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"I Was Not Sick and I Didn't Need to Recover": Methadone Maintenance Treatment (MMT) as a Refuge from Criminalization

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"I WAS NOT SICK AND I DIDN'T NEED TO RECOVER": METHADONE MAINTENACE TREATMENT (MMT) AS A REFUGE FROM CRIMINALIZATION

By

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Abstract

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Methadone Maintenance Treatment (MMT) has been undergoing a cultural and epistemological

shift away from an approach that emphasized client stabilization and a reduction of social harms

towards one grounded in values associated with the recovery movement. These changes include

promoting a view of addiction grounded in the disease model as well as efforts to make

abstinence and ancillary services such as recovery coaching/counseling, programs emphasizing

proper citizenship, and concern for clients' spirituality necessary parts of the program. As such,

the increasing use of recovery as the dominant conceptual framework for MMT represents a

change in how methadone, MMT, and those who use it are socially constructed. Recovery,

which is based on theories of addiction-as-disease, is seen by some as a means to restore MMT

to its rightful position as a medically-based treatment for addiction and a way to remove stigma

from individuals on the program. Others believe that the shift will act as a form of social control

by pathologizing drug use/users and obscuring the role of structural forces (criminalization) in

the harms experienced by drug users. Moreover, by constructing PWUD's choice to attend MMT

as unrelated to the ways that they are oppressed under criminalization, the recovery discourse

depoliticizes drug treatment issues, and, as such, implicitly supports the status quo

criminalization of PWUD. This dissertation uses qualitative interviews and ethnographic

methods to examine: how the shift towards recovery affects issues of agency and control among

individuals on MMT; how it influences debates over methadone's role as a form of drug treatment; and how addiction more generally is being constructed by the recovery discourse. Results demonstrate that despite MMT's institutional focus on recovery, most participants linked their use of MMT to the structural-legal context of prohibition/criminalization rather than through the narrative of the recovery model. Responses also suggested the recovery model functions in part to obscure the role of criminalization in the harms PWUD experience in favor of a model based on individual pathology. Thus, in contrast to the recovery model, MMT cannot be understood outside of the structural context of criminalization and the War on Drugs which shape illegal drug use as a difficult and dangerous activity, and consequently position MMT as a way to moderate or escape from those harms.

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Chapter 1 - Introduction

For the last 10-15 years, Methadone Maintenance Treatment (MMT) in the United States has been undergoing a cultural and epistemological shift away from an approach that emphasized client stabilization and a reduction of social harms towards one grounded in values associated with the recovery movement (Laszlo_editor, 2016; Substance Abuse and Mental Health Services Association [SAMHSA], 2015; White & Mojer-Torres, 2010). These changes include promoting a view of addiction grounded in the disease model as well as efforts to make abstinence from all substances (as opposed to just illegal opioids) as necessary parts of the program (Recovery Oriented Methadone Maintenance [ROMM] Client Placement in Phases of Treatment, 2011; White & Mojer-Torres, 2010). Moreover, since recovery conceptualizes addiction as a whole-person malady, it also involves a focus on ancillary services such as recovery coaching/counseling, programs emphasizing proper citizenship, and concern for clients' spirituality (White, 2007; White & Mojer-Torres, 2010).

As such, the increasing use of recovery as the dominant conceptual framework for MMT represents a change in how methadone, MMT, and those who use it are socially constructed. Whereas previous descriptions of MMT incorporated a focus on its pragmatic benefits - including reduced rates of prisoner recidivism, overdose, and rates of blood-borne disease transmission (Drucker et al., 1998; Joseph, Stancliff & Langrod, 2000; Bigg, 2001) - as legitimate motivations for engaging with treatment, MMT under recovery is more focused on ideology. Individuals, described as "patients", are increasingly expected conform to a medical narrative of treatment that includes a focus on the innate wrongness of drug use, the necessity of personal change, and a conception of addiction grounded in the disease model (White & Mojer-Torres, 2010; White, 2012). Therefore, the construction of MMT as a vehicle towards recovery

may devalue its more strategic functions which can be practical rather than value-based and are often linked to a structural critique of policies that criminalize drug users.

Although recovery is seen by some as a means to restore MMT to its rightful position as a medically-based treatment for addiction and a way to remove stigma from individuals on the program, it may not represent the experiences, or meet the needs, of a diverse population of people who use drugs who have very different drug use experiences, and who conceptualize their drug use and treatment goals differently. First, many people on MMT are using the program strictly as a means to reduce or eliminate their illegal opioid use and see MMT as unrelated to other forms of substance use. Others are not interested in abstinence as a treatment goal (or as defined by the recovery model) but use the program instead as a means of reducing harms related to active drug use such as overdose, withdrawal, and the constant hustle of dependence on illegal opioids. Such individuals, who benefit from MMT but are not seeking (or have not yet achieved) complete abstinence from all substances potentially face increased marginalization and discipline at their clinic, up to and including dismissal from the program – an outcome associated with increased risk of overdose, transmission of blood-borne diseases, and death (Magura & Rosenblum, 2001). Thus, the increasing use of recovery-based policies in MMT may hinder its ability to act as a form of harm reduction in the lives of drug users, thereby exposing them to the comparatively greater dangers of illegal drug use. This is particularly important in the current U.S. context of dramatic increases in opioid-involved overdoses (CDC, 2016).

Moreover, positioning MMT as being 'about recovery' has significant implications for the ways that drug use, drug treatment, and drug control are understood. The recovery model locates the difficulties illegal drug users encounter and their reasons for pursuing MMT as individually based, through addiction, rather than from structural forms of oppressions such as

criminalization and the War on Drugs. As such, the contextual reality of criminalization as a force of harm in illegal drug users' lives, and one that drives them towards the relatively safer form of opioid use available within MMT is obscured from the narrative. Using the same logic, positive treatment outcomes in MMT are seen as the result of a medical intervention rather than because of the quasi-legal environment of opioid use that MMT facilitates. Thus, the recovery model implicitly supports criminalization by locating drug users as the architects of their own problems while absolving state policies that criminalize them from responsibility.

This dissertation critically examines recovery in MMT, focusing both on how well its tenets and claims align with the goals and experiences of people in the program, as well as how the narrative of recovery affects related discourses of drug use and treatment.

Background

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

Recovery's meaning

While the term 'recovery' has always been understood to mean the cessation of a particular illness or ailment, the modern recovery discourse has its roots in the 19th century when temperance societies and related groups began discussing socially unacceptable alcohol use as a disease (Levine, 1978). The concept and language of recovery was later taken up by twelve-step groups who formed around a variety of practices including drinking, smoking, and narcotics use (White, Kelly & Roth, 2012). Although the move towards policies aimed at recovery has been occurring internationally, efforts in the United Kingdom (UK), Australia, and the U.S. have attracted the most attention (AIVL, 2012; UK Home Office, 2012). One important difference between the U.S.-based approach and those of the UK and Australia has been their stance on MMT; while recovery-based polices in the UK and Australia have focused on reducing use of MMT, seen as allowing individuals to "drift ….into indefinite maintenance, which is a replacement of one dependency with another" (UK Home Office, 2012: p. 3), U.S. agencies have adopted a view of recovery that sees MMT as on par with other legally-prescribed medications and thus, as an acceptable medical treatment for addiction (SAMHSA, 2009). Nevertheless, the US-based approach to recovery for those on MMT, often termed "Recovery Oriented Methadone Maintenance" (ROMM) maintains the same focus on abstinence, citizenship, and "improvement in global health", with the caveat that individuals taking their methadone as prescribed and otherwise meeting criterion for recovery are included within the definition (White & Mojer-Torres, 2010).

Although the specific criteria comprising recovery varies and is to some extent contested (White, 2012; Neale, Nettleton & Pickering, 2011), in the U.S., most definitions are based on that of the Betty Ford Institute Consensus Panel which defined recovery as "a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship" (2007: p. 222).

SAMHSA uses a similar definition centered on four "major dimensions" including health, home, purpose, and community (2016). Thus while abstinence is considered a prerequisite[1], recovery is based on a holistic conception of personhood that is understood as a lifelong process of growth, change, and reclamation of the self (Laudet, 2007; White, 2007). Recovery advocates William White and Lisa Mojer-Torres contrast recovery with remission, meaning abstinence in this context, stating: "Remission is about the subtraction of pathology; recovery is ultimately about the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and quality of life in the community" (2010: p. 8). Thus, recovery involves a full-fledged change in personhood in accordance with normative ideas about "how bodies should function and about desirable as opposed to undesirable ways of being" (Keane, 2002: p. 16) rather than simply abandoning 'problematic' drug use. This whole-person focus also greatly expands the jurisdictional boundaries of methadone clinics to intervene in multiple aspects of their clients' lives.

Recovery and disease

The notion of addiction-as-disease is central to recovery in that it establishes the condition one must recover from. Although there is flexibility regarding how the disease is operationalized (usually ranging from views based on the National Institute of Drug Abuse (NIDA)'s chronic brain disease model (Courtwright, 2010) to more mainstream conceptions associated with 12-step groups), recovery rests on the claim that "addiction" is a diagnostic, pathological condition requiring treatment, in this case methadone alongside a battery of psycho-

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

social-spiritual interventions. Yet, despite its current dominance culturally, addiction-as-disease

theories are far from universally accepted. Scholars from numerous disciplines point out that

they are both scientifically flawed and serve as a means of social control (Lewis, 2015; Conrad

& Schneider, 1992; Vrecko, 2010; Peele, 2014; Hart, 2013; Keane, 2002; Reinarman, 2005; Des

Jarlais, 1995). Addiction-as-disease theories have also been described as stigmatizing, and as

providing support for repressive drug policies, particularly towards poor and marginalized

peoples, through their focus on people who use drugs as pathological (Campbell, 2012; Levy,

2014; Reinarman, 2005). Examining methadone as one of many "technologies of addiction

therapeutics", science and technology scholar Nancy Campbell argues that medical and criminal

theories of drug use support and co-produce one another as well as "the very forms of addicted

subjectivity to which they are said to respond." (Campbell, 2011: p. 124).

Moreover, evidence demonstrates that people use, and benefit from MMT outside of the

context of the disease/recovery model (Bigg, 2001; Joseph, Stancliff & Langrod, 2000; Drucker

et al., 1998).   Harm reductionists point out that people often utilize MMT for pragmatic reasons

including withdrawal avoidance, which in turn reduces the likelihood of risky activity such as

syringe sharing; as a temporary means of reducing tolerance and physical wear-and-tear; and as a

means for dealing with instabilities of the illegal drug market (Harris & Rhodes, 2013; Mateu-

Gelabert et al., 2010; Koester, Anderson & Hoffer, 1999). MMT has also consistently been

shown to reduce overdose, recidivism, and transmission of blood-borne viruses (Novick et al.

2015; Joseph, Stancliff & Langrod, 2000)

A review of the early literature suggests that physicians Dole and Nyswander – who did

the foundational research leading to MMT in the mid-1960s – valued its potential to reduce

structural-legal harm in drug users' lives. They argue that "Methadone maintenance makes

possible a first step toward social rehabilitation by stabilizing the pharmacological condition of addicts (sic) who have been living as criminals on the fringe of society" (Dole & Nyswander, 1976: p. 2117). Moreover, in their ten-year review of MMT, they argue against excessive rules and regulations which they cite as the most common reason for "addicts" to reject treatment, and chastise the public at large for their morally-based lack of enthusiasm for substitution treatment, pointing out that "What was not anticipated at the onset was the nearly universal reaction against the concept of substituting one drug for another, even when the second drug enabled the addict (sic) to function normally." (p. 2117)

Resistance to recovery

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

Yet, with important exceptions (Harris & Rhodes, 2013; Fisher et al., 2002; Koester et al., 1999) the majority of scholarship on MMT does not account for how criminalization and the

War on Drugs shape the treatment experiences of people on the program. Similarly, there has been a lack of critical engagement with the increasing emphasis on conceptualizing MMT as recovery-based treatment (in the U.S.[2]). By examining alternative constructions that acknowledge its use as a pragmatic strategy to mitigate harms produced structurally by criminalization, this dissertation hopes to produce a richer, more contextualized picture of MMT and the reasons people who use drugs employ its services. Moreover, a more nuanced understanding of why people use/value/benefit from MMT may open up discursive spaces to examine the etiology of harms they experience as a product of oppression rather than solely from the pharmacological and physiological effects of substances.

Literature Review

This dissertation is based upon the following literature domains:

Medicalization

From the 1970's through recently, Health and Illness scholars documented the medicalization of deviance, a process whereby behaviors not necessarily conceptualized medically are increasingly seen as illnesses (Conrad and Schneider, 1992; Zola, 1972; Szasz, 1974). Cultural trends including the emergence and increasing professionalization of medicine, the reduced role of religion, the emergence of biophysiological theories of causation and the increasing social desirability of "treating" rather than punishing, all contribute to the shifting designation of deviance, from one of badness to one of sickness (1992). Moreover, because of cultural perceptions that link medicine and science generally with notions of objectivity,

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

behaviors are defined (and accepted) as either normal or pathological based on the views of the medical profession (Keane, 2002; Vrecko, 2010).

One hallmark of medicalization has been its ability to exert social control through "the authority to define certain behaviors, persons, and things." (Conrad, 1992: p. 216). As such medicalization is always about power, and which groups are able to establish and legitimate their definitions of morality and deviance (Conrad, 1992; Jutel, 2010). Scholars examining medicalization (see for example Zola, 1972, Illich, 1975, Rosencrance, 1985, Wilkerson, 1998) note that it derives much of its power through its ability to "construct and promote deviance categories with wide-ranging application" (1992: 23). For example, In *From Badness to Sickness*, a foundational text in the medicalization literature, Conrad and Schneider take as their starting point the idea that what is deviant in a particular society is not self-evident and term the social-political battle for meaning the "politics of definition" (1992). Hence, the ability to define (and to legitimate definitions of) certain behaviors, activities, or conditions as deviant is a political activity that is enmeshed within, and dependent upon power relations. This view, which builds upon both Marxist and Constructionist understandings of deviance (see for example Quinney, 1974; Foucault, 1973; Gusfield, 1963) sees the creation of deviance categories as an ideological contest involving a variety of class, status, and/or group interests, with respective actors all working to promote particular definitions that align with their goals. Thus, the notion of a Politics of Definition is helpful towards analyzing a complex cultural environment, like that of MMT, which does not easily conform to narratives of Medicalization and De-medicalization.

Although MMT has often been viewed as an example of the medicalization of deviance (Conrad & Schneider, 1992; Stevens, 2000), it is also a site of contestation and resistance, seen by some as a strategic means of survival in a regime that criminalizes people who use (certain)

drugs (Harris & Rhodes, 2013; Mateu-Gelabert et al., 2010; AIVL, 2012). Thus, the increasing use of recovery as the dominant conceptual framework for MMT represents an attempt to medicalize a program that is currently informed by multiple, and often conflicting points of view.

Scholars have also pointed out how medical categories like "healthy" are innately normative – thus they reflect the inequalities within our hierarchical society (Vogt, Hofmann, & Getz, 2016; Clark, 2014) For example, Susan Fraser points out that treatment responses both emerge from, and help construct regulatory norms based on "what it means to be human, citizen, woman or man." (Fraser & Valentine, 2008: p. 2). As such, treatment becomes a particularly effective means of disciplining and controlling subjectivities (see for example, Fraser & Valentine, 2008; Bougois, 2000; Foucault, 1973; Keane, 2002; Carr, 2011; Szasz, 1974).

Calls to define MMT through medical narratives have typically been framed by proponents as an effort to remove negative stigma associated with methadone and to grant individuals in MMT the more socially acceptable role of "patients" recovering from the disease of addiction (White & Mojer-Torres, 2010; White, 2012). Yet, those opposed to the recovery definition, such as drug-user rights groups, point out that such labeling restricts many to an unwanted disease category and obscures the role of structural-legal determinants in the harms experienced by drug users, thereby implicitly supporting anti-drug policies that criminalize them (INPUD, 2014; AIVL, 2012). Hence, the label of recovery and its relationship to theories of addiction-as-disease becomes a site of ideological contestation between groups with different beliefs, goals, and frames of reference for understanding the issue.

Proponents of disease theories of behavior argue that by designating a behavior's etiology as biophysical rather than moral, stigmatization and social marginalization will be reduced, or potentially eliminated (Berghmans et al., 2009; Rosenbaum, 1995). However, this has been

challenged by health and illness scholars who point out that modern, neo-liberal conceptions of health are intimately linked to notions of morality and that the unhealthy individual is increasingly seen as responsible for her plight by not making the (morally) correct (healthy) choices (Hansen, Bourgois & Drucker, 2014; Payton & Thoits, 2011; Lupton, 1995; Petersen, 1997). Moreover, a central critique of medicalization focuses on its ability to decontextualize individuals and their behaviors from the social world, thereby ignoring the role of social structures and/or institutions that give rise and contextual meaning to medical diagnoses (Conrad, 1992, Crawford, 1980). Building on Foucault, Robert Crawford points out how medicalization restricts notions of causality to the individual body and that "anything which cannot be shown to interact with the organism to produce a morbid state is increasingly excluded" (Crawford, 1980: 371). Scholars have noted how the adoption of a biomedical model of senile dementia neglects the role of social factors (Lyman, 1989), and how medicalized conceptions wife battering focus primarily on therapy at the expense of a critical analysis of patriarchy (Tierney, 1982). Drug-user rights groups have expressed similar claims in regards to the medicalization of addiction (AIVL, 2012; INPUD, 2011).

More recent work on medicalization has focused on the increasingly complex, multi-directional and technoscientifc processes of medicalization, termed *biomedicalization* (Campbell, 2012; Clarke et al., 2003). Biomedicalization extends the medicalization project through its increasing focus on health as a moral obligation, and attendant growth of surveillance and risk assessment aimed at individual bodies (2003). Moreover, biomedicalization points to the ability of emerging technological forms of intervention and surveillance as a highly effective means of producing and monitoring individual subjectivities (2003).

Addiction as disease:

Humans have used psychoactive substances for many thousands of years for a variety of reasons including religious activities, ritual, relaxation, and amusement (Weil, 1972). Yet, notions of addiction, conceived by the new paradigm as "a disease, or disease-like" began to form in the late 18th and early 19th century around the concept of alcoholism (Levine, 1978: 493). Central to the developing model of alcoholism-as-disease is the role of the will in choices to use or abstain from alcohol (1978). During the 17th century, individuals were seen to drink and/or get drunk because they wanted to, rather than because they had to. Yet, towards the end of the 18th century, individuals began describing their relationship to alcohol as one of overwhelming compulsion (Levine, 1978). This occurred in tandem with newly formed temperance organizations that developed theories about addiction centered on the notion of a disabled will, and abstinence as its only cure. Levine argues that this view of alcoholism was subsequently applied to other substances, and forms the basis of current understandings of addiction (1978).

While modern conceptions of addiction-as-disease continue to focus heavily on the notion of a disabled will and abstinence as its proscribed treatment, they are now seen primarily through a neurological lens that describes addiction as a "chronic brain disease" (Leshner, 1997; Volkow & Fowler, 2000). This is the view advanced by the American National Institute on Drug Abuse (NIDA), which funds most of the world's research on addiction and therefore exercises considerable influence over how it is framed (NIDA, 2007). Moreover, the neurological model draws much of its power from its relationship to science, seen as objective and free of influence by external, social factors (Vrecko, 2010; Buchman, Skinner & Illes, 2010).

