior, Grace, another Clinic Director, argued: ‘If you [addicts] can lie, you will lie. If you [addicts] can steal, you will steal... [But] as clinicians, we’re trained to know what they’re thinking’.

Moreover, by positioning treatment in this way, treatment providers were able to frame unpopular and restrictive clinic rules, therapeutically. For example, although clinic take-home policies – that force most people to come to the clinic everyday – are often criticized as overly restrictive and linked to high rates of patient dropout (Vocal-NY 2011; Pani et al. 1996), Marguerite, a Clinic Program Director, positions them as providing patients with a break from the presumed chaos of their daily lives. She states:

[Patients] also [benefit from] the structure. You know, they come in, this is a professional environment and people treating them with respect, and their coming in and they have consistency. They’re not living, wherever they’re living, it’s chaotic. They’re coming in here and there’s stability here (Marguerite, Clinic Program Director 2014).

Thus, treatment providers conceptualized addiction in a way that established a clear power dynamic between patients and treatment providers. Since it positioned patients as both bad and sick, any attempts by them to affect their treatment program would be interpreted through this lens, i.e. as a symptom of their addiction. Consequently, they had little power to affect their treatment program.

Treatment as Abstinence plus Self-reconstruction

Treatment providers also described Recovery-based treatment as a highly comprehensive intervention that required much more from people than abstaining from illegal drugs. Clinicians used narratives of Recovery to make judgements about virtually any aspect of their patients’ lives including proper use of free time, community service, and even consumption of soft drinks. These activities were positioned by treatment providers as important indicators of Recovery that merited intervention. For example, treatment providers stated:

It’s [Recovery] not only being drug free. There is also behaviors and thoughts that have to follow... That’s where a lot of our patients get caught out. A lot of them will be like (adopts mock whining tone) ‘Well I’ve been maintaining abstinence for six months and I haven’t gotten a schedule reduction’. Well ok, yeah you’ve been maintaining abstinence for six months but you’re not doing anything productive in your free time. You still come in here with the same negative attitude. You’re still having problems with your counselor. You’re still keeping that ‘stinking thinking... Yes we are an opioid treatment program but we’re here to address all of your addiction[s] and I tell them [patients] ‘if your addicted to Pepsi and you’re a Diabetic and it’s causing you health problems, we’re gonna be addressing your Pepsi use’ (Grace, Clinic Director 2014).

I don’t consider someone in recovery on the sole purpose that they’re not using, because there’s such a thing as a ‘dry drunk’, somebody who’s not using but is engaged in all of the behaviors of addiction... I would call that, they’re staying away from substances but that they have some steps in their recovery to focus on (Michele, Clinic Administrator 2014).

Part of the recovery process is for you to become part of the community, [and] for you to become a part of the community, you can’t just go and get your methadone, go back home and sit there. [So] how do we set you up to be a meaningful part of the community? That’s a critical part of recovery (Sandy, OASAS 2014).

Thus, treatment providers rejected a view of MMT solely as a means of reducing or eliminating problematic drug use and emphasized the importance of patients’ demonstrating a holistic change in their thoughts, behaviors, and attitude. Positioning the treatment in this way not only helps to justify Recovery’s expanded jurisdiction and infrastructure, it also devalues low-threshold approaches to MMT. Such models prioritize harm reduction over abstinence and work to make methadone more easily accessible for people who use drugs oftentimes by eliminating the kinds of regulatory apparatus and oversight that characterize Recovery (Strike et al. 2013).

Treatment providers’ descriptions of the clinic environment also aligned with their view of addiction as a whole-person ailment. Clinics were described as centralized locations for the treatment of a variety of behavioral, psychological, and meta-physical issues discursively linked by Recovery. Treatment providers referred to clinics as a ‘more comprehensive model’ and ‘wrap-around service’ that spoke to their wide-ranging view of addiction treatment and the diminished role of methadone the substance. Moreover, many of the programs focused specifically on

promoting the tenets of Recovery, such as on-site twelve-step meeting and ‘Peer-Recovery Coaches’, who were described as filling a similar role to that of mentor in twelve-step programs. As one Clinic Director explained:

We have a wrap-around service that includes primary medical care in addition to counseling, psychological, psychiatric, vocational, and nutritional and social. So, we provide a large number of services in the view that in order for recovery to occur, you want to affect as many life environments, from health all the way to how people eat. In addition, we have a vocational person because obviously being employed is an important resilience factor for further use (Wilson, Program Director 2014).

The focus on clinics as whole-person treatment centers was also reflected in the changing language treatment providers used. For example, they often deemphasized the role of methadone by describing the treatment as an ‘Opioid Treatment Program’ or ‘OTP’ rather than the previous moniker of ‘Methadone Maintenance Treatment’ or ‘MMT’. As Karen, an OASAS administrator, explained:

We’re moving now to saying Opioid Treatment Program, Opioid Treatment Services because we want to take away the ‘Methadone’ label. You call it ‘Methadone Treatment’ [and] it sounds like that’s all that happens is that people drink their methadone. If we call it Opioid Treatment, they have medication, it could be Methadone, it could be Buprenorphine. But we [also] have a whole comprehensive array of services. One of our things is removing all of that ‘MTP’, ‘MMTP’, ‘Methadone Maintenance’, ‘Methadone Treatment Program’. It’s ‘Opioid Treatment Program’ or ‘OTP’ and the Feds have that too’ (Karen, OASAS 2014).

Although the addition of new services is undoubtedly helpful to people who need them, they also greatly expand the clinics’ ability to exert influence over parts of their patients’ lives which had previously been unavailable to them. Treatment providers characterized the additional services as ‘tools in a toolkit’ rather than requirements, however, they were none-the-less positioned as important parts of the program, and whether or not patients utilized them, impacted their relationships with counselors and other clinic staff, which ultimately affected patient assessments and determined access to privileges. For example, although SAMHSA administrators stressed that patients would not be forced to adopt Recovery as their approach to treatment, they also noted that all patients are required to meet with their counselor every month, and that those ‘patient assessments’, are based on the tenets of Recovery. Thus, while there is no explicit mandate to adopt Recovery, it is built into the program structurally, ultimately meaning that those who are uninterested in community service, spirituality, or other aspects of Recovery may be viewed unfavorably.

Discussion

This article critically analyzed the institutional claim that Recovery represents a more patient-centric model that better enables people to structure treatment according to their own goals and values. Although treatment providers all stated that they saw Recovery in this way, their descriptions suggest that it is more proscriptive and restrictive than previous, less clearly articulated approaches to MMT. Since Recovery is based on the implicit desirability of abstinence and self-transformation, it functions as a barrier for the many people that use MMT for more pragmatic reasons such as avoiding overdose, withdrawal and arrest, or simply to escape the chaotic and risk-involved lifestyle associated with illegal drug use. Moreover, it will prevent those who would benefit from MMT but are not pursuing Recovery, from signing up, precisely when the risk of opioid-involved overdose is at its greatest.

That many individuals use and benefit from MMT for reasons outside of the Recovery model was particularly absent from how treatment providers conceptualized the program. Thus, Recovery can be read as an attempt to shore up the ontological and epistemological problems raised by MMT for government, who is interested in legitimizing MMT but within the current logics of prohibition. According to the narrative of prohibition, it is drugs and addiction, and not laws or policies, that cause the harms of drug use. Yet since methadone is an opioid, like heroin, its use as a maintenance medication problematizes this view. As sociologist Helen Keane explains, ‘methadone in the context of maintenance therapy is produced as a paradoxical substance with a double identity, it is both ‘not heroin and like heroin’; and it is both addictive and a treatment for addiction’ (2013, 18).

Moreover, the ability of MMT to dramatically improve peoples’ lives raises etiological questions about the treatment. Specifically, 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 drugs experience are more a product of drugs’ illegality than from their pharmacological properties. In other words, MMT ‘works’ by decriminalizing peoples’ opioid use. However, by incorporating MMT into the standard body of Recovery-oriented addiction treatment, and by re-framing it in a way that obscures its material basis as a pharmacological substitute for illegal opioids, Recovery works to paper over these cracks in the government’s prohibitionist narrative.