Yet, the neurological model of addiction-as-disease also has many critics. Scholars have been critical of the science supporting the disease model by arguing that neurobiological accounts of addiction are reductive and ignore the role of social and cultural factors (Peele 1999;

Keane, 2002; Buchman, Skinner & Illes, 2010). Others have pointed out that rather than liberating drug users from stigma and social exclusion, disease models of addiction retain their moral character and often function as a force of disempowerment and marginalization (Granfield & Cloud 1999; Peele, 2014). Similarly, in *Addiction as Accomplishment*, sociologist Craig Rienarman rejects the notion that addiction-as-disease theories emerged objectively from science, writing: "The disease concept was invented under historically and culturally specific conditions, promulgated by particular actors and institutions, and internalized and reproduced by means of certain discursive practices" (2005: p. 308).

Recovery

Much of the scholarship on the emergence of recovery in drug treatment modalities (particularly in the U.S.) is based on an un-critical acceptance of recovery, both as a positive treatment outcome and as the proper organizational structure for MMT programs. Most articles focus either on the best ways to encourage illegal drug users - understood as "addicts" - to pursue recovery-based treatment or how to best organize programs according to recovery-based treatment principles (White & Mojer-Torres, 2010; Vanderplasschen et al., 2013). This may be due in part to the stigma of MMT as compared to non-medication using treatment like 12-step models (Frank, 2011). People on MMT have typically been excluded from claims to recovery due to the belief that they were not truly abstinent. Thus, much of the scholarship related to MMT and recovery involves claims to MMT's legitimacy in regards to recovery-status (as well as articles on how best to integrate the two approaches) rather than critical examinations of recovery as a concept and/or treatment model (White, 2010; White, 2009). Others focus on ways to bridge gaps between abstinence/recovery-based and harm reduction-based treatment approaches (Futterman, Lorente & Silverman, 2004; Kellogg, 2003).

The most clearly articulated model of recovery-based treatment in MMT, termed

Recovery Oriented Methadone Maintenance (ROMM) is authored by well-known recovery

advocates William White and Lisa Mojer-Torres (2010). ROMM is firmly based in a conception

of "Opioid Addiction as a Chronic Disease" (2010: 3) and views drug users as "patients" in need

of both medical treatment and a variety of self-help/social-psychological services (2010).

ROMM calls for a number of recovery-focused interventions including the use of paid or

volunteer recovery coaches; inclusion of indigenous healers and healing practices within Opioid

Treatment Programs (OTPs); celebrating patient recovery milestones; and "visibly participating

(OTP staff and MM patients/families) in local recovery celebration events" (p. 15).

Moreover, ROMM links the acceptance of its principles to the ability of individuals to

access "take-homes", daily/weekly/monthly doses of methadone given to individuals in order to

avoid their being forced to attend the clinic every day (ROM Phases of Treatment, 2011). For

example, according to the ROMM guidelines, in order to receive any take-home doses,

individuals must: establish direct relationships with organizations that may lend support to

recovery; be engaged in recovery support activities; demonstrate awareness of how alcohol and

other drug use negatively effects recovery; and be exploring spirituality (ROM Phases of

Treatment, 2011: 6). Thus, ROMM explicitly links the ability of individuals to access treatment

to their acceptance of recovery-based principles and practices.

Harm Reduction

Harm Reduction is an approach to drug use (and other activities) that seeks to reduce

associated harms by providing services outside of the abstinence-only context that defines most

traditional forms of drug treatment (HRC, 2014). Typical examples include Syringe-Exchange

Programs (SEPs), Safer Injection Facilities (SIFs), and providing drug users with naloxone, an opiate antagonist that reverses the effects of opioid-based overdoses.

Although it's difficult to establish a definitive historical beginning for the harm reduction movement and any account of its inception will leave out important precursors, it is thought to have begun in England and Amsterdam during the early 1980's as both areas were dealing with rapidly increasing rates of drug use (particularly heroin) and related harms such as overdose, Hepatitis C, and the first signs of the HIV/AIDS epidemic (Stoker, 2006-2010; Riley et al. 2012). The early proponents of harm reduction began to coalesce around a common frustration with existing drug policies whose primary goals were to eliminate illegal/recreational drug use and had very little focus on improving the health outcomes for active drug users. Although most efforts began as illegal initiatives, far removed from mainstream medicine, the emergence of HIV/AIDS in the early to mid-eighties and its disastrous effects, particularly for people who inject drugs (PWIDs) and men who have sex with men (MSM), led to a political context more open to harm reduction initiatives. This more than anything else, helped to create a semi-legitimate political space for harm reduction oriented activities (Riley et al. 2012).

Harm reduction programs have notably demonstrated reduced rates of overdose, blood-borne disease transmission and prisoner recidivism, and are also associated with high rates of client satisfaction (Eshrati et al., 2008; Marlatt, 1996). Although harm reduction includes a variety of viewpoints, it is largely informed by a drug-user rights perspective that sees many/most of the harms associated with drugs as products of their illegal status and efforts on the part of the state to criminalize individuals who use drugs. Such groups argue that recovery and its necessary focus on drug use-as-disease obscures the role of criminalization in creating, or greatly adding to the difficulties and harms experienced by drug users (INPUD, 2014; AIVL,

2012). A similar view is expressed in the Vancouver Declaration, a statement complied by drug-user activists working to "enable and empower people who use drugs legal, or deemed illegal, worldwide to survive, thrive and exert our voices as human beings to have meaningful input into all decisions that affect our own lives" (Vancouver Declaration, 2006).

However, advocates have noted a tendency towards less radical positions in harm reduction associated with its increasing acceptance in mainstream medicine. Although harm reduction approaches to drug use/treatment are often seen dichotomously to abstinence-only approaches, the recent focus on recovery has led many to call for their integration (see for example McLellan & White, 2012; Futterman, Lorente & Silverman, 2004; Marlatt, Blume & Parks, 2001). Such arguments acknowledge harm reduction's acceptance of drug use as a potential benefit towards connecting difficult-to-reach drug users with treatment, but only within a framework that locates abstinence as the most beneficial outcome (Kellogg, 2003; Marlatt, Blume & Parks, 2001). More radical harm reduction activists and drug-user rights groups reject such claims as the co-opting of harm reduction's original philosophy of accepting drug use/users as a legitimate choice (AIVL, 2012). As the Australian Injecting and Illicit Drug Users League points out in its analysis of harm reduction's relationship to the 'new recovery' movement, "Harm Reduction is not and can never be reduced to a 'by the way', 'side thing' we do while we get on with the 'real' job of reducing the supply of, and demand for illicit drugs and getting people on the 'road to recovery'. Harm Reduction is about *active drug use*[3].... It is not, cannot and was never meant to be a point on a 'continuum' towards the 'real' goal of abstinence and a drug-free lifestyle." (AIVL, 2012).

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[3] Emphasis not mine.

Chapter 2 - Methods

Research Questions

1. How well do the tenets and claims of the recovery model in MMT align with the experiences of individuals in the program?

2. How, if at all, has the shift towards conceptualizing MMT as recovery-based treatment affected issues of agency and control among individuals in the program?

3. How does conceptualizing MMT as recovery-based treatment affect how drug use, drug treatment, and drug control are understood?

Data collection

This dissertation is based on approximately two years of qualitative research consisting primarily of semi-structured interviews and ethnography, as well as elements of auto-ethnography. This study was approved by the City University of New York (CUNY) Baruch College Internal Review Board (IRB).

Semi-structured interviews

Semi-structured interviews were conducted with a total of 42 participants from three populations: people on methadone maintenance treatment (MMT) (either currently or within the previous two years) (n=23); people who work as treatment providers (individuals working at MMT clinics and government administrative offices that regulate MMT) (n=10); and people who work with advocacy organizations that address the needs of People Who use Drugs and people on MMT (n=9).

Participants were recruited using a combination of convenience and snowball sampling based initially on contacts I had through my own experience as a drug user who is currently on MMT. After completing their interviews, these initial participants were provided recruitment flyers with a description of the study and my contact information, and asked to distribute them to others who might be interested in participating. Most participants lived in the New York City metropolitan area and I usually conducted those interviews in person, however some lived elsewhere and in these cases, I did the interviews by phone. Eligibility criteria for participation in the study included: ability to speak and understand English, and to understand, and provide informed consent. Participants were paid $20 (though not every participant accepted compensation) and interviews lasted approximately one hour, and were recorded to be transcribed later.

Although interview questions varied by participant category, they generally addressed participants' experiences with, and views of, illegal drug use and treatment. Interviews with participants from the MMT client group tended to be less structured than those with the other groups, often taking the form of a dialogue. This was important for two related reasons. First, people on MMT are by definition a marginalized group who are used to exercising caution in regards to what types of information they disclose. For example, admitting to using illegal substances or otherwise acting in ways outside of the accepted (recovery-based) behavior can result in serious penalties including the loss of take-homes, difficulties with clinic councilors, and even potential dismissal from the clinic. This meant that part of our conversations, particularly early on, involved my having to gain participants' trust.

After a certain amount of trial and error, and in cases where the participant seemed reticent to open up, I often revealed my own status as a drug user and person on MMT.

Although I had planned to not reveal any personal information, it quickly became apparent that the benefits of disclosing my status, in terms of richness and quality of data, as well as the increased honesty and comfort of the study participants, seemed to far outweigh the benefits I might gain in terms of not "biasing" my data. For example, participants often visibly relaxed or verbally expressed relief upon my disclosing my own history and status as someone on MMT. Similarly, my familiarity with the terminology, common culture, and shared experiences, also helped to position me as part of the community rather than an outsider, who are often (and with good reason) viewed with suspicion.

Secondly, because ideologies of oppression are often internalized (Reinarman, 2005; Gorelick, 1998; DeVault, 1996) - particularly in an institutional setting like MMT (Harris & McElrath, 2005; Foucault, 1972; Goffman, 1968) - it is likely that participants from this group may initially describe their experiences through the institutionally accepted narrative, regardless of how well it aligns with their experiences and/or treatment goals. The dialogue interview format I employed helped to create an environment where participants felt comfortable describing their experiences in ways outside of those concepts and language. Specifically, I tried to ask evocative questions that would encourage participants to be self-reflexive (see for example the interview with Cheryl in Experiencing Recovery chapter). In some cases, this strategy led to participants experiencing conceptual 'light-bulb' moments in regards to their own experiences.

These types of methodological concerns have been discussed extensively in Marxist and Feminist research, which are necessarily addressing internalized power structures and the ideologies that support them (Powers, 2001; Blume, 1998). In response, numerous feminist scholars, particularly those working with qualitative methods, have rejected the notion of a distanced and neutral observer, choosing a situated approach to knowledge instead (DeVault,

1996; Haraway, 1988). Situated approaches are those that acknowledge the positionality and power relationships existing between researcher, subject, and participant. They are most often used when studying groups that are structurally and ideologically marginalized, and generally place a greater emphasis on transparency and reflexivity than on neutrality and objectivity. Situated approaches to research are also more comfortable with the political and activist concerns of research, in that challenging power is seen as a valuable part of the process (DeVault, 1996). Addressing these tensions, feminist scholar Marjorie L. DeVault writes that they "provide the outline for a possible alternative to the distanced, distorting, and dispassionately objective procedures of much social research." (1996; p. 29).

However, conducting social research as an insider also involves a number of challenges, some that are specific to the researchers' insider status (Burns et al. 2012; Humphrey, 2013). Most prominent in this study were ethical challenges that arose when interviewing participants who were clearly experiencing pressure and guilt related to recovery's demands on them – particularly in regards to the necessity of complete abstinence. For example, some participants described instances of having been pressured and/or punished by their clinic for non-opioid (or sometimes opioid) drug use, which they would describe as being 'their own fault', often demonstrating significant distress over what they saw as a personal failure. My 'gut reaction' to these situations was to let them know that I did not necessarily see a problem with their behavior and that their clinic difficulties could be just as easily understood as the result of the unfair, and impractical demands of MMT's recovery culture and structural organization. This feeling was even stronger because of my own position of power as a doctoral student who is also a drug user on MMT - this meant that participants not only invested certain amount of pride and respect in

my accomplishment, but also that they assumed (incorrectly) that I was now in recovery and abstinent from illegal drugs.

Although I refrained from disclosing my political views on recovery and other subjects that were directly related to the study, I did attempt to create an atmosphere where participants felt free to describe experiences that contrasted with the dominant discourse. For example, if, during an interview, I got the feeling that a participant was conflicted or clearly parroting the clinics' view on the disease model rather than her own, I might say, "You know, not everyone thinks of their drug use as a disease, it's ok if you see it differently."

Thus, Marxist and feminist literature (Naples, 2003; DeVault, 1996; Haraway, 1988) served as a helpful guide to the types of issues that came up in this study, and I tried to adopt its situated, self-reflexive, and flexible approach. Similarly, I viewed each situation as both a negotiation and a learning process, where I attempted to balance the oft-competing values of research, activism, and a concern for the individual study participants, who are dealing with structural issues that I also have a personal and political stake in.

Despite the many challenges, I am confident that my insider status enabled me to gather data that would have been very difficult, if not impossible for someone without direct experience in this community. Moreover, I believe that most participants from the MMT-client group (the most clearly marginalized group) enjoyed discussing these topics. People who use illegal drugs are so often used to having their own lives and experiences framed by other, more powerful groups and actors that many expect to have little meaningful input in scholarly research. Rather, their experiences are generally flattened to produce quantitative representations of pathology like the number of overdoses they have experienced or the number of substances they have consumed

in a given time period. Hence, I believe that most participants (from the MMT-client group) found it refreshing to be asked about their own views of drug use and drug treatment.

Ethnography

Ethnographic observations were carried out primarily at the methadone clinic I attend in The Bronx, NY. I am at the clinic once every four weeks for a period ranging from 1 to 3 hours, and used this time to make field observations and notes. Since methadone clinics are often highly bureaucratic spaces that are also designed to protect their clients' anonymity, I felt that this strategy would be much easier than to try gain approval for ethnographic research inside of a clinic I had no relationship with. The clinic I attend is a large and bustling place with clients involved in multiple activities including: meeting with councilors, getting medical exams, or waiting around either to 'dose'[4] or to meet with their counselor. Thus, my visits often included a significant amount of 'down time' where I was able to talk with other clients and employees, and observe the general activities. Additionally, individuals who attend this clinic (and many clinics) often congregate outside after dosing, both for social reasons, and sometimes to participate in illegal drug deals. I usually spent 10-20 minutes there to get a sense of participants' conversations outside of the immediate clinic environment.

In addition to my regular visits to my own clinic, I was also able to visit approximately five other methadone clinics in New York City. These visits took place while interviewing clinic staff, owners, and/or administrators, who would sometimes provide me with a tour of the facilities which often included conversations with other clinic staff and clients. Although the vast majority of my ethnographic data was obtained from my own clinic, visiting other clinics, even if

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[4] "Dose" is the nearly ubiquitous term among people on MMT for obtaining their daily dose of methadone.

for a short period of time, provided an important context for determining differences and similarities among New York City (NYC) methadone clinics.

Auto-ethnography

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

Although I do not refer to my own experiences directly as data in this paper, they have structured my own views on this topic and, correspondingly, the direction of this study. Thus, it incorporates elements of auto-ethnography. As discussed in the Interview section of this chapter, my direct experience as someone whose used drugs was, for the most part, highly beneficial throughout the data collection phase of the project. I not only had access to a hard-to-reach population, but as a fellow person who uses/d drugs, I was also afforded a much greater level of trust than an outsider would likely have been given. Yet, it also led to a number of methodological challenges (also discussed in the Interview section).

Data Analysis

Although the data analysis portion of the study did not employ a specific coding strategy, it was guided by themes I had developed through my own 11 years' experience in MMT. Thus, while this study was not deductive, or based on hypothesis testing, I did begin the study as someone who was aware of many of the potential issues involving recovery in MMT.

I began the analysis process by repeatedly listening to participant interviews in order to develop some basic ideas as to how well the data aligned with my own knowledge and experience. As I listened to, transcribed, and thought about the data, I began to develop a series

of concepts and themes that I used to organize the data. This was not a rigid coding structure but rather, a set of emerging themes and notes. I also made attempts to test themes by seeking out alternative cases and potential explanations in the data.

Theoretical position:

The data analysis portion of this study was also guided by a variety of anti-positivist and post-structuralist theoretical positions. Interview data in particular focused on the tenets of Foucauldian discourse analysis (Foucault, 1972). In "Discourse Analysis and the Critical Use of Foucault" Linda Graham distinguishes Foucauldian forms of discourse analysis by their concern with power, representation, and a reticence to see method as an objective means of uncovering "truth" (Graham 2005). Although Foucault avoided delineating a specific methodology, his work consistently focused on the "constitutive and disciplinary properties of discursive practices within socio-political relations of power" as a way of illuminating "how language works not only to produce meaning but also particular kinds of objects and subjects upon whom and through which particular relations of power are realized" (Graham 2005: 4). Thus, by applying a Foucauldian perspective to the emergence of recovery in MMT, my project focuses on how the recovery discourse creates particular types of objects (for example, those in recovery or those not in recovery) who are then subjected to particular practices that are also delimited as part of the discursive project of recovery.

Thus, this study is grounded in a larger epistemological tradition of social constructionism (Berger and Luckman 1966). In *The Social Construction of Reality*, Berger and Luckmann argue that all knowledge is a product of social interactions whereby groups and individuals create concepts that inform and give meaning to their reality (1966). Over time, dominant ideas become embedded within society's institutions, thereby appearing to exist

objectively and distinct from the social and historical circumstances that led to their formation (1966). Based on this view, termed *Social Constructionism*, ideas are not seen as trans-historical or maintaining an essential quality, but rather are generated within a specific social and historical milieu (Berger and Luckman 1966; Conrad and Schneider 1991). Numerous scholars have applied these concepts to studies of scientific and medical knowledge detailing the role of social construction in areas generally thought to be objectively determined (see for example Rothman 1982; Smith 1990; Metzel 2009; Dingel et al. 2011). These studies demonstrate that contests over knowledge and meaning have significant effects for individuals and society, and to understand how knowledge is produced in this context, scholars must adopt a critical perspective that aims to deconstruct knowledge discourses in order to "expose the workings of assumption, commonsense and intuition." (Brook and Stringer 2005: 317).

Similarly, this study adopts a deconstructivist approach to understanding textual data (Derrida, 1976). In the preface to *On Deconstruction*, Jonathan Culler, following Derrida, writes that Deconstruction is not "a school or a method, a philosophy or a practice, but something that happens, as when the arguments of a text undercut the presuppositions on which it relies". (p. 2) Thus, at its core, Deconstruction is a means of thinking critically, and of interrogating rather than immediately accepting, the concepts that comprise an argument. This approach was particularly useful in regards to studying this topic since drug use and treatment culture is rife with concepts that are discursively positioned as objectively true or objectively good - even 'recovery' itself is constituted, both linguistically and within the social context of drug treatment, as an inherently 'good thing'. Using interview data to critically interrogate, or deconstruct the recovery discourse in MMT, offers a way of challenging such assumptions.

The phenomenon in MMT

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

Chapter 3 -

Producing recovery: A shift towards constructing the un-walled prison

"Recovery encompasses an individual's whole life, including mind, body, spirit, and community." (SAMHSA, 2012)

Recovery is a view of overcoming addiction that sees abstinence as a prerequisite, but also incorporates a larger, more general conception of wellness, as well as social and meta-physical aspects of an individuals' life such as spirituality and community involvement. It involves a fundamental shift in how drug treatment services in general, and methadone maintenance treatment (MMT) specifically, are understood, administered, and experienced. Thus, the institutional focus on framing MMT as a recovery-based treatment represents a new form of governance that requires people who use drugs (PWUDs) to undertake projects of total self-reconstruction aimed at revealing a healthier, more authentic self.

Background

Individuals involved with the administration of methadone maintenance treatment (MMT) spoke a great deal about the push by government organizations like the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of National Drug Control Policy (ONDCP) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS)[5] to base their treatment models on recovery. The shift was seen as an important change in how drug treatment services were being conceptualized and administered. As Robert Lubran, SAMHSA's Director of Pharmacologic Therapies explained:

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[5] New York state is the location of this study.

"I saw this [recovery] starting to trend maybe five or six years ago…. And it

started catching on here favorably and has continued, and I think will continue to

expand as we see the benefits of it and encourage programs to understand how

that can be beneficial to patients." (Lubran, 2014).

Lubran's comments are corroborated by the extensive efforts on the part of government

to promote recovery as the focus and lynchpin of substance use and mental health treatment

services. In 2010 ONDCP established a recovery branch whose purpose is to engage with

federal, state, and local government, as well as advocacy organizations, service providers, and

stakeholders with the goal of developing policies, programs, and campaigns that support long-

term recovery (ONDCP, 2015). Similarly, in 2010 SAMHSA "issued 30 new Access to

Recovery (ATR) grants to 23 states, 6 tribes, and the District of Columbia. Funded at $98.9

million annually over 4 years, this program expands treatment and recovery support services that

are critical to sustaining recovery" (ONDCP, 2015). According to their Recovery Oriented

Systems of Care (ROSC) guidebook SAMHSA states: "The adoption of recovery by the

behavioral health systems in recent years has signaled a dramatic shift in the expectation of

positive outcomes for individuals who experience mental health and substance use conditions"

(SAMHSA, 2010) and that "Recovery has been identified as a primary goal for behavioral health

care" (2015).

Although most administrators admitted that there are many definitions of recovery, and

in-fact stress that the model is about individualized care, they also described recent attempts by

both government and advocacy organizations to create a unified understanding of what recovery

means. Many referred to a 2006 meeting convened by the Betty Ford Institute (BFI), where

recovery was defined as "a voluntarily maintained lifestyle characterized by sobriety, personal

health, and citizenship" as an early attempt to operationalize the developing ideas behind 'recovery' (The Betty Ford Consensus Panel, 2007). SAMHSA and OASAS administrators explained that BFI's conception was important because it located recovery as distinct from abstinence. Although abstinence from all illegal substances was considered a prerequisite, recovery was seen as a totalizing process that went beyond the discontinuation of certain types of substance use.

Specifically, administrators and treatment providers described 'recovery' as diverging from previous treatment models in three ways: 1. Recovery reflects a trend towards eliminating conceptual distinctions between mental health and substance use issues, as well as between different types of substance use issues and treatment models. 2. Recovery is based on a medical (disease-based) understanding of drug use problems (addiction) 3. Recovery is based on a view of substance use problems (addiction) and their treatment as encompassing all aspects of the individuals' life.

Technologies of Power (governmentality)

Foucault's conception of governmentality, though not entirely operationalized, is helpful towards understanding how recovery discourse functions within MMT. Governmentality, sometimes understood as technologies of power, describes the wide range of control techniques aimed both at controlling the self and towards the large scale management of populations (Foucault, 1991). Nickolas Rose writes that technologies of power are those "imbued with aspirations for the shaping of conduct in the hope of producing certain desired effects and averting certain undesired ones" (Rose, 1999). For Foucault, Technologies of Power are always contextualized through historically situated forms of knowledge, or regimes of truth, that function as their own form of power (power-knowledge). As such, MMT as constituted through

recovery discourse, functions as a technology of power that produces certain kinds of people.

Helen Keane writes in "What's Wrong with Addiction", that recovery discourse "translate[s] the

enigmatic desires and dissatisfactions of the individual into precise ways of inspecting oneself,

accounting for oneself, and working upon oneself in order to realize one's potential, gain

happiness and exercise one's authority" (Keane, 2002). Thus, power functions not only through

overt constraint, but through producing new ways of being that are often experienced as free

choices (though they are still forms of constraint). Keane argues that medical categories are

particularly imbued with this type of power:

> "Therapeutic authorities work in the service of liberty and personal choice, which
>
> ironically makes them more profoundly subjectifying than other more obviously
>
> oppressive forms of authority. Therapeutic authorities seem to emerge from inside
>
> ourselves, from our desires for happiness and striving for fulfillment. The
>
> understanding of freedom as a regulative norm provides a useful insight into
>
> recovery discourse, which urges troubled individuals to attain autonomy and find
>
> happiness through open-ended projects of self-examination and self-
>
> improvement" (Keane, 2002)

1. All Pathways lead to Recovery

The focus on recovery by government agencies is part of an effort towards

mainstreaming substance use disorders and treatment alongside other issues conceived of as

mental health problems. SAMHSA and OASAS administrators felt that in the past substance use

disorders had been seen as fundamentally different from more traditional mental health problems

leading to increased levels of marginalization and stigma for patients, treatment providers, and

drug treatment services in general. Moreover, within substance use treatment, conceptual

distinctions existed between programs using medication-based versus those using "abstinence-

based" treatment, defined here as programs that do not use medications as part of treatment

(usually methadone or buprenorphine), such as 12-step groups or therapeutic communities[6].

The new model positions recovery as the overarching goal for all substance use and

mental health disorders, and differences in treatment choices are seen as individual pathways

towards it. Thus, everyone is ostensibly pursuing the same outcomes as defined by the recovery

model. As SAMHSA's website explains:

"The process of recovery is highly personal and occurs via many pathways. It

may include clinical treatment, medication, faith-based approaches, peer support,

family support, self-care, and other approaches" (SAMHSA, 2014).

An individualist approach?

SAMHSA and OASAS administrators as well as local treatment providers actively

promoted recovery as being an individualist model, describing it as "less of a cookie-cutter

approach" and as a program that "the individual gets to define". However, this tended to apply

only to decisions regarding 'how' to pursue recovery, and not to patients' views on the overall

desirability of 'recovery' as a treatment goal. The ability of patients to exert agency over how

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[6] The term 'abstinence' is used in wide variety of contexts and its meaning can vary substantially. When referring to treatment programs, 'abstinence-based' can often mean 12-step programs like Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) that reject the use of medications, contrasted against programs like MMT.

their treatment was conceptualized or the overriding treatment goals, depended on whether, and to what extent, their views corresponded to the tenets of the recovery model. For example, administrators stressed that recovery could be pursued in a myriad of culturally appropriate ways and that characteristics such as race or ethnicity, religion, gender, mental health, disability, sexual orientation or gender identity should ideally inform a patients' recovery plan. However, when asked how the clinic would respond to patients whose goals conflicted with the recovery ideology – such as those who see MMT as a way to use less drugs or use drugs more safely (i.e. legally) – responses ranged from overtly punitive (the patient would be disciplined until eventually kicked out) to covertly punitive (counseling as to the 'rightness' on abstinence, disease model, etc.).

Some acknowledged the usefulness of harm reduction as a means of reaching out to patients or keeping them involved with treatment, and stated that a certain amount of drug use would be tolerated early in the patients' treatment, but it was always framed as a deviation rather than part of the patient's intended path. Others rejected harm reduction outright and relied upon discourses that position "the addict" as someone incapable of self-control or acting in their own best interests to justify this position. For example, when asked about patients who see MMT as a way of gaining stability and control over their lives without becoming abstinent, one treatment provider responded:

> "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. (Bigitschke, 2014)

Thus, patients who see their treatment as a means towards achieving recovery as defined

by the dominant discourse, were free to pursue it through a variety of culturally appropriate

strategies. However, those who conceptualize their treatment as a form of harm reduction – or in

any way outside of the recovery discourse – were seen by treatment providers either as liars and

self-deceivers, or as not yet ready for recovery, which was always seen as the true purpose of

treatment.

MMT as the most stigmatized

The focus on inclusivity is particularly relevant in regards to MMT since one of the

central distinctions within the substance use treatment community involves the legitimacy of

MMT as a treatment and/or form of recovery. Since MMT is often seen as fundamentally

different from treatment programs that do not use medications (such as 12-step groups),

individuals on the program have typically battled the view that they could not identify as being in

recovery because they were taking methadone. Administrators believed that the focus on

recovery as a universal among individuals with substance use and/or mental health issues would

reduce this distinction. Belinda Greenfield, OASAS's Director of Addiction Medicine & Self

Sufficiency Services explains:

"**Greenfield:** Specific to methadone, it's kinda fragmented… I think there's been

a lot of gains made over the recent years about people talking about their recovery

from addiction but not as often do we hear about people's recovery from

addiction using medication, and using methadone specifically. So when you

listen to recovering peoples' stories oftentimes there is no medication involved to

treat the addiction. Or you may hear 'I was in a methadone program but now I'm

no longer in a methadone program, and I'm drug free.

Frank: So methadone wasn't considered a form of recovery?

Greenfield: Right. And the way we speak about recovery and what we don't say

in relation to recovery, like for instance I may be in recovery and not share that

I'm on an addiction medication for fear of being stigmatized. We omit that

information or we don't even bring it up or don't include them, individuals that

are doing well but on an addiction medication as a part of them doing well. That

signifies that they're a part of the recovery community…. It is an important piece

for New York State to try and bridge that gap, to recognize that the use of

medications is another recovery path. It's no better or worse than the 'drug-free'

path. Actually, for myself, I try to remove the language around 'drug-free' versus

methadone maintenance because again it creates a hierarchy, it creates a

differentness. There shouldn't be that kind of thinking that says one person's path

to recovery is better than another's. (Greenfield, 2014)"

2. Recovery is based on a medical conception of addiction

Administrators from SAMHSA and OASAS as well as clinic counselors and treatment

providers clearly stated that their respective organizations view addiction as a disease and that

encouraging clinics and patients to adopt this view were essential parts of the organizations'

mission to promote recovery. As Greenfield states:

> "[The disease model of addiction] definitely for OASAS is first and foremost.
> That's how we reference it. That's how we label it. That's how we position
> ourselves and how we position the treatment services, is that 'you need to
> consider this as a chronic disease and look at it through the lens of a chronic
> disease'." (Greenfield, 2014).

Administrators' use of language also revealed a focus on presenting addiction within a

medical context. Problematic drug use was consistently described as a "disease", "disease-like",

or as a "medical issue", and medical terminology such as "relapse" and "remission" was used to

describe drug use events. Similarly, some administrators and treatment providers employed

analogies between addiction and diseases like Asthma or Diabetes – which often require lifelong

use of medication – to explain why being maintained on methadone does not disqualify patients

from the recovery label.

The Politics of Definition

Health and Illness scholars have used constructionist frameworks to argue that the

designation of behavior as "medical problems" or "diseases" is an inherently political act that

carries with it a set of fixed identities, power relationships, and codes of behavior (Conrad, 1980;

Zola 1972; Foucault 1988). As Conrad, who called this process the "Politics of Definition"

pointed out, "Medical work can lead to the creation of new norms whose violation is deviance,

or….. new categories of illness. This increases the jurisdiction of medicine or some segment of it

and legitimates the medical treatment of sick deviants." (Conrad, 1980, p. 23). Thus, the

institutional designation of certain forms of drug use as addiction, and addiction as a disease, explains the actions of the clinic through the logic of treatment. Disciplinary actions, intrusive forms of monitoring and surveillance, and the imposition of an ideology that may conflict with patients' own views, are all seen as necessary and for the patient's own good. Individuals who may conceptualize their relationship to MMT in ways outside of those delineated through the medical discourse – for example, those who see MMT as a harm reduction strategy for avoiding/minimizing their exposure to the forces of criminalization, including problems such as disease transmission or withdrawal; or those who see MMT as a way of stabilizing their lives without the attendant focus on disease and recovery - are positioned in opposition to the dominant ideology and likely to encounter increased levels of surveillance and discipline.

Although addiction-as-disease narratives are generally supported through appeals to science, post-structuralist and feminist science scholars (among others) have problematized notions of science as objective, linear, or trans-historical. They argue instead, that science is a historically situated narrative, based on specific epistemological practices, and socially constructed in much the same way as other forms of knowledge (Foucault, 1973; Barad, 2014). Moreover, health and Illness scholars have pointed out the political efficacy of scientific narratives, arguing that because science is associated with notions of objectivity and truth, the designation of a narrative as 'scientific' conveys significant cultural capital (Reinarman, 2005; Keane, 2002). Craig Reinarman demonstrates this in "Addiction as Accomplishment: The Discursive Construction of Disease" by pointing out the organizational push by Alcoholics Anonymous (AA) (and others) to "popularize the disease concept by putting it on scientific footing", noting that "science was not the source of the concept but a resource for promoting it" (2005: 313).

Rienarman also uses social learning theory to examine how addiction-as-disease models are taken up by individuals entering treatment (Rienarman, 2005; Weinberg, 2000). Such individuals - who enter treatment either through state compulsion or "voluntarily"[7] - must adopt a particular frame of reference for understanding their drug use based on addiction-as-disease narratives. Echoing Goffman, Foucault, and Szasz, Reinarman's account illustrates how treatment is often structured to reward and punish individuals based on their willingness to accept the institutional narrative (Reinarman, 2005; Goffman, 1968; Foucault, 1973; Szasz, 1961). "Addicts" participate in a performative process where they learn to describe their newly reconstituted life stories utilizing the linguistic rules of disease discourse. While not denying the lived experience of drug users in treatment, Rienarman argues that "What are taken to be physiological-pharmacological effects do not present themselves to users in some raw, pre-categorical form, without the linguistic encasements provided prior to ingestion by culture (Reinarman, 2005: 316). Thus, addiction-as-disease narratives are re-produced both institutionally and through individual accounts, which are themselves co-constitutive of one another.

Obscuring Structures

Scholars have also recognized that the tendency for disease narratives to focus on the individual as the site of intervention necessarily obstructs the role of structural factors (Clark, 2014; Reinarman & Levine, 1997; Crawford, 1980). According to the logic of the disease model/recovery narrative, the problems that brought individuals to MMT are strictly the result of their disease, addiction, which – whether conceptualized as biological, spiritual, or behavioral (or a combination thereof) – conceives of the problem as an individual one. The contextual reality

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[7] The contextual reality of prohibition and the war on drug users complicates notions of volition in regards to individuals entering substance use treatment.

of prohibition as a force of harm in illegal drug users' lives, and one that drives them towards the relatively safer space of quasi-legal opioid use within MMT is obscured from the model. Thus, the recovery narrative implicitly supports prohibition by reifying the belief that drug use problems are the result of individual level diseases and not related to how the state polices substance use/ers, thereby justifying a variety of medico-punitive responses to illegal drug use including MMT.

The designation of MMT's function as the medical treatment of addiction is also problematized by the many alternate narratives that conceptualize the program differently. Harm reduction advocates, drug user rights groups, and others have focused on the pragmatic benefits of MMT including reduced rates of prisoner recidivism, reduced rates of blood-borne disease transmission, and as a means to stabilize one's life (Joseph, Stancroft and Langrod, 1999; Drucker et al. 1998; Langendam et al. 2001). A study of individuals on MMT in the UK found that while the majority of people on MMT are seeking abstinence, significant numbers report 'reduced drug use' and 'stabilization' as their primary treatment goals (Mckeganey et al. 2004).

Moreover, social theorists like Chris Smith have used anarchist concepts like *autonomous zones*, to argue that harm reduction efforts provide criminalized groups with spaces (physical, ideological, etc.) that exist outside of the dominant power structure (2012). He cites underground crack kit distribution, peer-based naloxone distribution, and illegal Safe Injection Facilities (SIFs) as examples of harm reduction's true anarchist spirit, thereby problematizing clear-cut notions of rule breaking and rule following for criminalized groups and individuals. Smith's approach is important since it recognizes the many ways that criminalization and the War on Drug Users complicates notions of freedom and volition for drug users in treatment, pointing out that harm reduction is, at its core, an attempt to carve humanizing spaces out of a

punitive landscape. In this context, MMT is not necessarily (or only) a place of treatment, but a refuge where drug users can avoid the harmful consequences of criminalization and experience greater levels of agency of over their drug use choices. Behaviors such as faking a drug tests to avoid dismissal, which are seen as rule-breaking or even crimes by the recovery discourse, are re-cast by Smith as manifestations of survival and resistance in a regime that actively targets drug users (2012).

Describing the disease

Reflecting the varied and complicated landscape of substance-use-as-disease models, participants drew upon a combination of disease theories to describe addiction. Although some were based in part on the neurological disease model advocated by the National Institute of Drug Abuse (NIDA) that conceives of addiction as a neurological pathology, most accounts reflected a more behavioral, spiritual, and metaphysical view. Typically when neurological models were invoked, participants supported their views with references to science that positioned current treatment practices as the product of technological advances which have finally revealed the truth about addiction and its proper treatment. As one clinic director explained "With the newer science, with imaging, and things like that, seeing how the brain actually does change, there's a lot more scientific consensus that addictive behavior over time changes the actual way the brain works." (Sheerin, 2014). Yet, as the interview continued, his view diverged from the classic neurological understanding of addiction as a chronic, lifelong condition towards a model that better incorporated the possibility of recovery[8], stating "However, the biological, medical piece of permanence of condition which necessitated the belief that people had an addiction for life has

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[8] It is unclear whether the participant was referring to recovery as the eventual cessation of methadone maintenance or if he was including individuals maintained on methadone as being in recovery.

changed over the years because of the finding that in certain types of addictive or dependent behavior, people do enter recovery for extended periods of time." (2014).

Most treatment providers' responses reflected a view of addiction that is primarily behavioral and spiritual, rather than pharmacological. For example, Larry Taub, Director of residential services at the Lower East Side Service Center, stated:

"Recovery is a productive lifestyle that's not drug involved. All of the things that the Big Book would say is recovery we would say is recovery…. [Spirituality 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. The therapeutic community is your local 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" (Taub, 2014)

However, Taub, despite this view of addiction, still utilized the neurological disease model as a tool for moderating addicts' shame and encouraging individuals to pursue recovery. He 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…. I think it's [the neurological disease model]

an incorrect way to talk, but I find it's absolutely critical for the following reason,

and ok for the following reason, that one of the reasons [that] people don't

approach recovery is shame and guilt. If you allow the disease concept talk to

happen, it mediates shame and guilt and removes a barrier to getting to

treatment." (Taub, 2015)

Treatment providers also utilized a number of themes and concepts associated with 12-step groups to understand and explain the disease of addiction. Concepts like the 'dry drunk' are traditionally associated with 12-step groups' and speak to addiction as a spiritual and behavioral 'disease of the will' rather than a neurological disorder. Similarly, the importance of community and self-reconstruction, which fit more easily within a behavioral model, also attest to the amalgamated and slippery character of recovery discourse within MMT.

"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,

like for example, not engaging in criminal activity." (Vick, 2014)

Reinarman (and others) have addressed the particularly amorphous character of addiction-as-disease discourse, calling the history of disease theories of addiction a "conceptual acrobatics" (2005). It is this difficult-to-pin-down quality, he argues, that makes addition-as-disease narratives so easily applied to a variety of seemingly unrelated phenomenon, that now includes shopping, love, gambling, internet use, and the need for human contact. Yet, even when

focusing on drug use alone, Reinarman argues that "the complexities of drug-using behaviors continue to defy rigorous categorization under the heading of addiction-as-disease" (2005).

The role of Stigma

The use of the disease model as a conceptual scheme for understanding addiction was seen by many as a strategy for reducing stigma attached specifically to methadone within the drug treatment community. Thus administrators echoed a common claim among MMT advocates within the recovery movement that if addiction were accepted as a disease, methadone would be better accepted as treatment. A SAMHSA administrator explains:

> "When they start seeing it as an illness, and like all other illnesses have
>
> medication attached to it, that help people to get better, then they start talking
>
> about the different pathways to recovery, and one of those pathways is medication
>
> assisted treatment" (Wilma, 2014).