In this case, the Recovery discourse seeks to construct addiction through an amaterialist lens that positions it primarily as a problem of personhood and individual values, unrelated to the physical characteristics of opioids such as tolerance and withdrawal, or the structural policies that govern their use. This position de-politicizes the role of treatment in the lives of people who use drugs by framing their choices as motivated solely by addiction and not as an attempt to escape from the effects of policy (Frank 2018). Yet, by incorporating a view of MMT that acknowledges the materiality of methadone as an opioid and MMT as a form of

substitution treatment, their decisions can be understood, at least in part, as a move from using illegal to legal opioids rather than from addiction to Recovery.

The findings of this study align with related scholarship that rejects the view of MMT as a stable and bounded entity governed by clearly identifiable causal relationships and sees it instead as dynamic and made through its interaction with politics, culture, institutions, and people (Fraser and Valentine 2008; Fraser et al. 2014). In particular, the emphasis on accounting for MMT’s material characteristics is supported by Fraser and Valentine’s call for analyses that incorporate ‘both the social/cultural/discursive and the material’ (2008, 21). It is similarly linked to deconstructive accounts of addiction narratives that demonstrate how the phenomenon of ‘addiction’ resists categorization through binaries like health/sick; normal/pathological; addict/recovered addict (Moore et al. 2017; Fomiatti et al. 2017; Pienaar et al. 2017). Such accounts were used by the treatment providers in this study, oftentimes to construct patients as disordered, and themselves as experts.

It is important to point out that this article’s critique of Recovery is not about the lived experience of people in recovery or pursuing recovery-oriented goals. Recovery can be a meaningful and useful paradigm for some people to understand their drug use and treatment. Rather, it focuses on the discursive production and institutional use of Recovery, to demonstrate how such narratives — particularly when elevated from personal choice to the level of policy — can be used to restrict, control, and punish those with different aims for treatment.

In this article, I argue that MMT should be available for the full range of beneficiaries and not just those seeking Recovery as conceptualized by the discourse. Substantial research demonstrates that ‘low threshold’ approaches — which are used successfully in Canada and Europe — have higher retention rates, happier clients, and a reduced risk of overdose (Strike et al. 2013; Brugal et al. 2005). Moreover, the coercive structure that has long been a part of MMT, but that Recovery expands upon, should be dismantled in favor of non-punitive model that supports harm reduction. As Fraser and Valentine point out in *Substance & Substitution*, ‘Other people are subject to rules as well, of course, but MMT operates in ways unthinkable in other treatment formats... Far from being active consumers or patients sharing treatment decisions and responsibility with their doctors, methadone clients are positioned within an apparently outmoded, paternalistic relationship of compliance’ (2008, 86).

This is particularly important in the context of dramatically increased rates of opioid-involved overdose where access to treatment should take on an increased urgency. Potential changes could include abandoning the use of punishment for failed drug screens and/or liberalizing take-home policies. These policy shifts would push MMT in a direction that better reflected institutional rhetoric on promoting patient agency, and more importantly, would work towards reducing rates of opioid-involved overdose. As one of the harm reduction advocates I spoke

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with pointed out: ‘I totally respect anyone who considers themselves on a path to recovery, in recovery, whatever. I just don’t think it should be required to participate in those activities to receive a lifesaving medication.’

Author Bio

David Frank recently graduated from the Graduate Center of the City University of New York in Sociology and is currently a Postdoctoral Research Fellow at New York University’s Behavioral and Science Training program in substance use research. Dr. Frank uses primarily qualitative methods to study substance use and treatment issues. His work examines opioid use, overdose, and methadone maintenance, and focuses in particular on the role of structural factors like criminalization and the War on Drugs in behaviors thought to be caused by drug use or ‘addiction’. He is currently interested in reducing barriers to methadone maintenance treatment as a means of reducing overdose.