Scholars have been critical of claims that medicalization can liberate behavior from morally-based forms of stigma, arguing that biomedical models of causation encourage essentialist thinking (Haslam, 2011; Phelan, 2005), and can lead to stereotyping and prejudice (Bastian and Haslam, 2005). In a meta-analytic review of biogenetic explanations' effects on stigma, Kvaale, Haslam & Gottdiener found that medicalization does not cure stigma and may create barriers to recovery by setting the stage for a self-fulfilling prophesy (2013). Moreover, scholars focused on the medicalization of drug use (and other behaviors) have problematized the binary that positions medical and moral approaches to deviance as dichotomous, with medical models generally seen as progressive in contrast to moral models which are viewed as punitive

and conservative (Tiger, 2012; Reinarman, 2005). In her study of Drug Courts - a program based on a "medical model" and often cited as a progressive policy response to addiction - Rebecca Tiger demonstrates how the medical and moral/punitive models are often more collusive than oppositional (Tiger, 2012). Similarly, Nancy Campbell argues that recovery discourse positions those unable or unwilling to adopt it's tenets as "embody[ing] a threatening moral contagion" (p. 243) and Reinarman points out that "addiction-as-disease has just as often been a discursive weapon wielded by a state that has declared war upon citizens who ingest disapproved substances" (317).

3. Recovery is all-encompassing

"Although sobriety is considered to be necessary for recovery, it is not considered as sufficient."

(The Betty Ford Institute Consensus Panel, 2007)

Administrators and clinicians as well as government websites and educational materials stress that recovery is about much more than the discontinuation of substance use. Reflecting the addiction-as-disease narrative that sees addiction as multi-faceted problem of the self that involves biological as well as moral, spiritual, and behavioral issues, the concept of recovery is equally totalizing. Specifically, treatment providers and administrators focused on community, spirituality, and a general sense of morality to describe the extra-abstinence aspects of recovery:

> "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' (Wilma from SAMHSA, 2014).

In line with this shift, SAMHSA and OASAS's recently adopted the term "Opioid

Treatment Program (OTP)" to replace a variety of other terms that focused more specifically on

methadone. The new acronym positions methadone maintenance as just one of the many aspects

of a comprehensive Opioid Treatment Program:

> "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." (Greenfield,
> 2014).

A normative construction

Based in part on the BFI's 2006 definition, SAMHSA has established a working

definition of recovery as "a process of change through which individuals improve their health

and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA 2012)[9].

Here, recovery is comprised of four major dimensions: Health; Home; Purpose; and Community

that reflect normative conceptions about proper ways of living and how bodies should function.

For example, SAMHSA's definition of Purpose as "Meaningful daily activities such as a job,

school, volunteerism, family caretaking, or creative endeavors, and the independence, income,

and resources to participate in society" (SAMHSA, 2012) is not only based on the assumption

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[9] OASAS's website offers a similarly all-encompassing definition insisting that recovery "goes beyond abstinence alone to include a full re-engagement based on hope, resilience, health and wellness, and includes family, friends and community. Recovery starts when a person begins to make better choices about his or her physical, mental and spiritual health." (OASAS, 2015)

that activities such as volunteering or maintaining a job are meaningful activities that reflect an individual's purpose, but also obscure the hierarchical reality of our society where access to income and resources are unequally available. Similarly, Health is presented here as an uncomplicated and universal concept, rather than a reductive and normative one that can be made to support any number of lifestyle choices included using, or not using drugs (Keane; 2002). SAMHSA's focus on home, purpose, and community also reflect a particular set of (neoliberal) values that position the drug treatment services user as a consumer, decontextualized from structural constraints, who should desire the 'right things' as established by the recovery discourse.

The emergence of the Unwalled Prison

The treatment culture's focus on the whole person can be seen as a modern iteration of what Erving Goffman called the "Total Institution" (Goffman, 1968)[10]. Goffman used the term to describe mental institutions (as well as other confined places) that control all aspects of their inmates' lives. Total Institutions subject their charges to a highly regimented system of scheduling and regulation based upon the official aims the institution, and intended to remove their sense of self and individuality, ostensibly to be re-configured as someone who "will maintain the standards of the establishment of his own accord after he leaves the setting" (1968). Thus Total Institutions were places where individuals classified as deviants, could be re-made according to normative standards. While Goffman's description is largely focused on aspects of spatial constraint reflecting the physical removal of the 'mentally ill' that was common before

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[10] Szasz, Foucault and others have used similar models to critique the medical establishment's ability to constrain individuals both physically and ideologically (power-knowledge).

deinstitutionalization, much his focus on surveillance, regimentation, distinct social roles and power imbalance, applies to the world of MMT under recovery. Individuals are broken down, or mortified, in order to create "'good patients' who are dull, harmless and inconspicuous". (1968).

A changing clinic culture

The emphasis from federal and state agencies on recovery as an all-encompassing treatment model has led to changes in the clinic culture as well as in the services they are expected to provide. One of the biggest changes involves the clinics' increasing concern with monitoring their patients' non-opioid drug use[11]. Although clinics have some amount of latitude regarding what drugs to test for and how to handle failed drug screens, the recovery discourse positions all forms of substance use, or behaviors thought to be related to addiction more generally (gambling, 'co-dependent' relationships, etc.), within the clinics' mandate and jurisdiction[12]. Punishment for non-opioid drug use nearly always results in patients being denied takehomes, but can also be used to justify discharging otherwise compliant individuals despite evidence demonstrating that most discharged patients do poorly (Knight et al. 1996). When asked if patients were allowed to smoke marijuana and remain in the program, Jeffery Sheeran from Montefiore Medical Center responded:

> "No 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, ect. that has ongoing use that interferes
> significantly with their health or treatment. We do include marijuana as well as
> alcohol." (Sheeran, 2014).

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[11] From a pharmacological perspective, methadone is only effective as a treatment for opioids.
[12] Some clinics – typically those who ascribe to a harm reduction approach – are more tolerant of drug use, believing that patients are still benefiting from their participation in the program.

Here, the logic of recovery's all-encompassing mandate, reflected through Sheeran's use of the term 'substance abuse treatment program' rather than 'methadone maintenance treatment program' justifies the clinic's intervention in a much wider range of behaviors. Pushing the clinic's jurisdictional boundaries even further, some treatment providers argued that their mandate goes beyond drug use to include anything the counselor perceives to be unhealthy for the patient:

> "Yes we are an opioid treatment program but we're here to address all of your addiction[s] and I tell them '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." (Bigitschke, 2014)

Treatment providers admitted that the changes have led to significant problems for some long-term patients who resented the clinic's new found concern with their use of alcohol, marijuana, or other non-opioid drugs:

> "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. 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 everyday smelling of alcohol. We're gonna talk about how that impacts your health. So these patients who have

been doing this for years are now like 'What are you talking about?!'"
(Bigitschke, 2014).

The recovery model also involves the implementation of more contact between patients and counselors. Whereas previous incarnations of MMT were characterized by clinicians as long lines of patients, who would immediately leave after receiving their medication, the recovery model required a great deal more:

> "It's no longer just coming in and getting your dose, your medication. They have
> to do therapy, they have to do individual counseling, they have to go to group. So
> there's certain requirements that used to not exist and they've started implement
> in the last 3 to 5 years. Back in the day, ten years ago, you would just go and get
> your medication, sip, drink, maybe give a urine, and then you'll have maybe a
> monthly tox, a monthly session. And that was the norm. You saw the patient once
> a month you know 'You good? You ok? Everything good?'. Now the counselors
> are expected to see the patients based on where they're at. They come in and
> during the first ninety days of treatment they're expected to be seen weekly. They
> are expected to go to group" (Bigitschke, 2014).

While treatment providers admitted that the change is experienced by many patients as a negative, it also meant that many clinics were able to offer more services than had been previously available. Although clinics varied in the services they provided beyond those required by state and federal regulations - which generally relate to the number of required counseling sessions – recovery-oriented grants have incentivized clinics to incorporate greater amounts of services (SAMHSA, 2015; OASAS, 2015[2]). Moreover, clinicians universally described a cultural shift in substance use treatment services whereby the clinic was increasingly seen as a hub for patients' needs, often referred to as a "one-stop-shop." Some of the larger clinics incorporated a surprising amount of services including: medical care; cooking areas and

equipment; laundry; television rooms and recreational space; as well as help with accessing social services and links to numerous other agencies:

> "[We're] moving towards a more comprehensive model that incorporates lots of different other things that people can be doing to help themselves, and to better themselves, and to feel good about themselves, and lead healthier lives. There's a lot of conversation around wellness services. It could be nutrition, it could be acupuncture, it could be yoga, meditation. And using, other than the typical individual/group counseling services as a way of supporting peoples' individual recovery path." (Greenfield, 2014)

> "We have a wrap-around service that includes primary medical care in addition to counseling, psychiatric, vocational, and nutritional. 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 which affects their health." (Sheerin, 2014)

Although SAMHSA and OASAS administers characterized many of the additional services as 'tools in a toolkit' rather than requirements, they are nevertheless becoming institutionalized. While patients might not be punished for refusing to attend yoga lesions (yet), they will be assessed for their willingness to participate in recovery-based activities, yoga being one of them. Similarly, clinics will be assessed by SAMHSA and OASAS (in New York State) regarding their implementation of recovery-based services. Thus, the focus on extra-abstinence activities becomes increasingly normalized through subtle, innocuous, and nearly invisible changes in policy that radically restructure the treatment model and patient experience.

Treatment providers admitted that many of the clinic changes are being driven by changes in insurance. The increasing focus on addiction-as-disease, and recovery as its treatment has enabled more people to access greater amounts of services. But it also contributes

to the expanding jurisdiction and promotion of medical services. Clinic director, Carol Roberts Matthews explains:

> "When you talk about changes that will be occurring in these programs you have to look at the information on insurance. The insurance is changing: managed care, Medicade, it's actually driving the changes. It's not that we're not gonna provide services but it's how we get paid for services, and so it's gonna direct and change how the clinics will be re-vamped and re-structured….. OASAS has new instruments that we will be using.. We'll be looking at the identifiers, the psycho-social needs of the patient, and sometimes, although we think they will fit the needs of our program, this tool will say maybe [they] need a higher level of care or a lower level of care, so they may not be able to get into our service and that will be driven by, that's where the managed care companies will come into play."

The role of 12-step language and concepts

Treatment providers made significant use of 12-step language and concepts to justify the recovery model's more intrusive focus. Concepts such as the 'dry drunk' or 'stinking thinking' not only reflect the clinics' power to interpret and categorize often highly subjective behaviors, but also demonstrate the wide jurisdictional boundaries of the addiction-as-disease narrative. The totalizing view of disease/recovery adopted here allows treatment providers power in areas extending beyond those traditionally conceived of as "medical" and presume access not only to behavioral issues, but to meta-physical aspects of their patients' inner-lives.

> "It's 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'." (Bigitschke, 2014).

As the quote demonstrates, the focus on extra-abstinence behavior within recovery is so powerful that patients expecting privileges on the basis of abstinence alone are sometimes positioned as ridiculous. Moreover, the discourse of recovery invoked here is based upon, and actively constructs a particular view of 'the addict' as a wholly compromised person rather than an individual seeking to reduce, eliminate, and/or manage some forms of drug use. The narrative presents "addicts" as a monolithic category, and one that is wholly incapable of knowing what is best for themselves, which justifies denying them agency over their treatment.

Conclusion

Government organizations who deal with substance use issues are re-framing treatment to focus on recovery. The new paradigm is purposely open-ended to make recovery accessible to a wide range of people, but is grounded in a disease model of addiction that includes aspects of the neurological model as well as moral and spiritual conceptions of disease associated with 12-step organizations. Government administrative organizations and local treatment providers (clinics) see recovery as a means for bridging conceptual distinctions between substance use and mental health disorders/treatment, and between different modalities for treating substance use disorders. They are focused in particular on mainstreaming MMT (and other MATs to a lesser extent) which they argue, have been ghettoized within the drug treatment community resulting in high levels of stigma for patients, treatment provides, and the treatment in general. Although administrators and clinic employees saw recovery as a more individualistic model, this applied only in regards to making the treatment culturally sensitive and available to a diverse clientele rather than allowing patients agency over their treatment.

While all of the administrators and clinicians framed addiction as a disease or medical problem, they used a combination of neurological and behavioral/spiritual models to describe it. Most positioned medical approaches to drug use in contrast to moral and/or criminal ones, and believed that the acceptance of addiction as a "medical problem" or "disease" would work to remove stigma from people who use drugs. Treatment provider's descriptions of addiction-as-disease, however, tended to focus primarily on behavior and meta-physical concepts like spirituality. The construction of illegal drug use as addiction, and addiction-as-disease supported the efforts of the clinic to promote recovery as the primary focus of MMT and treatment in general. Medical conceptions of addiction and treatment also provided ideological support for clinics' intrusive and punitive practices complicating the commonly accepted view that medical approaches to drug use are distinct from moral/punitive ones. Administrators at the clinic level focused less on neurological conceptions and were more likely to describe addiction in behavioral and spiritual terms.

Recovery was also seen by government agencies and treatment providers as a totalizing process of self-reconstruction that went beyond the discontinuation of certain kinds of drugs. Methadone clinics are increasingly seen as one-stop-shops where patients can access numerous social services as well as information on nutrition, healthcare, and other services seen to be important to recovery. Individuals on MMT are increasingly assessed according to standards like community involvement, spirituality, and health generally, which were all understood normatively. Similarly, concepts traditionally associated with 12-step groups are used more frequently in reference to MMT. Thus, MMT under recovery is conceptualized as a program designed to re-structure the entire person rather than a program to treat a particular category of drug use behavior. Individuals who conceptualized their treatment in ways outside the recovery

discourse tended to encounter problems with their clinic councilors sometimes leading to

punishment and/or dismissal.

Chapter 4 -
Experiencing Recovery: The Decontextualized drug user

People on MMT (either currently or within the last two years) expressed a wide variety of viewpoints regarding the role, and importance of recovery in MMT[13], yet nearly all of the participants reported an increasing focus on recovery within their clinic. Specifically, they described the increasing use of recovery language in their interactions with clinic counselors and staff, and a growing pressure to conceptualize their own drug use through the disease model and a desire for recovery. Many also reported that their clinic had implemented stricter rules regarding illegal substance use and/or drinking alcohol, and become a more intrusive force in their day-to-day lives.

Interviews with people on MMT also problematized the view of recovery as a flexible, patient-centered model, capable of meeting the needs of a diverse population of drug users who have very different drug use experiences, and who conceptualize their drug use and treatment goals differently. Individuals with drug treatment goals that contrasted with the recovery model, such as harm reduction, were seen by other patients as unready for treatment or as taking advantage of the program and hurting those who were using it "correctly". This is partly because recovery is based on a decontextualized understanding of illegal drug use that ignores prohibition and the War on Drugs as a driving force in drug users' treatment decisions. Drug users regularly involved themselves with MMT as a way of managing, or potentially escaping the day-to-day difficulties of illegal drug use, and only adopted the language of recovery through exposure to the recovery-based treatment culture. Similarly, participant responses suggested that the

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[13] This may be due, in part, to the high level of diversity among methadone clinics in the United States where the multi-layered system of regulation – including federal, state, and local agencies – produces significant differences in individual clinic policy and culture (SAMHSA, 2015)

recovery discourse functions, in part, to obscure the role of structural factors in the problems

drug users' experience, in favor of a view based on individual pathology.

Although all of the participants recognized, to some extent, the institutional push towards

a recovery-based culture, and the increasing use of addiction-as-disease narratives within MMT,

participants can be divided into three different subsets reflecting their responses to the emerging

recovery discourse. Participant responses did not always align perfectly with only one distinct

category, rather these are intended as 'ideal types' which represent the primary claims and

positions of each subset. Specifically, there were: 1. Supporters: participants who supported the

move towards recovery and lived according to its tenets; 2. Resistors: participants who directly

challenged the recovery model; and 3. Negotiators: participants who supported the shift towards

recovery but whose descriptions of how they used and benefited from MMT conflicted with a

recovery-based approach to substance use treatment.

1. Supporters: Supporting the move towards recovery and living by its tenets

Approximately one quarter of the participants on MMT both supported the move towards

recovery, and also reflected a recovery-based ideology in their personal accounts of drug use and

treatment. These were individuals who had discontinued both illegal substance use and drinking

alcohol, and who, in most cases, self-identified as being "in recovery". Supporters who chose

not to self-identify as being "in recovery", said that they were so removed from the world of

illegal drug use that it was no longer a part of their identity whatsoever, yet their behavior and

view of drug use aligned with those of the recovery model.

A hegemonic understanding

Supporters adopted the hegemonic understanding of recovery as grounded in complete

abstinence from "drugs" and alcohol but also incorporating a focus on community, citizenship,

and spiritually – all understood normatively. This conception of recovery as a fundamental

change in personhood is reflective of the current recovery movement within substance use

treatment settings whereby individuals seek to re-make their entire lives in contrast to their

previous addict-selves (SAMHSA, 2015[3]; MARS, 2016; Keane, 2002; White, 2007; White,

2000;). The following responses are typical of Supporters' views on recovery as encompassing

more than the discontinuation of certain types of drug use:

> "To me, it's [recovery] not just not using drugs, it's changing my attitude,
> behaviors, who I hang out with, the way I present myself, the way I live everyday.
> Cause now I try to help people. I try to do what people did for me when I was
> struggling, and that helps me stay clean." (John, 2016)

> David: How do you define 'recovery'?
> Gene: I define it [recovery] as working, living life in society, raising a family if
> that's the case and being part of society.
> David: Would abstinence be required to be in recovery?
> Gene: yeah, absolutely.

Although recovery is presented here as an uncomplicated (and even objective) diagnostic

entity, its reliance on normativity problematizes that view. Since the definition of recovery

includes things like work, school, and being perceived as a good citizen, it obscures the

hierarchical nature of our society where access to monetary and other forms of capital are

dispersed unevenly and often along racial and class lines. For example, since African Americans

and Latinos are less likely than whites to be employed (US Dept. of Labor, 2016), they will be

similarly disadvantaged in regards to assessments of recovery. Thus social and cultural

inequalities become embedded within the seemingly objective term, giving it the power to discriminate without appearing to do so. Scholars have argued that in the post-civil-rights era, racism functions most often through ostensibly race-neutral language and policies like these (Doane & Bonilla-Silva, 2003; Bonilla-Silva, 2001) and Reinarman and Levine make a similar claim in regards to racialized sentencing policies that distinguish between crack and powdered forms of cocaine (1997).

Recovery also institutionalizes normative ideas about how to live properly, such as community participation and spirituality, which are far from universal. By linking addiction to such vague and subjective markers as choice of friends, the importance (or meaning) of altruism, and/or maintaining the "right attitude", recovery becomes a powerful tool for the enforcement of norms. Moreover, since it is based on a totalizing conception of wellness with a limitless jurisdiction in regards to re-making the self, recovery-based discourses could easily be applied to any number of personal lifestyle choices including: choice of romantic partner, membership in particular organizations, or voting.

Science and the disease model

Supporters also conceptualized their drug use through the lens of the disease model. Moreover their accounts of addiction were similar to those of treatment administration organizations like Substance Abuse and Mental Health Services Administration (SAMHSA) and New York state's Office of Alcoholism and Substance Abuse Services (OASAS), who rely upon an intentionally flexible conception of addiction based in the medical model but incorporating biological, spiritual, and community-based components. Thus, participants from this subset utilized various combinations of addiction-as-disease theories to understand their drug use and its treatment. For example, in the following interview portions, Nadine stresses the genetic

component of addiction and feels strongly that it is a disease, while Marshall, who prefers the term "illness" sees addiction more in terms of actual damage to his brain through early childhood drug use.

> David: When you think about addiction, do you think of it as a disease?
> Nadine: Yes! Yes, it is a disease! It is. It is a disease.
> David: Ok, tell me more.
> Nadine: It's a disease because, like I said, my father was an alcoholic. And I think it's because different people, like their mother or father, or somebody in their family has had this disease before. And that's why I feel that it's a disease.
> David: Because of genetics?
> Nadine: Yes, genetics. It could be to alcohol or pills or whatever.

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

Part of Supporters addiction-as-disease narrative involved establishing conceptual distinctions between heroin and methadone. Although they are pharmacologically similar – a quality that enables methadone's use in MMT – Supporters positioned methadone as a "medicine", discursively the opposite of heroin, the "drug" that it treats. When describing how MMT worked, most avoided narratives that stressed methadone's role as a substation medication, i.e. one whose efficacy is based on its similarity to heroin and other illegal opiates, and instead used discourses that positioned methadone as an active medicinal agent, working to repair the harm caused by heroin (and/or other illegal opioids). As Chad, a patient who also organizes for recovery-based advocacy groups confidently stated: "Methadone actually allows an endogenous system in the brain, a natural system, to heal." (Chad, 2014)

Like clinic and government administrators, Supporters also used notions of science as a means of legitimizing the disease model and marginalizing those who hold opposing viewpoints. Despite the high level of disagreement among scholars on any unifying of theory of addiction, as well as numerous critiques of the disease model (see for example Keane, 2002; Buchman, 2010; Reinarman, 2005; Courtwright, 2010), science was presented as a monolithic entity with uniform views that were seen as 'truth' by definition. When I asked Chad about criticism of the disease model, or other ways of understanding drug use, he answered:

> "Every credible academic, medical, and research organization in the world does agree [that addiction is a disease]. What I say to them is: there is no 'disease model', there is no 'disease theory'. If we are people that believe in science, it's a fact." (Chad, 2014)

Power dynamic and reduced agency

Such responses, however, must be understood contextually within the coercive power dynamic between patient and treatment provider. As Goffman and others have pointed out, institutions exert ideological pressure upon their charges to accept the dominant narrative (1963; Foucault 1988). Reinarman focuses specifically on this "pedagogical process, in which addicts-to-be learn the lexicon of disease/recovery from counselors, therapists, judges, probation and parole officers, treatment providers, and other addicts" in his analysis of how the disease model is produced by specific actors and institutions (Reinarman, 2005: 315). This is particularly the case for populations like "addicts" or people diagnosed with a mental illness since they have a reduced level of agency in regards to avoiding said institutions. For example, some people must attend methadone maintenance clinics by court order and face potential jail time for non-compliance (Brecht, Anglin & Wang, 1993) and even those who attend MMT 'voluntarily' are operating within the context of criminalization which complicates notions of volition in regards

to choosing to attend (or not attend) substance use treatment. Thus participant responses, particularly when they align so closely with the dominant institutional narrative, may be read as evidencing the internalization of the disease model, as much as a patient's actual views on the phenomenon – indeed, the context of constrained agency for illegal drug users blurs the line between the two.

Othering

Individuals from this subset also saw the tenets of the recovery model as a hierarchical means of determining which patients were "there for the right reasons" and others, who needed to be purged from treatment. They were very against the notion that MMT could or should be used as a way of reducing harms in the lives of active drug users, and felt that anyone not pursuing abstinence-based recovery had no place in the program. For example, the following responses are representative of Supporters' views on patients using MMT for pragmatic or harm reduction reasons.

> "If you're trying to use [illegal drugs] and be on MMT, you're only fooling
> yourself and eventually you're gonna get caught anyway…. And that [using
> heroin while on mmt] defeats the purpose. It defeats the purpose, if you're on
> methadone, why do you need to use heroin. It doesn't make sense. To me it
> doesn't……It's a privilege to be in maintenance. It should be a privilege that you
> earn. It's only right that they do that [kick people off for using drugs]" (Nadine,
> 2014)

> "Listen, everybody screws up, everybody slips, I'm not saying that [they should
> be kicked off the program for that]. But if that's the reason they're getting on [to
> reduce the harms of drug use rather than pursue abstinence-based recovery] then
> 'no'" (Francine, 2014)

Thus, those in support of recovery reflected the institutional viewpoint that individuals utilizing MMT for pragmatic reasons, or as a form of harm reduction, were either not ready for treatment or that they were trying to cheat the system. Koester, Anderson & Hoffer reject this interpretation in their qualitative study of what motivates heroin users to enter MMT (1999). The authors found that in contrast to the all-or-nothing view advocated by the recovery model, heroin users often engage with MMT to manage rather than discontinue their drug use. They characterize MMT as a pragmatic strategy utilized in multiple ways by a highly criminalized population with very limited options. The authors point out that "before discounting the methadone treatment attempts of street users who continue to use illicit drugs as illustrations of their manipulative behavior or 'lack of readiness' for treatment, we consider both the immediate benefits of these treatment interludes in reducing other risks associated with the addict lifestyle, in temporarily improving an addict's quality of life, and possibly acting as pilot tests for an addict's eventual long-term commitment to treatment." (p. 2151). They argue that we should consider "drug users' own models of drug use and treatment" and that "these addict-led adaptations of methadone maintenance treatment may encourage us to rethink what we mean by 'successful' treatment" (p. 2151).

Interestingly, despite their support of the disease model, most advocated punishing individuals for drug use, problematizing the claim that medical and punitive models are disparate, and dichotomous approaches to drug treatment. Although those in support of the recovery model consistently positioned MMT as a form of healthcare, it was described as a particularly punitive one that must be earned by accepting the dominant narrative and behaving as proscribed, or else. This aligns with Rebecca Tiger's analysis of Drug Courts, another form of drug treatment ostensibly based on a medical model, but whose actual approach combines a

complicated alchemy of medical and punitive approaches to controlling the behavior of drug users (Tiger, 2012). Similarly, by describing MMT as a "privilege that must be earned" Supporters framed it as a benevolent and paternalistic intervention that drug users should be thankful for rather than critical of. This framing of the program positions any critique of the system as a selfish attempt to bite the hand that feeds.

Moreover, because participants from this subset see individuals using MMT for harm reduction as giving a bad name to "legitimate" patients, they often advocate reporting them to clinic staff. This not only results in the marginalization and dismissal of numerous patients who benefit from MMT, but has also contributed to a combative environment at clinics as well as on MMT-based web forums where such issues are sometimes discussed.

2. Resistors: Directly challenging recovery

Other participants, particularly those with greater exposure to harm reduction and/or drug user rights activism, directly challenged the recovery discourse. These participants, who also accounted for approximately one quarter of the MMT patients, were particularly critical of the disease model of addiction. They challenged addiction-as-disease narratives in a number of ways, but most often by arguing that drug use is a highly diverse activity and that outcomes are influenced by a multitude of variables. Resistors relied upon their own experiences with drug use and treatment to illustrate the reductive quality of addiction-as-disease narratives, pointing out how the difficulties they encountered as a heroin or prescription opioid user (and consequently, what MMT alleviated) often involved problems associated with prohibition such as the scarcity/high price of illegal drugs and/or the threat of violence and arrest rather than just the pharmacological effects of using opioids. Thus, many saw MMT not as a medicine used to

treat the disease of addiction, but as a pragmatic means of avoiding or minimizing the harms of *illegal* opioid use:

> "[As a heroin user, you] Gotta hustle to get that money and I wasn't taking care of my girl or me, and it's just rough. It was rough…. [I got on MMT to] stop that hustling, that was the main reason. That everyday, three times and four times, trying [to get] money to supply me and my girl, it was too much. Too much." (Grace, 2016)

> "I think it's [heroin] the healthiest drug you can possibly take. The drawbacks are the cost and the system you have to go through to get it. It's all the imposed stigma that creates the detrimental aspects." (Pauline, 2014)

Others criticized the disease model by arguing that while everyone experiences problems and difficulties, drug users' problems are artificially constructed as evidence of a particular theory of addiction. As one participant responded when asked about recovery.

> "I have never considered myself in recovery because I don't believe that anybody is perfect. I've lived with a lot of different people, whether they're roommates, mother or father, brother, and they've all had their own problems. Some of them have been [with] substances, and some have been, in my opinion, worse than that." (Barry, 2014)

Harm reduction vs. recovery

Resistors often positioned recovery and harm reduction as oppositional ideologies within substance use treatment. This was most often the case when participants had been exposed to, or were personally involved with, harm reduction politics. For example, Pauline, who has a long history of involvement with the harm reduction movement used that experience to reject the identity of 'addict-in-recovery'. Although she has been abstinent from illegal drugs for many

years, when asked if she defined herself as being in recovery, Pauline differed, emphatically declaring herself a "total harm reductionist":

> "Never, never, because I was not sick. I was using responsibly. I never missed work, I never was irresponsible, I always paid my bills, I took care of shit and I was not sick and I didn't need to recover. I'm a total harm reductionist........I don't believe in it [The disease model of addiction]. I believe it's [drug use] a choice. I believe it's a totally reasonable choice, it can be a responsible choice. I do recognize that there are people who don't use drugs responsibly, there's people who I believe can't use casually, just like with alcoholics…. But that said, I think for most people, it's a choice. It can be a responsible choice, and one that enhances your life and your abilities." (Pauline, 2014).

Pauline's focus on harm reduction as a means to reject the recovery label and its association with the disease model of addiction is interesting since harm reduction is, in many ways, a medicalized response to drug use (and other behaviors seen as involving risk). However, her response illustrates the strong current of resistance in harm reduction to any universal theory of addiction, particularly one based on individual pathology. While there are undoubtedly disease model advocates who value harm reductions' less punitive approach (for articles on attempts to merge the two approaches see: Futterman, Lorente & Silverman, 2004; Marlatt, Blume & Parks, 2001; and Kellogg, 2003), most harm reductionists are interested in shifting the addiction (or drug use problems) discourse away from looking at 'individuals with a disease', and towards one that supports the "rights of people who use drugs" (Harm Reduction Coalition, 2016). Thus, many harm reductionists resist the increasing use of medical rhetoric to address the etiology of drug users' problems and focus instead on criminalization and the War on Drugs.

However, her use of normative and subjective markers of success, like paying bills and not missing work, to argue that she is not an addict complicates the narrative. Whereas harm reduction has traditionally avoided the use of such categories as a proxy for addiction, preferring instead to "meet the client where they're at", the recovery paradigm has embraced them. Thus while Pauline declares herself a harm reductionist (and much of her narrative reads as such), it is also imbued with recovery-oriented values. This can potentially be read as mirroring harm reduction's recent history of colonization by comparatively normative and mainstream views of drug use. As discussed in Chapter X, activists often argue that the more radical, core beliefs and grass-roots philosophy of the movement have been diluted as harm reduction becomes a more mainstream part of modern medical practice. In this context, Pauline's response suggests the proliferation of recovery narratives, even onto the terrain of seemingly oppositional philosophies like harm reduction.

Similarly, despite Resistors institutional critique of recovery and the disease model, some framed their relationship to the clinic using familiar tropes of addiction that position the drug user both as the architect of her own problems, and as someone who deserves to be treated poorly (until earning the trust of the clinic/society). For example, when I asked Grace, who still uses drugs, believes they should be legalized, and does not identify as being in recovery, how MMT could work better for her, she initially replied "I would want less days [to have to go in to the clinic], cause I have to go 6 days a week." Like most people on MMT that use illegal drugs, Grace is not given takehome doses (with the exception of Sunday when the clinic is closed) and must commute to the clinic every day. Although this practice is often criticized as an overly punitive, impractical, and unnecessary obstacle in the way of treatment for an already

marginalized and treatment-averse population, Grace believes that "it's my obligation to get my act together and stop giving dirty urines." (Grace, 2016)

Criticism of the disease/recovery model, however, was not limited to individuals involved with the harm reduction movement who might be expected to reject the paradigm. Others argued that the dichotomy established by the model, between recovery and active addiction, was both pejorative and overly-simplistic, and was therefore unable to account for the myriad ways that people interact with drugs. Participants also criticized the biological determinism of the disease model using discourses of personal responsibility and by rejecting the assertion that drug users are devoid of agency in regards to their drug use decisions:

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

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

MMT for active users

In contrast to the recovery model, which posits abstinence as the central goal (or at least the preferred outcome) of treatment, participants from this subset often stressed the benefits of MMT for active drug users. This was firstly evident through their accounts of what initially motivated them to try MMT. Although everyone was asked about the circumstances that led

them to pursue treatment, very few mentioned a desire for abstinence or recovery, and none used

medicalized or disease language. Instead, participants focused on MMT's ability to stabilize

their lives by reducing/eliminating the need to participate in dangerous, time consuming, and

illegal activities. Some wanted to use less opioids or to discontinue opioid use entirely while still

using other drugs, while many were unsure of their drug consumption goals and simply wanted

to escape the world of criminalized drug use. For example, Barry, who initially tried MMT after

the fatal overdose of a close friend, explicitly states that abstinence was not his goal upon

entering treatment but instead describes MMT as a strategy for minimizing the day-to-day

dangers and difficulties involved with dependence on an illegal substance:

> "I was tired of waking up and feeling like shit every morning and driving to the
> West side and picking up dope. I actually wasn't that tired of it to be honest with
> you, but I figured there was a better way, something else to make me feel normal,
> because I didn't feel normal otherwise……I didn't want abstinence from all illicit
> drugs by any means. I definitely wanted to stop the lifestyle that I was going to go
> back down." (Barry, 2014)

> "I don't think that the methadone community has the idea that abstinence as being
> the total goal of recovery for MAT. [It's] to get your life together. I mean you
> can't be fucking going to the West side, shooting dope, shooting dope in the
> bathroom at work, you've got to get high every six to eight hours. There's no way
> to live a life like that." (Barry, 2014)

Barry, who occasionally used illegal opiates and crack cocaine, as well as smoking

marijuana and drinking regularly had few, if any problems at his initial, harm reduction-based

clinic. Methadone allowed him to avoid the hazardous daily commutes to buy heroin and to

minimize the concomitant dangers involved with illegal drug use. He maintained a job, took

classes, and described his life as the most stable it had been since he began using heroin.

However, after moving to Massachusetts, he found the clinics to be much stricter, and quickly

ran into difficulties with his counselor, particularly over the clinic's use of breathalyzers to test

for alcohol use. He argued:

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

After numerous problems with his clinic, Barry eventually decided to leave treatment and

unfortunately died shortly thereafter of an opioid-involved overdose. Research on leaving MMT

(either voluntarily or through an administrative detox[14]) demonstrates that Barry's experience is

not unique. Individuals' evidence increased rates of substance use, as well as numerous related

negative health outcomes including overdose and death upon leaving treatment (Cousins et al.,

2011; Magura & Rosenblum, 2001; Farrell et al. 1994).

Other participants reported health risks like skin abscesses, transmission of blood-borne

diseases, and the fear of overdose as reasons for trying MMT. One began treatment after finding

out she was pregnant and knowing that withdrawal during the course of her pregnancy - a near

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[14] An Administrative Detox in a punitive measure, enacted by the clinic, whereby the patient's dose is systematically reduced to zero at which point the patient is discharged (they are used both as a response to rule breaking and for failure to pay clinic fees). Administrative detoxes are often carried out much more quickly than is medically recommended, and certainly too quickly for the patient to be beyond withdrawal upon the cessation of methadone. Thus, patients are generally terrified of being Administratively detoxed.

certainty if she remained using only illegally obtained opioids - could jeopardize the health of her unborn baby. Harm reduction projects like syringe exchange programs (SEPs) and safe injection facilities (SIFs) have demonstrated that indirect health risks like these are more associated with criminalized drug use than drug use itself (Hagan et al., 1995; Lurie, 1993; Moses, Vlahov & Normand, 1995) and studies have found that MMT is the most effective means of avoiding them (Ball & Ross, 2012; Farrell et al., 1994; Joseph, Stancliff & Langrod, 1999). Thus, Resistors often described MMT as a means of avoiding harms contextually associated with drug use under criminalization rather than on avoiding drug use itself.

Withdrawal

Resistors also focused on how MMT allows them to avoid withdrawal. Withdrawal was seen as problematic not only because of its unpleasant effects, but because of the inability to work, stay in school, or pursue non-drug related activities when periodic sickness was a regular occurrence. Participants provided numerous accounts of their experiences before MMT (or during periods when they were not involved with the program), of waking up in the morning, already in withdrawal after being unable to procure opiates the night before, and then losing a job, either from calling in sick, or going to work and preforming poorly. Resistors who continued to use substances often conceptualized MMT as a backup or a safety net, for periods when they were unable to obtain their drug of choice. Thus, opioid-dependent individuals were able to participate in normal life activities like work and school that were impossible to maintain while relying strictly on the illegal market.

Similarly, participants reported a strong connection between withdrawal and their willingness pursue risky activities such as syringe sharing or buying from an unknown source.

One individual stated only half-humorously, "I don't share needles ever. But if you catch me dopesick enough, I'll shoot up with anything" (Guy, 2014).

Studies have documented how drug users in withdrawal are more likely to engage in risky practices (Hughes, 2004; Connors, 1994; Ross et al., 1994), and that MMT is one of many "indigenous strategies and tactics" used to manage their consumption and avoid risky behavior (Mateu-Gelabert, 2010). Thus, participants used MMT strategically, either as a safety net during periods of particular difficulty, or as a long-term plan to avoid withdrawal entirely. This allowed them to maintain employment or enroll in school without the pressures of having to obtain an illegal substance multiple times each day, and without the constant threat of withdrawal. Yet, as the following interview portion demonstrates, such behavior is usually seen as negative by the clinic regardless of how the patient conceptualizes their treatment:

> "It [my reason for getting on MMT] was basically to have a way to not be sick and function better without having to take dope. But then what it turned into, I started taking dope on top of that, and it became a get out of jail free card, where I could use on top of it [methadone], and the methadone kept me from being sick. They made it sound like a negative thing cause their goal is for you to be completely abstinent." (Vic, 2014)

Clinics' role in policing non-opioid drug use

Not surprisingly, participants from this subset did not believe that clinics should be policing their patients' non-opioid drug use, and argued that their increasing concern was irrelevant, counter-productive, and dangerous. They pointed out that such policies discourage people from signing up for treatment and also marginalize, and/or push many individuals who benefit from MMT out of the program. Many had stories of friends or family experiencing

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conflict at their clinic that were uncannily similar to Barry's. When asked about the clinics'

increasing involvement with patients' non-opioid drug use, Resistors argued:

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

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

Even some of the participants who believed in recovery were critical of clinics'

increasing concern with their patients' non-opioid drug use. Although these participants

believed that everyone should be encouraged to pursue abstinence-based recovery, they pointed

out that non-compliant patients are still better off on MMT than off of it. For example, Gene,

who had been in various MMT programs for more than 40 years contrasted the new recovery

approach with the views of Drs. Dole and Nyswander, the highly respected physicians who

began the first experiments with MMT:

> "The people that started the program, Dole and Nyswander, they looked at the
> program as harm reduction… They also accepted certain behaviors, smoking pot,
> even not being employed, as long as there wasn't really criminal activity and they
> looked at it as harm reduction. The other people that came into the system later
> on, they're much different. They didn't believe in harm reduction to a degree…
> When I left the system, the whole thing was treatment plans, monthly notes,
> etc…. They never tested years ago for marijuana use. Then all of the sudden they
> started testing for it, and putting increases into people's schedules, and stuff like
> that. [This started] about ten, twelve years ago." (Gene, 2014)

A review of Dole and Nyswanders' publications at least partially supports Gene's claim.

Firstly, Dole and Nyswander did not remove participants from early clinical trials for illegal drug

use, and even saw their "experiments in drug usage" as potentially beneficial since methadone

"blocks" the euphoric effects of short acting opiates[15], and drug users were unlikely to continue

using illegal opiates after spending money without result (Dole & Nyswander, 1965). More

importantly, although Dole and Nyswander were clearly working within a medical model (and

before the thrust of the harm reduction movement), their language suggests that much of MMT's

power resides in its ability to decriminalize, writing that "Methadone maintenance makes

possible a first step toward social rehabilitation by stabilizing the pharmacological condition of

addicts who have been living as criminals on the fringe of society" (Dole & Nyswander, 1976:

2117). Moreover, in their ten-year review of MMT, they argue against excessive rules and

regulations which they cite as the most common reason for addicts (sic) to reject treatment, and

chastise the public at large for their morally-based lack of enthusiasm for substitution treatment,

pointing out that "What was not anticipated at the onset was the nearly universal reaction against

the concept of substituting one drug for another, even when the second drug enabled the addict to

function normally" (2117).