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

References

- Australian Injecting & Illicit Drug Users Union (AVIL). 2012. “‘New recovery’, harm reduction & drug use policy statement’.
- Ball, John C., and Alan Ross. 2012. *The effectiveness of methadone maintenance treatment: patients, programs, services, and outcome*. Springer Science & Business Media.
- Berger, Peter, and Peter Luckmann. 1971. *The Social Construction of Reality*. New York: Random House.
- Best, David W. and Dan I. Lubman. 2012. ‘The recovery paradigm: A model of hope and change for alcohol and drug addiction’, *Australian family physician*, 41(8): 593.

- Betty Ford Institute Consensus Panel. 2007. ‘What is recovery? A working definition from the Betty Ford Institute’, *Journal of Substance Abuse Treatment*, 33(3): 221–228. <https://doi.org/10.1016/j.jsat.2007.06.001>
- Bourgois, Phillipe. 2000. ‘Disciplining addictions: The bio-politics of methadone and heroin in the United States’, *Culture, medicine and psychiatry*, 24(2): 165–195. <https://doi.org/10.1023/A:1005574918294>
- Brugal, M. Teresa, Antonia Domingo-Salvany, R. Puig, Gregorio Barrio, Patricia Garcia de Olalla, and Luis De La Fuente. 2005. ‘Evaluating the impact of methadone maintenance programs on mortality due to overdose and aids in a cohort of heroin users in Spain’, *Addiction*, 100(7): 981–989. <https://doi.org/10.1111/j.1360-0443.2005.01089.x>
- Callon, Cody, Evan Wood, David Marsh, Kathy Li, Julio Montaner, and Thomas Kerr. 2006. ‘Barriers and facilitators to methadone maintenance therapy use among illicit opiate injection drug users in Vancouver’, *Journal of Opioid Management*, 2 (1): 35–41. <https://doi.org/10.5055/jom.2006.0006>
- Campbell, Nancy. 2011. ‘From ‘magic bullets’ to medical maintenance: The Changing meanings of medical approaches to drug use in US drug policy’, in *The drug effect: Health, crime, and society*, edited by Suzanne Fraser and David Moore, 122–136. Cambridge: Cambridge University Press.
- Conrad, Peter, and Joseph W. Schneider. 2010. *Deviance and medicalization: From badness to sickness*. Philadelphia: Temple University Press.
- Cousins, Graine, Conor Teljeur, Nicola Motterlini, Colin McCown, Borislav D. Dimitrov, and Thom Fahey. 2011. ‘Risk of drug-related mortality during periods of transition in methadone maintenance treatment: a cohort study’, *Journal of substance abuse treatment*, 41, 3: 252–260. <https://doi.org/10.1016/j.jsat.2011.05.001>
- Drucker, Ernest, Peter Lurie, Alex Wodak, and Petal Alcabes. 1998. ‘Measuring harm reduction: the effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV’, *Aids-London-Current Science then Rapid Science Publishers then Lippincott Raven*, 12: S217–S230.
- Duke, Karen. 2013. ‘From crime to recovery: the reframing of British drugs policy?’, *Journal of Drug Issues*, 43, 1: 39–55. <https://doi.org/10.1177/0022042612466614>
- Earnshaw, Valerie, Laramie Smith, and Michael Copenhaver. 2013. ‘Drug addiction stigma in the context of methadone maintenance therapy: an investigation into understudied sources of stigma’, *International journal of mental health and addiction*, 11, 1: 110–122. <https://doi.org/10.1007/s11469-012-9402-5>

David Frank – ‘We’re Gonna Be Addressing Your Pepsi Use’

Fairclough, Norman. 2013. *Critical discourse analysis: The critical study of language*. London: Routledge. <https://doi.org/10.4324/9781315834368>

Fomiatti, Renae, David Moore, and Suzanne Fraser. 2017. ‘Interpellating recovery: The politics of ‘identity’ in recovery-focused treatment’, *International Journal of Drug Policy*, 44: 174-182. <https://doi.org/10.1016/j.drugpo.2017.04.001>