Resisting recovery

Because of their deviant views, participants from this subset often maintained a strategic

approach when dealing with clinic staff. Although the extent of effort required to stay out of

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[15] The ability of methadone to "block" the effects of other opioids is potentially a misnomer. While using methadone certainly makes it more difficult to obtain the euphoric effects of other opioids, this is usually conceptualized (by drug users) as a function of methadone's potency and its related effects on patient tolerance. Thus, people on standard doses of methadone are unlikely to feel other opiates because methadone is more potent than other competing opiates - it would probably be more accurate to say that methadone 'trumps' the euphoric effects of other opiates. Since methadone is significantly less euphoric (though not devoid of euphoria) than short-acting opiates like heroin, the euphoric results of taking short-acting opiates while maintained on methadone are usually negligible. However, with a comparatively low dose of methadone, it is possible to achieve euphoric effects from short-acting opioids and some patients specifically seek out this balance. For more information of how methadone is constructed in regards to pleasure see Houborg, 2012.

trouble varied tremendously based on the clinic's philosophy, Resistors tried to minimize any chance of conflict by appearing to be 'going along with the program' and telling staff 'what they want to hear'. For some, this simply meant discussing their treatment goals using the language of disease and recovery. However, others had to engage in more serious forms of trickery to avoid increased surveillance and discipline at their clinics. For example, while all clinics require monthly drug screens from patients, some conduct the test via a urine sample provided while a staff member looks on. Not only was this controversial practice cited by patients as a stressful, humiliating, and unduly invasive experience, it also posed practical problems for individuals who continued to use illegal drugs. Since a 'dirty urine' usually results in the loss of take-homes (meaning that individual would have to attend the clinic every day) and could lead to an administrative discharge, they significantly affect the quality of life for MMT patients. Consequently, participants reported knowing patients (who used illegal substances) who regularly bought black-market "clean" urine from compliant patients whose urine would show the presence of methadone, but nothing else - some even used prosthetic genetalia, modified to give the appearance of urination.

3. Negotiators: Participants supporting recovery but whose treatment accounts problematize recovery-based treatment

The third subset of patients however, were not only the most numerous – approximately half of the MMT patient group - but most reflected the tensions inherent in the recovery model. Although Negotiators rhetorically touted the tenets of recovery, such as the disease model of addiction, the need for a complete personal transformation, and the belief that abstinence was the true purpose of MMT, a critical analysis of how they used, and benefited from the program often conflicted with recovery's one-size-fits-all approach.

Norms, Social Construction, and othering

Although Negotiators believed in recovery and most rejected the idea that MMT could or should be used as a form of harm reduction, their views concerning what constituted acceptable behavior were often shaped by their norms, values, and socially constructed worldview. This was apparent first through the difficult-to-pin-down meaning of the term "drug", a concept implicated in nearly all of addiction and recovery discourse. The subjective and culturally determined nature of "drugs" as a category ultimately leaves questions as to what counts as "recovery" up to endless debate, and usually determined by individual and group norms. Thus, participants who occasionally drank alcohol tended to view that as within the bounds of recovery but rejected recreational marijuana use. Others smoked marijuana and argued for its acceptability while dismissing the claims of those who drink. Since the recovery discourse is involved in expanding the conceptual boundaries of addiction-causing substances and behaviors, one can imagine how debates over substances like cigarettes, chewing gum and sugar, or behaviors such as playing the lottery can further complicate the already tenuous boundaries between recovery and active addiction.

Normative views were, as always, affected by racial, class, and age-based variables that often took the form of othering. The following interview with Francine, a long-time MMT patient in recovery, demonstrates not only how the ostensibly objective standards of recovery can be adapted to normative ideas about deviance, but also how such an approach obscures structural hierarchies and cultural differences. Initially Francine expresses a hard-line, abstinence-only approach to individuals using MMT for harm reduction purposes, stating:

> "I think that's [using methadone to moderate drug use or for otherwise non-
> abstinence reasons] absolutely ridiculous and it pisses me off when I see people

that are doing that. Because it gives us such a bad name. Cause it [MMT] does

work and you get these assholes who are still getting high… It pisses me off

because you have these people who would get on it because they figure well they

can't afford to get high anymore so they get on 'meth', and they're not doing it

for the reason of they want to clean up their lives and that really irritates me…

Why be on it? Why do that? You have such a chance of getting yourself together.

Why are you gonna take it and then still go and screw around? It just makes no

sense to me." (Francine, 2014)

However, when asked to clarify which substances constitute grounds for punishment, it

becomes clear that her conception of recovery is molded not only around class-based cultural

norms that differentiate between acceptable and non-acceptable forms of drinking, but also by

her own preferred drinking behavior:

David: So when you say that people should have to be abstinent in order to be on

the clinic, would that include things like alcohol and marijuana?

Francine: Absolutely, absolutely. You know, I never had a problem with alcohol.

Do I drink? I have a drink, but you know, I don't really drink socially. It would

just be like at a wedding.

David: Ok, so it wouldn't apply to drinking alcohol?

Francine: But not drinking just to drink, you understand what I'm saying. Like if I

went out to dinner for my parents or something and we all had a bottle, or a glass

a wine [that would be ok]. But as far as drinking, to sit at home and have a drink,

no I don't think that's necessary.

Firstly, Francine's views on acceptable forms of drinking are clearly based on her own

preferences. Moreover, her descriptions are highlighted by references to wine and going out to

dinner, both forms of drinking associated with higher socio-economic status groups. Yet

drinking at home, a far more affordable form of drinking culturally linked to working class

imagery is constructed by Francine as problematic and outside the bounds of recovery. It is not

difficult to imagine how the symbolic markers associated with different substances (for example, blunts, Champaign, malt liquor etc.) could affect its position in regards to recovery, and in this way, racial and class-based hierarchies are simultaneously built into, and obscured by, the seemingly objective narrative of recovery.

The etiology of drug use problems and the purpose of MMT

When asked, participants from this subset dutifully referenced the disease model to explain their drug use problems. However, a more detailed account of their drug use and treatment histories suggested structural and legal factors as causing the majority of the difficulties they experienced while using drugs. Like the Resistors, many in this group reported problems associated with safe and reliable access to drugs and consequently, withdrawal, as a primary motivation for initiating MMT. For example, although the following responses are from participants who reported seeing addiction as a disease and believe that recovery is the true purpose of MMT, their accounts of the circumstances that drove them to MMT focus entirely on the practical and structural-legal difficulties of obtaining illegal drugs under prohibition rather than a medical or health related inability to 'just say no' to "drugs":

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

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

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

Despite Negotiators reliance on the disease model, it seems ill-suited to describe their actual experiences as drug users and MMT patients. Their accounts directly reference heroin's status as an illegal drug as well as the dangers associated with the black-market as downsides to heroin use that motivated them to try MMT. Similarly, they identify the added ease and stability of MMT as compared to the hustle of illegal drug use. Thus, Negotiators' accounts suggest that MMT allows opioid-dependent individuals to access opioids without the dangers and hassles imposed by criminalization – this mirrors my own experience with MMT.

Other Negotiators painted similar pictures of MMT. For example, Sofia, who conceptualizes her drug use through the disease model and still occasionally uses drugs but is working towards recovery, reported that "It was hard to get the money to get heroin everyday…….When I didn't get the money, I was getting sick" (2016). She has currently been on MMT for 13 years, and although she uses marijuana, alcohol, and occasionally crack cocaine and heroin, MMT works for her "because I didn't have to worry about getting sick or nothing. I could just go to the methadone clinic, drink [my dose of methadone] everyday, and not have to worry about withdrawal or nothing like that." (Sofia, 2016). When I asked if she was more concerned with being abstinent or stable, she immediately responded that stability was her primary concern, adding that "It worked out great for me. At the time [before getting on MMT] I didn't have no place to stay. Once I got on the methadone program everything started to fall into place" (Sofia, 2016). Although Sofia views her experience with MMT as being very successful and stresses that it has improved her life tremendously, her clinic counselor regularly pressures her to abandon all substance use – a position that Sofia frames as "trying to tell me the right

things". Similarly, she views the increasing use of surveillance and punishment by the clinic as "concern [for her]", despite the fact that it has direct effects on her ability to access takehomes (she currently gets none) and could eventually result in her being Administratively Discharged.

The following interview also challenges the recovery model's attempts to frame MMT patients' success as the result of switching from a "drug" to a "medication". Casey, a patient in long-term recovery who is completely abstinent from drugs and alcohol also described her addiction through the language of the disease model. However, she focuses on the similarities rather than the differences between heroin and methadone, eventually experiencing a conceptual 'lightbulb moment' regarding their relative potential as treatment substances:

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

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

Like the responses above, Casey locates the difficulties of opioid use not in their pharmacology - in fact she states that opiates have always helped her to the point of saving her life – but in their structural position as an illegal drug and the lifestyle that illegality engenders. In contrast to the Supporters attempts to discursively separate the two substances, Casey's account suggests that MMT's ability to improve lives is not related to methadone's 'medicineness' as compared to heroin's 'drugness', but because of the quasi-legal environment of opioid use that MMT allows. Her hunch about the efficacy of heroin as a maintenance medication is supported by recent success of Heroin Assisted Treatment (HAT) in Switzerland and elsewhere (Fisher et al. 2007; Uchtenhagen, 2010).

Pressure to conform

Casey's response also illustrates the intense pressure to conform to the dominant recovery-based narrative. She clearly hesitates before stating her belief that heroin functioned as a positive in her life, firstly by qualifying her response as "weird" and then by pointing out that her parents would probably subscribe to the opposite position. Thus the dominant recovery narrative, continually re-enforces that idea that drug use problems are the result of individual-level determinants while simultaneously obscuring the social-structural-legal factors. Correspondingly, social and institutional pressure encourages patients to view their success with MMT as the result of a medical intervention rather than from the ability of opioid-dependent individuals to continue using opioids in a decriminalized manner – a narrative far more likely to lead to policy-based critiques of criminalization.

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

> "It was all centered on the idea that you had done something wrong, that you were in the wrong, that you were this drug addict and you could be making amends for all these things you've done. There was no sense of a drug user being a person. They didn't look at anyone's story, situation, or struggle, which is the reality of any person, and every person's story, situation, and struggle is different. And that plays a part. It plays a part in whether or not a person can be able to go do stuff [drugs] again, and that be ok. I'm not opposed, I wish I could do that, and I don't think there's anything wrong if I did take a morphine vacation. I know because of myself and the way that my brain works that I can't take that chance cause I'm way happier now. But do I think that's wrong? God no. You know, this bothered me so much, cause you know, I haven't done drugs in, it'll be almost 7 years, and I found myself, when I took this half an Adderall and failed this drug test, I'm like 'Have I relapsed?!' Like in reality, I haven't done anything wrong, I was just sick and took half of my friend's medication. But I was like, I found myself asking these questions: 'Now can I not say that I'm clean?' and it's ridiculous and that's been so drilled into my head. I have great guilt, I feel bad about it. In the reality I know I didn't do anything wrong, I didn't jeopardize my livelihood or whatever, and had I not gone through all this drug shit, I would've never thought that." (Sarah, 2014).

It is important to note that Sarah's fears are not based only on abstract ideas about being "clean" or "in recovery". Earlier in the interview she described almost losing custody of her two children after Child Protective Services (CPS) became concerned about her participation in MMT, in particular, her dose which they felt was too high. The situation was resolved only after Sarah's therapist (outside of MMT) assured CPS that she was a good parent and a compliant patient in recovery. She states:

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

Faith in the medical model

Although for most Negotiators, multiple, and often contradicting discourses seemed to exist side-by-side, sometimes in an unexamined fashion, one participant explained the inconsistencies through a sincere belief that a medicalized view of drug use will reduce/eliminate stigma from drug users. Kerry Wolfe, a long-time MMT patient who self-identifies as a harm reductionist but also supports recovery hoped that re-framing MMT in terms of recovery might remove/reduce stigma applied to methadone and people who use it. She saw the push towards recovery within MMT as a response to the numerous anti-methadone campaigns that were most active 10-15 years ago. Specifically, Wolfe described how groups like Helping America Reduce Methadone Deaths (HARMD) – an anti-methadone organization who launched a campaign to stop people on MMT from being able to drive – had not only sought to marginalize people on MMT but to substantially deprive them of rights. Similarly, Wolfe described efforts to link increasing rates of overdose to MMT patients via the suggestion that they were selling their

medicine on the black market - a claim that has been refuted by Cicero & Inciardi whose study

demonstrates that most diverted methadone originates from pain patients rather than those using

methadone for substance use issues (Cicero & Inciardi, 2005). Thus, Wolfe argued that a

concerted advocacy movement among people on MMT, began to coalesce in order to combat

stigma and misinformation using the disease model of addiction and its corollary focus on

recovery as central aspects of their rhetorical strategy. Although the current focus on recovery

has not been restricted to MMT, Wolfe's point about the political and social efficacy of the

medical model as opposed to a belief in its validity may be responsible for recovery's recent

rapid expansion. Echoing this view, Craig Reinarman points out that addiction-as-disease

narratives have risen to dominance, in part because "it is a view that serves useful purposes for

users themselves and for society in general" (Reinarman, 2005: 309).

Moreover, participants based their acceptance of recovery on the oft-repeated dichotomy

between medical and moral approaches to drug treatment that position medical models as

progressive and moral models as reactionary. This binary model not only restricts drug

treatment options to only two, but obscures their often cooperative rather than oppositional

nature. For example, Vic, had used MMT multiple times over a 10 year period, usually to

moderate his heroin and prescription opioid use, and never with a serious attempt at complete

abstinence. He stated that MMT had consistently helped him to survive during more difficult

periods of use, and enabled him to use less drugs throughout. Thus, his experience could be

described as a textbook example of how harm reduction-based treatment benefits drug users.

Yet, Vic was enthusiastic about the growing acceptance of recovery in MMT and when asked

about the disease model, he stated:

"I do view it, yes, as a disease, and I'm glad that they're starting to at least take it more seriously because for awhile they just thought that it was your fault and it's on you." (Vic, 2014).

Conclusion

The recovery model does not reflect the drug use experiences or treatment needs of a large portion of people on MMT. Study participants' ages ranged from 22 to 70, and they came from a variety of racial, class, and socio-economic backgrounds, all of which affected their perceptions of drug use as well as the relative harms they experienced – though not in clearly identifiable demographic patterns. Moreover, participants differed in their drug use experience as well; some had been injecting heroin for many decades while others had been using prescription opioids orally for only a couple of years. Thus, participants' views on issues such as the desirability of complete abstinence, how they defined complete abstinence, the need for a transformation of self, the role of drugs and/or the state, in their drug use problems, and a number of other issues were all influenced by a multitude of intersectional variables related to each person's individual background, experience, and worldview.

Similarly, participants who had been on MMT for many years or who had used it intermittently throughout the years described the treatment as fulfilling different functions at different times in their lives. Many reported pursuing complete abstinence from all substances during one period on MMT, and using it as a safety net during another. In most cases, their motivations were a complicated mix of both practical and ideological concerns that reflected that individuals' current and past life circumstances. Hence, patients' accounts of drug use and treatment conflicted with the recovery model's linear-progressive narrative and positivist approach which flattens such distinctions.

Although institutional proponents of recovery, such as SAMHSA and OASAS touted the flexibility and patient-centeredness of the model, it was often experienced by patients as proscriptive and disciplinary. Individuals who conceptualized their drug use histories and/or treatment goals outside of the recovery model – particularly those who were not seeking complete abstinence from illegal drugs and alcohol - were likely to encounter institutional discipline, including the reduction or elimination of their take-home doses (thus forcing them to attend the clinic everyday), and sometimes resulting in the patients leaving or being discharged from treatment. While medical approaches to drug use, like recovery, are often touted as progressive alternatives to more overtly punitive models, both positions locate drug use as a monolithic and wholly negative activity that must be controlled. Moreover, by constructing drug users' choice to attend MMT as unrelated to the ways that they are oppressed under criminalization, the recovery discourse depoliticizes drug treatment issues, and, as such, implicitly supports the status quo criminalization of drug users.

These issues occur in part because the recovery model is based on a decontextualized conception of illegal drug use that ignores the effects of criminalization and the War on Drugs as a force pushing drug users towards "treatment". Drug users, particularly illegal opiate users who are both highly criminalized and marginalized, often engage with MMT as an attempt to manage, reduce, or potentially eliminate the harms that accompany dependence on a criminalized substance, and not because of an ideological desire to "recover" from their "addiction". However, most drug users in treatment adopt the language of recovery through their interaction with MMT (or drug treatment in general), where acceptance of the dominant narrative is not only linked to material benefits, but serves as a protective factor against increased surveillance and discipline on the part of the clinic.

Chapter 5 -

Talking about recovery: MMT as treatment or refuge

Most of the advocates for drug user rights and services were at least somewhat critical of the recent shift towards a recovery-based approach to treatment. These were individuals who currently work with – and in most cases, have long histories of working with – organizations that provide harm reduction services to drug users (i.e. Syringe Exchange Providers (SEPs), Naloxone distribution, and education on safe injection practices are primary examples). In many ways, advocates' comments were similar to those of participants on MMT who resisted recovery-based treatment, in that they focused on MMT primarily as a pragmatic refuge from the harms and difficulties of criminalization, and rejected attempts to conceptualize it through the lens of the disease model. Similarly, most advocates identified strongly with the non-proscriptive, or value-neutral aspect of the harm reduction philosophy, and saw recovery as potentially infringing on one of the few spaces (physical, economic and discursive) where normative beliefs about drug use(rs) were being challenged.

Advocates were most critical of two related aspects of recovery: (a) the recovery model's use of science and the medical model to conceptualize drug use/treatment; and (b) recovery's proscriptive stance on abstinence and disregard for the many active drug users who benefit from MMT. However, both of these themes spoke to advocates' general dissatisfaction with the recovery model's failure to acknowledge prohibition/criminalization, both as a leading factor in the harms drug users' experience, and as an incentive for drug users to enter MMT. Moreover, advocates argued that the shift towards recovery-based treatment was occurring alongside a related professionalization of the harm reduction movement that most saw as parts of the same inter-related process.

There were however, two advocates who strongly believed in the recovery movement and work with organizations that claim to support both philosophies. While these advocates still considered themselves harm reductionists and argued that the two approaches were not incompatible, they typically framed harm reduction as a prelude to abstinence which was always seen as superior. Thus, for these activists, harm reduction was a means of connecting with drug users, with the larger goal being abstinence-based, and recovery-oriented, behavioral change.

Professionalization of harm reduction

> "Selling out is usually more a matter of buying in. Sell out, and you're really buying into someone else's system of values, rules, and rewards" – (Bill Watterson)

Many of the advocates involved with either harm reduction or drug user rights organizations described the increasing focus on recovery as occurring within a context of increased professionalization among harm reduction and drug user rights groups. Most felt that while these groups, who had previously operated as small, often illegally run grass-roots organizations comprised primarily of active drug users and close allies began to accrue mainstream acceptance and greater levels of funding, the focus on some of the core principles - particularly a neutral or amoral approach to active drug use/rs - became diluted.

Harm reduction activists, particularly those who had been involved with the movement for a long time, described a dichotomy between an "activist past" and a more medicalized or public health focused version of today's harm reduction. Although nearly all of the activists described harm reduction as being, in many ways, a public health intervention, it was also conceptualized as having been outside of, and other to, mainstream public health culture and approaches which were seen by many as stagnant, ineffective, judgmental, and largely unable to meet or even understand the needs of drug users.