Foucault, Michel. 2003. *Madness and civilization*. London: Routledge. <https://doi.org/10.4324/9780203164693>

Frank, David. 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. <https://doi.org/10.1080/10826084.2017.1310247>

Fraser, Suzanne, Kiran Pienaar, Ella O. Dilkes-Frayne, David Moore, Renata Kokanovic, Carla Treloar, and Adrian Dunlop. 2017. ‘Addiction stigma and the biopolitics of liberal modernity: A qualitative analysis’, *International Journal of Drug Policy*, 44: 192-201. <https://doi.org/10.1016/j.drugpo.2017.02.005>

Fraser, Suzanne, David Moore, and Helen Keane. 2014. *Habits: remaking addiction*. Hampshire: Palgrave Macmillan <https://doi.org/10.1057/9781137316776>

Fraser, Suzanne, and Kylie Valentine. 2008. *Substance and substitution: Methadone subjects in liberal societies*. Basingstoke: Palgrave Macmillan <https://doi.org/10.1057/9780230582569>

Gryczynski, Jan, Jerome Jaffe, Robert Schwartz, Kristi Dušek, Nishan Gugsu, Cristin Monroe, Kevin O’Grady, Yngvild Olsen, and Shannon Mitchell. 2013. ‘Patient perspectives on choosing buprenorphine over methadone in an urban, Equal-Access system’, *The American journal on addictions*, 22(3): 285-291. <https://doi.org/10.1111/j.1521-0391.2012.12004.x>

Harris, Magdalena, and Tim Rhodes. 2013. ‘Methadone diversion as a protective strategy: the harm reduction potential of “generous constraints”’, *International Journal of Drug Policy*, 24(6): 43-50. <https://doi.org/10.1016/j.drugpo.2012.10.003>

Hunt, Dana, Douglas Lipton, Douglas Goldsmith, David Strug, and Barry Spunt. 1985. “‘It takes your heart’: The image of methadone maintenance in the addict world and its effect on recruitment into treatment’, *International Journal of the Addictions*, 20(11-12): 1751-1771. <https://doi.org/10.3109/10826088509047261>

- International Network of People who Use Drugs (INPUD). 2014. ‘INPUD Position Statement on Language, Identity, Inclusivity and Discrimination; Draft version 2’, Retrieved from: <http://inpud.wordpress.com/position-papers/inpudposition-statement-on-language-identity-inclusivity-anddiscrimination/>
- Joseph, Herman, Sharon Stancliff, and Joseph Langrod. 2000. ‘Methadone maintenance treatment (MMT): a review of historical and clinical issues’, *The Mount Sinai Journal of Medicine*, New York 67(5-6): 347-364.
- Keane, Helen. 2013. ‘Categorizing methadone: Addiction and analgesia’, *International Journal of Drug Policy*, 24(6): 18-24. <https://doi.org/10.1016/j.drugpo.2013.05.007>
- Keane, Helen. 2002. *What's wrong with addiction?*, Melbourne University Publish.
- Koester, Stephen, Kenneth Anderson, and Lee Hoffer. 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. <https://doi.org/10.3109/10826089909039442>
- Langendam, Miranda W., Giehl H. van Brussel, Roel A. Coutinho, and Eric J. C. van Ameijden. 2001. ‘The impact of harm-reduction-based methadone treatment on mortality among heroin users’, *American journal of public health*, 91(5): 774. <https://doi.org/10.2105/AJPH.91.5.774>
- Levine, Harry G. 1978. ‘The discovery of addiction. Changing conceptions of habitual drunkenness in America’, *Journal of studies on alcohol*, 39(1): 143-174. <https://doi.org/10.15288/jsa.1978.39.143>
- Magura, Stephen, and Andrew Rosenblum. 2001. ‘Leaving methadone treatment: lessons learned, lessons forgotten, lessons ignored’, *The Mount Sinai Journal of Medicine*, 68(1): 62-74.
- Mateu-Gelabert, Pedro, Milagros Sandoval, Peter Meylakhs, Travis Wendel, and Samuel R. Friedman. 2010. ‘Strategies to avoid opiate withdrawal: Implications for HCV and HIV risks’, *International Journal of Drug Policy*, 21(3): 179–185. <https://doi.org/10.1016/j.drugpo.2009.08.007>
- McKeganey, Neil, Zoe Morris, Joanne Neale, and Michele Robertson. 2004. ‘What are drug users looking for when they contact drug services: Abstinence or harm reduction?’, *Drugs: education, prevention and policy*, 11(5): 423-435. <https://doi.org/10.1080/09687630410001723229>
- Millson, Peggy, Laurel Challacombe, Paul J. Villeneuve, Carol Strike, Benedikt Fischer, Ted Myers, Ron Shore, and Shaun Hopkins. 2007. ‘Reduction in