The role of active drug users in the harm reduction movement

      A central aspect of the activist/public health division concerned the level of involvement of current or active drug users within harm reduction organizations. Advocates spoke emphatically about the importance of the early days of harm reduction (during the 1980's and 1990's) when many of their activities were illegal and organizations were started and led by active drug users. As long-time harm reduction/drug user rights activist and Vocal New York's Policy Director Matt Curtis explains:

> "[peer led drug user rights activism has] always been there, it's the reason we
> have harm reduction in the first place. The first Syringe Exchange Program (SEP)
> in the world was started by drug users. The first Naloxone program was started by
> drug users. All of it. The reason we have supportive laws for this, at least in many
> places, is driven by people who use drugs. I struggle to think of a harm reduction
> organization that started anywhere from the late 80s through the 90s that wasn't
> started by people with a direct experience of drug use, and often current drug
> use." (Curtis, 2014).

      The direct participation of, and leadership by active/current drug users was viewed by activists as a real world expression of the harm reduction philosophy and part of what distinguished it from other public health interventions. Bart Majoor, who currently works with St. Ann's Corner Harm Reduction similarly described the importance of drug users in harm reduction's activist beginnings:

> "I entered the field in The Netherlands 35 years ago at the moment harm
> reduction was being born there and there were these large groups of [drug] users,
> mainly people from outside [of The Netherlands]: the US, all over Europe, and
> the problem was, for the first time the government was confronted with a large
> group of illicit drug users, which was hardly a phenomenon before that… They
> were in the parks, all over the place, homeless, and didn't want [to] or couldn't
> stop using." (Majoor, 2014).

      Most activists felt that drug users are less involved in harm reduction organizations today and that they had been gradually pushed out of key positions and relegated more and more to

unpaid, "volunteer" roles. Drug user rights activist Cheryl White describes this historical shift in "Beyond professional harm reduction: the empowerment of multiply-marginalized illicit drug users to engage in a politics of solidarity towards ending the war on illicit drug users" (White,). She argues that the proliferation of non-drug users in key organizational positions is emblematic of a co-opted version of harm reduction that is un-willing to critique the structures that produce harm for drug users. Anthropologist, Gordon Roe agrees, stating: "This 'official' harm reduction saw itself as having matured beyond the sort of activism that engaged in embarrassingly direct and counter-productive attacks on drug prohibition. It was now much more a career than a cause, and the political and community voices of harm reduction again became marginalized" (Roe, 2005: 245)

Thus, activists saw the change as part of a gradually occurring shift over the last ten to fifteen years as harm reduction became more acceptable as a legitimate public health career path. Greater levels of accountability, the pressures of increased funding opportunities, and managing increasingly large organizations combined with a powerful stigma against drug users – particularly injection drug, and heroin users that form much of harm reductions' traditional membership and target population - led to a gradual erosion of active/current/publicly open drug users in key positions. Curtis explains:

> "[active drug user involvement in harm reduction] has changed a lot as programs have gotten better supported and there's been a professionalization. An older generation of folks has died or retired or moved on or been pushed out because they aren't perceived to have the technical credentials and skills to lead an organization as its grown. You can talk about that [active drug use] with your peers or behind closed doors or at a conference… but you certainly couldn't talk about it with a funder or the Department of Health." (Curtis, 2014)

A less radical harm reduction?

Activists expressed mixed feelings about the increased professionalization of harm

reduction. On the one hand, it greatly increased opportunities for such groups and programs to

seek out, and receive funding for their efforts thereby enabling them to provide more and better

resources to their target population. Yet, many felt that the changes made harm reduction efforts

less responsive to the needs of drug users and more focused on normative outcomes, such as

reduced levels of drug use. As Curtis points out:

> "That's [harm reduction's activist roots] a very important part of the history of the
> harm reduction movement in the U.S. that gets glossed over or forgotten as we go
> on this path towards 'OK now were going to be doing Medicaid billing and all of
> this other stuff that is 'good' in a lot of ways because it's creating more resources
> and better things for participants, but 'bad' in a way that it definitely creates some
> tension with the small, nimble, activist approach which is where you find the real
> philosophy or approach of harm reduction…..That 'Any Positive Change' model
> gets subtly chipped away at the more you're using some indicator-based program
> to do behavior change for your participants." (Curtis, 2014)

Walter Cavaleri, the founder/director of the Canadian Harm Reduction Network and a

founder of the Toronto Harm Reduction Task Force also expressed a concern that increasing

professionalization could fundamentally alter the nature of what harm reduction is:

> "I've seen it years ago [harm reduction losing its radical edge] and it's been
> growing and growing, and although I want harm reduction as a concept to be
> introduced in every bit of the work that people who use drugs do, I worry that it
> becomes rigid and formalized and institutionalized and I saw that happen in social
> work which used to be a wonderfully radical profession, [but] has become now
> something that is really quite different. It is engaged in becoming more and more
> like psychology w/o the really good discipline of psychology. But [it also means
> that] 'hey, I can go out and earn a living'" (Cavaleri, 2014).

Activists linked the professionalization of harm reduction to the increasing use of a

'recovery discourse' in drug user interventions through public health's tendency to focus on

quantifiable outcomes, most often in the form of reduced drug use or reduced of levels of

individual and/or social harms thought to be related to drug use. In an environment where grant

money is dependent on presenting empirical evidence demonstrating reduced levels of drug use among participants, harm reduction's focus on 'meeting the client where they're at' (a central tenet within the harm reduction community, that requires interventions to not impose a particular view on their clients' drug use) becomes difficult to maintain. Majoor explains:

> "Originally it [harm reduction] was an approach for drug users who were not able or capable of stopping their use. [harm reduction is] about normalization of illicit drug use… [but] Public Health thinking is so un-pragmatic and so judgmental and so out of touch with reality, that even with loads and loads of evidence –and a lot of talk of the CDC [Centers for disease Control and Prevention] about 'evidence based interventions', they still deny a large body of harm reduction work and it absolutely lacks implementation." (Majoor, 2014).

The increasing professionalization within harm reduction also created (or emphasized) a tension between more radical elements of the movement who sought to maintain the focus on active drug use/ers (including a critique of prohibition and criminalization, and ultimately arguing for the rights of individuals to use drugs as they saw fit), and others who either saw harm reduction as a way of engaging with drug users in order to promote abstinence or who felt that the benefits in the form of money and increased opportunities to affect policy justified a certain amount of compromise.

Taeko Frost, the Executive Director at Washington Heights Corner Project (a NYC-based harm reduction organization), described the difficulties of working within the two different ideologies:

> "I see that [a distinction between a more radical versus public health version of harm reduction] all the time. I feel like I'm someone who walks that line every day. People [on the more medicalized side of harm reduction] talk about 'in the perfect world, drugs would be eliminated' and for me the perfect world includes drugs and that's a radical concept…. And so I kind of balk when I hear that….. It sucks being a social worker or being social work people, you say 'you try to work yourself out of a job', that's the purpose. But for me, with harm reduction, I'm never gonna work myself out of a job because, for me, if all of the things we want

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happen [legalization of all drugs; an end to prohibition and criminalization], the role of harm reduction is still to do what we did at the very core, harm reduction services would be places where people use drugs together safely. That's what I envision if everything gets so medicalized - that harm reduction programs would shift to be spaces where people used together in a less medicalized way than SIF's [safe injection facilities] even. I think it's great to have RNs and it's good to have medical personnel, but I think there are people who use drugs because they enjoy it, and there are people who are really good at managing their drug use… and I do think that there's a space for that. But me as a doctoral candidate in public health and someone who's very epidemiologically oriented and runs a public health agency, I also have seen how in the last 20 years we're [harm reduction] seeing this opportunity to be included in this space and I think it would be remiss of us not to acknowledge that it is an opportunity. I mean, how long can we do this 'fuck you' thing?" (Frost, 2014)

Recovery-based harm reduction?

However, not everyone saw the distinctions between harm reduction and more mainstream public health approaches as oppositional or in conflict with one another. Activists involved with the recovery movement, saw the increased professionalization of harm reduction as the vindication of an activist movement through science. Zac Talbott, an activist with Medication Assisted Recovery Services (MARS), an organization focused on integrating recovery concepts into methadone and Buprenorphine maintenance treatments explains:

"What we've seen is the evolution towards this focus away from just harm reduction, which is what Methadone was, because we didn't have the science that we now have…. Like most medical treatments or like most diseases, we could effectively treat it before we understood it. So we knew methadone worked, Drs. Dole and Nyswander figured that out, but we didn't know why. We knew that it reduced crime, we knew in the 80's that it reduced the incidence of new HIV infections, we knew that it allowed people to get back to life, but we didn't know why." (Talbott, 2014).

Similarly, Ed Manchess Director of Harm Reduction services at Boom Health Care saw the increased public acceptance of harm reduction in positive terms, particularly through the ability to access grants and provide clients with more and better services. However, Manchess,

in contrast to most of the harm reduction advocates in the study, sees promoting abstinence as part of harm reduction's mission. He explained,

> "The city of New York, the human resources administration is really recognizing harm reduction as an effective mode of serving individuals that are using drugs or engaged in other risky behaviors towards living a healthier lifestyle and we've been seeing that more and more in some of the grants that are coming out. In addition, we here at Boom Health, we believe in recovery and we actually have a recovery program here, that's new to the organization, just recently acquired a grant from SAMHSA (Substance Abuse and Mental Health Services Agency) I believe. We're the only syringe exchange program in the country that has this type of program. It's a peer-to-peer recovery program. So basically it's a somewhat of a social networking strategy where if I were a peer in whatever stage of recovery, my task would be to recruit other people that may want to change their life [from] active or semi-active drug use to becoming abstinent from using drugs." (Manchess, 2014).

> "The program definitely [believes], and other programs are realizing that the stages of change really applies to so many different aspects, and so many different types of substance use. It seems to work with everyone." (Manchess).

Thus, differences between recovery-oriented activists and those who were critical of it often stemmed from different visions of the harm reduction philosophy and how to best implement it. For example, while Manchess sees harm reduction as a way of helping drug users to live "a healthier lifestyle" by moving towards abstinence, his response can also be read as evincing the diluted character of the movement's core philosophy. As discussed earlier, harm reduction was largely brought into being through the efforts of underground drug users and HIV/AIDS activists as an alternative to abstinence-based models. Yet Manchess clearly maintains a hierarchical outlook that presumes the universal rightness of abstinence.

Moreover, he describes the mission of peers as one of 'recruitment'. Although Manchess insisted his approach is non-coercive, the high stakes and dangerous context of criminalization problematizes issues of volition in regards to drug users' treatment choices. Since many drug users in MMT are motivated by a desire to escape the difficulties of prohibition/criminalization,

they are particularly vulnerable to coercion. Additionally, the power dynamic between clinician

and patient, amplified by the patients' physiological dependence on methadone, further

complicates the issue. Frost, who is critical of more proscriptively organized programs, explains:

> "That's something that I see all the time, people get tired of the hustle of
> whatever they're doing and methadone is an option, an option to not be sick,
> whether they're buying methadone off the street for a week, or if they're actually
> getting into a program. I think the criminalization of it really obscures the
> purpose, the intention, everything. It's really hard to parse out how much of it is
> what a person really wants when there's a clear social context of using licit versus
> illicit drugs and the implications that has for people getting arrested or just being
> tired of doing what they're doing. I think the criminalization really interferes with
> peoples' ability to make informed choices for themselves and therefore interferes
> with their success because they're not making a decision based on what they want
> necessarily, they're making a decision on trying to get away from the things they
> don't want, and I think there's a distinction between what somebody wants, and
> doing something because you're trying to get away from things that you don't
> want. And I think that's what's happening now." (Frost)

Summary

Activists' views on the increasing professionalization of harm reduction were shaped by

ideological as well as practical concerns. Those who saw harm reduction as a way of

normalizing illicit drug use, challenging prohibition/criminalization, and empowering active drug

users expressed mixed feelings about its increased professionalization. While most

acknowledged that greater levels of acceptance, and access to funding enabled harm reduction

services to do more for their clients, they also felt that the movement's guiding philosophy of

providing services to active drug users without the traditional focus on reducing levels of drug

use had atrophied. The gradual reduction of active drug users, and their relegation to volunteer

roles within harm reduction organizations was seen as exemplifying this shift. Thus, drug user,

and harm reduction activists saw themselves as constantly negotiating between the new

opportunities that increased funding provided and the potential ideological concessions that were

seen as eroding the original philosophy.

Other activists, who endorsed the increasing focus on recovery, saw the professionalization of harm reduction in evolutionary terms. The early efforts of more radical drug user activists were positioned as the first steps that paved the way for today's more mainstream version of harm reduction. Science, particularly the neurological brain disease model of addiction was seen as enabling drug user services to go beyond harm reduction towards a more professional, medicalized approach that included a focus on drug use as disease and abstinence (along with recommendations for normative behavioral change) as its treatment. Although this group of recovery-oriented activists couched their beliefs in the language of harm reduction, it was generally seen as a way of engaging with drug users in order to move them towards abstinence which was always seen as the most desirable outcome ipso facto.

Medical/Disease Model

Nearly all of the drug user/treatment activists were critical of the medical model and its focus on understanding addiction as a brain disease. While they viewed methadone as a lifesaving medication that improved, and in some cases saved the lives of drug users, they rejected that this was because methadone treats a chronic brain condition. Instead, most advocates argued against any universal theory of addiction and viewed the problems drug users' experience as diverse and multi-factorial but nearly always linked to prohibition/criminalization. In contrast, those in support of recovery saw the disease model as a scientifically agreed-upon fact, and viewed it as way of liberating MMT patients from stigma. However, their responses also suggested that the disease model's proliferation was linked to the institutional advantages a disease label would provide such as legal protection and disability funding.

Deconstructing disease

Advocates firstly rejected the claim that the medical model is, in fact, truly medical.

Instead they argued that while the medical model uses the rhetoric of treatment, it functions in a

paternalistic and punitive manner. Similar arguments have been made about Drug Courts,

another ostensibly medical approach to dealing with drug users (Tiger, 2012).

> "We've still got prohibition in this country, and we've still got a war on drugs,
> we've got a criminalizing response. And much of the medical model that was
> oversold to the American public as an alternative to the moral model is essentially
> a criminal model, and therefore it's still a moral model….. It's not so much
> different from the criminal model because the medical model is still being
> perpetrated with this prohibitionist mentality and a War on Drugs, with police
> doing everything they can to make life difficult for people who use drugs, and
> most of the establishment following suit." (Bellamy-Taylor)

Additionally, advocates reported numerous problems with the disease model's

construction of problematic drug use (addiction). Sharon Stancliff, a medical doctor, questioned

the theoretical foundation of the disease model that rests upon the claim that "drugs" alter brain

chemistry. Instead, she argued from a constructionist position that that the categories used to

distinguish between "drug" and "not-drug"; "disease" and "not-disease" were constantly shifting

and culturally determined.

> "Some people's brains probably function better with something different in there,
> but probably we all do in various ways…. Does that make it a disease? (Stancliff)

Stancliff was also critical of the recovery models' theorization of addiction through the

use of vague and subjective concepts presented as science. She was particularly concerned with

how institutionally accepted the relationship between such concepts and drug treatment had

become, noting that the American Society of Addiction Medicine (AMA) referenced "humility"

and "gratefulness" in its treatment guidelines.

> "First of all 'recovery' is not a medical term. I was just reviewing some guidance
> from the American Society of Addiction Medicine on maintenance therapies

that's up for public comment, and they've got this whole paragraph about humility and gratefulness and all this stuff. I mean, I totally respect anybody that considers themself on a path to recovery, in recovery, whatever, I have no problem with that. But I don't think it should be a requirement to participate in those activities in order to receive a life-saving medicine." (Stancliff).

Stancliff, and others, were critical of this shift, arguing that the increasing institutional concern with the psycho-social functioned as a barrier between drug users and the services they need. This was seen as particularly egregious in light of the recent dramatic increases in opioid-involved overdoses (CDC, 2012) because of MMT's demonstrated success in reducing their incidence (Brugal et al. 2005; Capelhorn et al. 1996).

> "It seems to me that OASAS (The New York State Office of Alcoholism and Substance Abuse Services) is going down this path of focusing on the psych-social, recovery, etc. when we've got a, I don't like calling it an 'epidemic', but we've got an opioid crisis of some kind going on, and so we're out there passing out Naloxone, and we've got all these people that don't want people to be on [methadone] maintenance, or [to] have a reasonable time on maintenance - which is truly the treatment to prevent overdoses - unless they'll do all the psycho-social stuff." (Stancliff)

> "Drug use becomes such a part of peoples' lives in a way that's inter-woven, that saying that 'it's all bad' is just completely wrong…. The American Society of Addiction Medicine and all those kinds of people are never really going to get, that maybe using drugs saves people's lives." (Stancliff)

Similarly, advocates argued that the disease model is reductive and deterministic. Concepts such as the biological permanence of addiction and necessity of relapse were seen as inconsistent with the experiences of drug users who, they argued, have much more complex and nuanced relationships to drug use. Some also referenced a historical process whereby the disease model has come to dominate over alternative views of drug use leading to a culture of un-critical acceptance. The following responses are typical of advocates' comments:

> "We've had 20, 30 years of this disease model of addiction kind of gaining clout, and even in a way that's much more received wisdom than it is really based on an

accurate understanding of, or incredibly oversimplified understanding of what the science says about this. Probably if you went back to the 60s or 70s you'd have a much more, or a somewhat more of a consensus describing addiction, or dependence as a syndrome that plays out differently with different people, [one] that has different etiologies. And now, there's this idea that's almost deterministic: chronic relapsing, progression of disease. People don't even think about it, they just repeat it." (Curtis)

"What I still see a lot and what I hear a lot, is the disease model in terms of 'you'll never get rid of it, 'you might be clean but you'll still struggle for the rest of your life'. That's not what I see, that's not how I deal with it and I don't understand why people who've been clean for 37 years still say 'I'm an addict' or 'I'm an ex-addict'. You know, why are you doing that? I mean, I just don't get it. And the other big elephant in the closet is of course the largest number of people who've ever had a problem with addictions or dependency, in whatever way, know how to manage it themselves, and you know, either mature out of it, or find some, only on the weekends, or integrate it. There's all kinds things that I've seen and read about – I've seen a lot of people who use substances in the 35 years I've been in this field, and a lot of them pretty hard core. So I've seen a lot of things that have taught me that it's not as simple as they try to say. Now when I teach I always talk about complexity. And that 'just say no' and all these models that are propaganda from the prohibitionist context, that are bullshit, it's nonsense. It's a very complex reality with a lot of sides to it and that's why I love harm reduction as an approach because it allows these different aspects." (Majoor).

The critique of permanence of addiction was brought to light, culturally, in regards to the fear that American soldiers fighting in the Vietnam War – many of whom had become dependent on opiates – would come home addicted, causing endless problems for their communities and the country at large (Robins, 2006). In actuality, upon returning home, most of them simply quit on their own, casting doubt on pharmacologically deterministic theories of addiction.

Activists were critical not just of the disease model, but of the need for any model to explain addiction, a concept most saw as problematic to begin with. They argued that the problems drug users experience were so diverse, and affected by so many variables, that any model which sought to explain them all, would inherently be reductive. Additionally, they pointed out that such models typically function as a form of othering, or a way distinguishing the

"acceptable" from the "unacceptable". Their comments often aligned with constructionist and post-structuralist critique which problematizes the use of fixed and bounded categories to understand phenomenon.