- injection-related hiv risk after 6 months in a low-threshold methadone treatment program’, *AIDS Education & Prevention*, 19(2): 124-136. <https://doi.org/10.1521/aeap.2007.19.2.124>
- Moore, David, Kiran Pienaar, Ella Dilkes-Frayne, and Suzanne Fraser. 2017. ‘Challenging the addiction/health binary with assemblage thinking: An analysis of consumer accounts’, *International Journal of Drug Policy*, 44: 155-163. <https://doi.org/10.1016/j.drugpo.2017.01.013>
- National Institute on Drug Abuse. 2018. ‘Overdose death rates’, Retrieved on November 7, 2018 from: <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>
- Neale, Joanne, Charlotte E. Tompkins, Carly Wheeler, Emily Finch, John Marsden, Luke Mitcheson, Diana Rose, Til Wykes, and John Strang. 2015. ‘“You’re all going to hate the word ‘recovery’ by the end of this”: Service users’ views of measuring addiction recovery’, *Drugs: education, prevention and policy*, 22(1): 26-34. <https://doi.org/10.3109/09687637.2014.947564>
- New York State Office of Alcoholism and Substance Abuse Services (OASAS). 2018. ‘Building a Foundation for Recovery in New York State’, Retrieved on August, 24, 2018 from: <https://www.oasas.ny.gov/recovery/index.cfm>
- Nolan, Senoaid, Kanna Hayashi, M-J Milloy, Thomas Kerr, Huiru Dong, Vivianne Das Lima, Leslie Lappalainen, Julio Montaner, and Evan Wood. 2015. ‘The impact of low-threshold methadone maintenance treatment on mortality in a Canadian setting’, *Drug and alcohol dependence*, 156: 57-61. <https://doi.org/10.1016/j.drugalcdep.2015.08.037>
- Pani, Pier Paolo, Roberto Pirastu, Antonia Ricci, Gian Luigi Gessa. 1996. ‘Prohibition of take-home dosages: negative consequences on methadone maintenance treatment’, *Drug and Alcohol Dependence*, 41(1): 81-84. [https://doi.org/10.1016/0376-8716\(96\)01240-9](https://doi.org/10.1016/0376-8716(96)01240-9)
- Parpouchi, Milad, Akm Moniruzzaman, Stefani Rezansoff, Angela Russolillo, and Julian Somers. 2017. ‘Characteristics of adherence to methadone maintenance treatment over a 15-year period among homeless adults experiencing mental illness’, *Addictive behaviors reports*, 6: 106-111. <https://doi.org/10.1016/j.abrep.2017.09.001>
- Peterson, Alexis. 2016. ‘Increases in fentanyl-related overdose deaths—Florida and Ohio, 2013–2015’, *MMWR, Morbidity and mortality weekly report*, 65. <https://doi.org/10.15585/mmwr.mm6533a3>
- Peterson, James. A., Robert P. Schwartz, Shannon G. Mitchell, Heather S. Reisinger, Sharon M. Kelly, Kevin O’Grady, Barry Brown, and Michael H.

- Agar. 2010. ‘Why don’t out-of-treatment individuals enter methadone treatment programs?’, *International Journal of Drug Policy*, 21(1): 36-42. <https://doi.org/10.1016/j.drugpo.2008.07.004>
- Pienaar, Kiran, David Moore, Suzanne Fraser, Renate Kokanovic, Carla Treloar, and Ella Dilkes-Frayne. 2017. ‘Diffracting addicting binaries: An analysis of personal accounts of alcohol and other drug ‘addiction’’, *Health* 21(5): 519-537. <https://doi.org/10.1177/1363459316674062>
- Rudd, Rose A. 2016. ‘Increases in drug and opioid-involved overdose deaths—United States, 2010–2015’, *MMWR. Morbidity and mortality weekly report*, 65. <https://doi.org/10.15585/mmwr.mm655051e1>
- Saloner Brendan, and Shankar Karthikeyan. 2015. ‘Changes in substance abuse treatment use among individuals with opioid use disorders in the United States, 2004-2013’, *Journal of the American Medical Association*, 314: 1515-1517. <https://doi.org/10.1001/jama.2015.10345>
- Schwartz, Robert, Jan Gryczynski, Kevin E. O’grady, Joshua M. Sharfstein, Gregory Warren, Yngvild Olsen, Y., Shannon Mitchell, and Joseph Jaffe. 2013. ‘Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995–2009’, *American journal of public health*, 103 (5): 917-922. <https://doi.org/10.2105/AJPH.2012.301049>
- Sordo, Luis, Gregorio Barrio, Maria J. Bravo, B. Iciar Indave, Louisa Degenhardt, Lucas Wiessing, Marica Ferri, and Roberto Pastor-Barriuso. 2017. ‘Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies’, *bmj*, 357: j1550. <https://doi.org/10.1136/bmj.j1550>
- Strike, Carol, Margaret Millson, Shaun Hopkins, and Christopher Smith. 2013. ‘What is low threshold methadone maintenance treatment?’, *International Journal of Drug Policy*, 24(6): 51-56. <https://doi.org/10.1016/j.drugpo.2013.05.005>
- Substance Abuse and Mental Health Service Administration. 2012. ‘SAMHSA’s working definition of recovery updated’, Retrieved on November 6, 2018 from: http://store.pear-vt.org/wp-content/uploads/2015/08/SAMHSA_Working_Definition_Recovery.pdf
- Substance Abuse and Mental Health Service Administration. 2014. ‘Treatment Episode Data Set. 2014’, Retrieved on November 1, 2018 from: https://www.samhsa.gov/data/sites/default/files/2014_TEDS_Discharge.pdf
- Substance Abuse and Mental Health Service Administration. 2010. ‘Recovery Oriented Systems of Care (ROSC) Resource Guide’, Retrieved on Sept. 5,

David Frank – ‘We’re Gonna Be Addressing Your Pepsi Use’

2015 from: http://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

Substance Abuse and Mental Health Service Administration. 2018. ‘Recovery and Recovery Support’, Retrieved on November 6, 2018 from: <https://www.samhsa.gov/recovery>

Tiger, Rebecca. 2013. *Judging addicts: Drug courts and coercion in the justice system*. New York: NYU Press.

Vocal-NY. 2011. *Beyond Methadone: Improving Health and Empowering Patients in Opioid Treatment Programs*, Retrieved on March 27, 2019 from: <http://www.vocal-ny.org>

Weiss, Gilbert, and Ruth Wodak. (Eds.). 2007. *Critical discourse analysis*. New York: NY: Palgrave Macmillan.

White, William L., John Kelly, and Jeffrey D. Roth. 2012. ‘New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid’, *Journal of Groups in Addiction & Recovery*, 7(2–4): 297–317. <https://doi.org/10.1080/1556035X.2012.705719>

White, William L., and Lisa Mojer-Torres. 2010. *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, William L. 2007. ‘Addiction recovery: Its definition and conceptual boundaries’, *Journal of substance abuse treatment*, 33(3): 229-241. <https://doi.org/10.1016/j.jsat.2007.04.015>