> "I think you've got to look at the whole need for a model and what's that about. Why does it have to be fixed when everything is in flux and always changing? But more importantly, you wouldn't want a model that differentiates me from you, or us from them, which only reinforces the tendency to speak of addicts and alcoholics as somehow different from everyone else." (Bellamy-Taylor)

> "I think that's [recovery] in a way, a spinoff of the whole medicalization of what is called 'addiction' – another term I'm not comfortable with – that the dependence on drugs, and sometimes 'misuse' of them, the compulsive use of them, whatever, is really as Zinberg put it, a bio-psycho-social problem rather than just a medical one." (Cavaliere, 2014)

Some also pointed out that many of the problems endemic to the disease model stem from the ways that drug users have traditionally been studied. For example, Matt Curtis pointed out that studies are often based on convenience samples drawn from treatment programs, thereby leaving out the vast number of drug users who either quit on their own, or who maintain non-problematic relationships with drug use. This, he argues, creates a highly biased, and misleading picture of drug use and drug users.

> "Part of it has been like a positive intention to de-stigmatize people, like 'it's not their choice that they're doing this', 'they're not bad people', 'it's a brain disorder', or like it's genetic. There's all this kind of stuff that props up the idea that is well intentioned and that people also think has something to do with science. But, it makes it incredibly over-simplified and I think very distant from what a lot of individuals experience in their own life and their own relationship to drugs. We know through the scientific literature, although it always gets swept aside, the vast majority of people who develop some problem with their drug use stop or moderate on their own. But we have this clinic bias where the population that's getting studied the most, obviously is not those people – the 70 or 80 percent of people who never need treatment, because they're not in contact with those researchers who are all using convenience samples of people on methadone programs or rehab centers or syringe exchanges." (Curtis)

Curtis' statements are supported by Craig Rienarman's Foucauldian-influenced work on understanding the disease model as a historically situated, cultural project. In "Addiction as Accomplishment" he argues that rather than emerging from the "natural accumulation of scientific discoveries", the disease concept was "invented under historically and culturally specific conditions, promulgated by particular actors and institutions, and internalized and reproduced by means of certain discursive practices" (2005: 308).

Efficacy of the Disease Model

One of the primary claims voiced both by advocates and patients who support recovery is that conceptualizing addiction as a disease will remove stigma from people on MMT. As discussed, people on MMT programs often experience high levels of stigma, sometimes resulting in loss of employment, family problems, and the need to keep one's status as a person on MMT secret (Conner & Rosen, 2008; Earnshaw, Smith & Copenhaver, 2013). Scholars have mixed views on the advantages of a medical designation in regards to stigma. Some argue that it can be beneficial by providing "access to the 'sick role', institutional recognition, access to services, and resource allocation" (Burke, 2011: 188). Recovery advocate Zac Talbott argued from this position stating:

> "Every case we win for methadone patients in court, every time we win against a community that is trying to prevent a clinic from opening, would not happen if it were not a disease. Because the powers that be.. that's why it's a disability, that's why the ACA (Affordable Care Act) protects patients. The vast majority of effective advocacy we've accomplished is because it has been proven. And that's why we want to be referred to as patients. Clients don't have patient protections or patient rights." (Talbott)

Interestingly, particularly in light of Reinarman's analysis, Talbott's response seems to conflate the scientific validity of addiction-as-disease with the social/cultural/legal advantages that accompany that designation. While the two positions are not mutually exclusive, his

statements align with the work of scholars who focus on the disease model as a rhetorical strategy rather than ontological reality (Szasz, 1961).

In contrast, while most advocates acknowledged the institutional advantages of the medical model, they saw it primarily as means for exerting control over drug users and providing support for the War on Drugs. Some also rejected the claim that conceptualizing drug use as a disease would reduce stigma for drug users. They pointed out that while the disease model has been culturally dominant and institutionally accepted for more than a decade, people on MMT remain highly stigmatized.

> "The disease model so hasn't [liberated people from stigma] for all of the reasons we've been talking about…. it hasn't, it just hasn't happened. (Bellamy-Taylor, 2014)

MMT and Active Drug Users

> "Whether a particular act is legal or illegal depends on what we call it."
> (Thomas Szasz, 2007)

Most advocates were highly critical of the recovery models' focus on abstinence, and contrasted it with what they argued was harm reduction's value-neutral approach to treating people who use drugs. Although they were supportive of individuals who chose to pursue abstinence, they rejected its elevation from personal choice to treatment model or institutional policy. This, they argued, established a proscriptive approach that is highly removed from the actual experiences of criminalized drug users who are often using MMT to manage the harms of illegal drug use rather than to stop using drugs entirely. Activists' descriptions of illegal drug use as a difficult and dangerous activity that pushed drug users towards treatment were very similar to the first-hand accounts of drug using participants. Moreover, they pointed out that recovery's monolithic approach to treatment is both reflective of, and reifies the proscriptive and

punitive models harm reduction seeks to dismantle. Some of them summarized the issue, as one

of: 'harm reduction incorporating recovery, but recovery not incorporating harm reduction'.

MMT as protection from criminalization

Activists began by pointing out that much of the harms associated with drug use are

either directly related to prohibition/criminalization or are made substantially worse through that

context.

> "That's the first thing you see in everyday life [of drug users] is the damage, the
> harm done by the prohibitive context. The police, the courts. If there's one thing
> that's damaging, it's the prohibitive drug context." (Majoor, 2014)

> "Most of the folks who do use drugs for one reason or another are forced
> therefore to spend so much time and money on the pursuit of drugs, because
> they're illegal, overpriced, all of that stuff." (Bellamy-Taylor, 2014)

> "So many people I have met over the years have really been using drugs quite
> sensibly, using them to get better health. But so many spanners are in the way
> when they do that: the laws, the quality of drugs, the strength of drugs, the stigma
> of drugs and drug use, that it's hard for them to do what they need to do to be
> healthy." (Cavaliere, 2014)

Consequently they emphasized the protective factor that MMT affords active drug users

(and drug users who are 'clean' i.e. only using methadone), particularly against harms associated

with criminalization. Most stated that in their experience, the majority of people on MMT are

not pursuing complete abstinence from all substances, and that many are not even pursuing

complete abstinence from illegal opioids. Rather, they argued that participation in a MMT

program provided active drug users with a safety net against the regular occurrence of

withdrawal as well as the greater likelihood of risky behavior that accompanies it. Activists also

pointed out that MMT releases drug users from having to procure illegal substances multiple

times each day and the associated risk of arrest it brings. Thus, MMT was primarily seen as a

pragmatic means of decriminalizing one's life in order to avoid the marginalization and dangers that accompany illegal drug use. As Majoor explains:

> "It [MMT] has nothing to do with abstinence, it has everything to do with not being sick. It's a daily, safety protection to be sure that you don't get dopesick." (Majoor)

> "It [recovery] really shouldn't be there – it's a methadone maintenance program and it's a great harm reduction intervention in the sense that it reduces a lot of harm compared to shooting up 4 to 6 times a day, having to run around. I think it's a great intervention, it's proven to be a great intervention. It's the context of prohibition that creates this push towards abstinence." (Majoor)

> To support their position, activists referenced the abundance of evidence-based studies that demonstrate the efficacy of MMT in regards to reduced levels of HIV/AIDS transmission, overdose, and prisoner recidivism (Drucker et al. 1998; Langendam et al. 2001; Gibson, Flynn & McCarthy, 1999), and that the program works particularly well when delivered in a 'low threshold' context that tolerates participant drug use (Brugal et al. 2005; Langendam et al. 2001; Ameijden, Langendam & Coutinho, 1999).

Similarly, advocates contrasted the early experiments with MMT - which focused on promoting stability rather than abstinence - with the current standard of care. They argued that Drs. Dole and Nyswander, who did the foundational research on MMT in the 1960's saw the program as a means of reducing harm in the lives of drug users and not as a tool for promoting abstinence.

> "When you read all of the studies on methadone, Naltrexone (which I hate), Buprenorprine, most of the people in the studies didn't stop using all of their drugs, or even opiates. They weren't thrown out because it was a study and then we take it into the real world and tell people that they should stop all drugs or get kicked off. It just doesn't make any sense" (Stancliff)

I talked to [name deleted] who was part of the Federal Committee who created the rules on MMT, and he told me that originally the urine checks were really meant to inform the councilor at the methadone clinic about other use so that they could talk about it, and absolutely not in a punitive context. And that's because of the prohibition context - it turns into something else." (Majoor).

As discussed in the previous section (Professionalization of harm reduction), activists consistently referenced a process whereby data collected for informational purposes becomes re-fashioned as a means of imposing hierarchies, labels, and control. This was linked to prohibition, but also to less visible processes of medicalization that are driven, in part, by the need for quantifiable results. For example, many advocates pointed out how government and nonprofit monies are intimately linked to an organizations' ability to quantify their outcomes hierarchically. Frost acknowledged the possibility that it may be impossible for organizations linked to mainstream forms of funding to maintain harm reductions' values:

> "That's been a huge challenge for harm reduction, is like defining what our outcomes are. And it's because it's built on an anonymous services, because there's so much stigma attached to active drug use so you have to keep it anonymous which means you're not following people for a long time, you don't have the traditional type of clinical/medical records, or biomarkers like urine tests or whatever. And, the goal is not to work towards abstinence, the goal is individually defined, sometimes on a day-to-day basis. So how do you develop outcomes on something that is so individually defined? You know, harm reduction operating from a truly, truly, truly, patient-centered model and based on anonymous services has been why harm reduction has been so successful, and also the reason why we haven't really been accepted… and so I think the tendency to medicalize comes from that, where it's like 'ok if we medicalize, we can start counting things and reporting things because it's not enough to give testimony after testimony after testimony, it's just not the way that the money works." (Frost, 2015)

The need for a nuanced model

Advocates also relied on their own experience working with drug users to point out the problems with the recovery model which they saw as reductive and potentially dangerous for

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drug users. They were critical of the models' clear delineation between acceptable behavior

(recovery) and unacceptable behavior (any "drug" use), and argued that a more nuanced model

was needed to account for the variety of ways that people use drugs.

> "I think there's a whole bunch of people who are lazily adopting, or because they believe it, adopting the more recovery-oriented approach, and see it as like a failure of either the patient or the treatment or something if people are continuing to use drugs even if it's a kind of 'chipper' [opioid user who only uses occasionally in order to not develop a physical dependence] kind of thing. Which is crazy, I mean it's the whole problem with abstinence-based rehab… You're setting it up in such a way that 'relapse' becomes a bigger deal than it should be, because it's like an event and now you have to start over again. [smacks hand into palm for emphasis], and it's really setting the person up to be like 'well if Im gonna use again, I guess I'm just gonna use again', it's not like a moderation thing where that might be okay for that person and healthy and certainly a lot healthier than completely going off the rails." (Curtis)

> "I don't even know what recovery means anymore. I think if a person's life situation and health, physical and mental health, improves, that's recovery. Recovery to me is not a totally abstinent-[based] entity. In fact, that may be the most harmful thing for some people." (Cavaliari)

> The focus on abstinence among methadone providers also limits the ability of harm

reduction organizations to provide maintenance (either Methadone or Suboxone) to their clients.

Frost, who runs a NYC based harm reduction center, explains:

> "That's a service that we know people need, but we can't bring in a provider whose not willing to do treatment for people who are active drug users. There are some doctors who just won't treat people who are active drug users so we would have to make sure that the provider understood that they were providing services in a harm reduction way…. I think with drug treatment on-site, I would have the same type of questions for a provider – it would not make sense to bring in a provider whose going to be, you know, doing urine screens every time they come in. Is there a provider that's willing to work within that? How comfortable does the provider feel if they start feeling confident that the participant is selling their suboxone to buy dope?" (Frost)

> Instead, many advocates argued for a "low-threshold" approach to treatment. The term

low-threshold is sometimes used synonymously with harm reduction based treatment services

and generally refers to clinics whose goal "is not necessarily to eliminate illicit drug use but to establish and maintain contact with opioid users to reduce some of the health and social risks associated with drug use" (Millson et al. 2007). Although there are different approaches to low-threshold treatment, common features include: the removal of admission waiting lists; less punitive (or non-punitive) responses to participant drug use; and a willingness to allow clients to be maintained on low doses which allow individuals to better experience the euphoria of short-acting, illegal, opioids.

> "We have several programs around the province of low-threshold methadone I don't know whether you have them in the United States – where you don't have as many piss tests, and where they don't kick you out if you're using cocaine. They really do their best to keep you somewhat stable. (Cavaliere, 2014)

> "We need to lobby, to use our power, which is basically that we have an incredible link to the client, and use that as leverage to organize services that are really low-threshold, and of a quality that the participant wants, and not what the medical establishment wants." (Majoor, 2014)

MMT as decriminalized opioid use

The need for, and existence of, low-threshold clinics directly addresses the tension between understanding MMT as a form of "drug treatment", and understanding it as a strategic refuge from the forces of criminalization. That MMT patients remain using, and are physically dependent on opioids (methadone) problematizes most conceptions of addiction and treatment that are based on clear distinctions between "drugs" and "not-drugs". Moreover, it suggests that MMT's efficacy is not pharmacologically derived but rather a result of the decriminalized context of opioid use that MMT affords. The success of individuals on Heroin Assisted Treatment (DPA, 2016) adds further credence to this argument. Although discourses that paint MMT as a legalized means of providing "drugs" to "addicts" are generally framed in the extreme negative and used to de-legitimize the treatment, that idea can also form the basis of a structural

critique of criminalization. This is particularly the case in light of the numerous studies

demonstrating methadone's success in reducing death rates, criminality, and transmission of

blood-borne infectious diseases, as well improving health and social productivity (Joseph,

Stancliff and Langrod, 2000; Marsch, 1998; Capelhorn et al., 1996).

Anarchist thinker Hakim Bey's concept of the Temporary Autonomous Zone (TAZ) is

useful towards understanding the ways that many drug users utilize MMT. Bey describes a TAZ

as "an uprising which does not engage directly with the state, a guerilla operation that liberates

an area (of land, of time, of imagination) and then dissolves itself to reform elsewhere before the

state can crush it…..the TAZ can 'occupy' these areas clandestinely and carry on its festal

purposes for quite a while in relative peace." (1985: 101). Thus, TAZ's, like harm reduction

itself, are pragmatic strategies for exercising freedom and autonomy within a punitive landscape.

Since both philosophies start from the position that systems of power and control should be

resisted, concepts of rule-breaking or deviance are re-cast, both as pragmatic means of survival,

and as ethical responses to power. Thus, "illegal immigrants" who get married to remain the

United States, poor people who engage in food stamps fraud, and drug users who use MMT to

gain a quasi-legal supply of opiates are operating within a context of TAZ. Advocate, Walter

Cavaliere's comments reflect this view:

> "They [drug users] want to build a better world for themselves, for others, and for
> the world in general. [There are] Some things that the drug user does that I as a
> [harm reduction] worker cannot do, at least at the moment. I can't hideout a
> person that is hiding from the police, I can't run a safe drug-use site in my home,
> or other things as well, I can't or I choose not to take drugs into prison. I don't
> want to get myself in trouble. Those are harm reduction things that the drug user
> uses and I think need to be explored more. What is lacking in harm reduction, and
> maybe what is lacking in the whole recovery movement is a real understanding of
> the restrictions put on people by nature of the illegality of what they do, and what
> they're forced to do because of that illegality. This can never be resolved and the

recovery people can never be completely recovered in my terms, meaning a better life, until the drug laws are changed to reflect reality." (Cavelieri)

In line with this view, most activists sought to make MMT as low-threshold as possible by offering individuals a full range of options outside of an abstinence-based context.

> "If someone doesn't want to or cannot stop [using opioids] at this moment, well what does he or she want? Clean syringes? Other paraphernalia? Information? Fine, that's it. That's what you give him." (Majoor)

> "If there's people that really just want to come and get their methadone, let them. If people don't want a higher dose because they still want to use, let them. Keep them coming and keep them safe, because they're safer." (Stancliff)

Not surprisingly, the recovery-oriented advocates rejected this view, arguing instead that clinicians should be encouraging drug users to move towards abstinence. Perhaps ironically, considering harm reductions' origins as an alternative to abstinence-based treatment, this position was framed by proponents as "harm reduction". For example, Ed Manchess, program Director at a NYC harm reduction center, stated:

> "Some of them [methadone clinics] are becoming more interested in harm reduction, not just in the sense of dispensing methadone as a way of stating that they practice harm reduction, cause I don't really think that's a practice of harm reduction. I think the practice of harm reduction is more in the dialogue you have with someone and how you may use some type of interviewing techniques or motivational techniques, getting someone to foster change, rather than coerce people to change." (Manchess)

Manchess' conception of harm reduction is particularly interesting in that it suggests a complete re-fashioning of the value-neutral approach of 'meeting drug users where they're at' towards a program meant to foster individual-level, abstinence-based, behavioral change. Similarly, his distinction between "getting someone to foster change" and coercion functions as a rhetorical slight-of-hand designed to mask the proscriptive approach of his organizations' practices. When understood in regards to the power dynamic between clinician and drug user his

suggestion that his approach is either non-coercive or a form of harm reduction seems difficult to support.

Conclusion

Most advocates were highly critical of the increasing use of recovery to conceptualize MMT and saw the shift as occurring alongside the emergence of a less radical iteration of the harm reduction movement. Specifically, advocates argued that the medical/disease model that undergirds most recovery rhetoric was both highly reductive, and problematic in its ability to obscure the role of prohibition/criminalization as a negative force in the lives of drug users. Similarly, most advocates criticized the recovery models' proscriptive stance on abstinence which they pointed out was inconsistent with the realities of drug users who often use MMT to manage the problems associated with criminalization; in some cases, using the program as a means to gain stable, affordable, and most importantly, legal access to opiates outside the context of the War on Drug (users). Thus, advocates used paradigms of resistance to explain the ways drug users utilized MMT and saw recovery as part of a regime of social control linked to the War on Drugs.

Chapter 6 -
Discussing Recovery

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

How well do the tenets and claims of the recovery model align with the experiences of individuals in the program?

MMT as a means of reducing harm

In contrast to the medicalized narrative of the recovery model that positions MMT as a form of treatment for addiction, most participants (from the MMT-client group) described their reasons for pursuing MMT in pragmatic terms related to the structural context of criminalization. Specifically, they focused on the practical difficulties of having to regularly acquire illegal drugs, and related problems when their efforts were unsuccessful. Most notable was their use of MMT to avoid withdrawal which was seen as problematic not only because of its extremely unpleasant effects, but because of the inability to work, stay in school, or pursue non-drug related activities when periodic sickness was a regular occurrence. Participants also reported dangers associated with the police and criminal justice system, as well as the high prices, unregulated drugs, and

unreliability and constant chaos of the illegal market as additional problems. These difficulties were seen as having a synergistic quality that made dependence on an illegal substance an unsustainable lifestyle.

Participants described MMT as alleviating these problems by providing a means to safely, affordably, and reliably acquire opioids outside of their criminalized context. They specifically emphasized the pragmatic advantages of MMT, such as stability, legality, and the elimination of withdrawal. This not only reduced or eliminated the difficulties and dangers associated with illegal opioid use, but allowed them the time and stability to build a life free of the need to constantly seek out drugs. Thus, participants contrasted the constant hustle, dangers, and chaos of illegal drug use with the relative ease and stability of MMT.

Similarly, and in-line with most participants' (from the MMT-client group) view of MMT as a means to reduce or eliminate the problems associated with illegal opioid use (the only class of substances that methadone treats from a pharmacological perspective), many were not interested in abandoning substance use completely. Some wanted to use illegal opioids less often without quitting entirely, while others wanted to quit using illegal opioids but continue using other substances (most often alcohol or marijuana). Most participants found the focus on addiction generally, and the ability to police a wider range of substances that it enabled, to be counterproductive, demoralizing, and a barrier towards joining the program to others not currently involved in treatment.

These results align, to some extent, with those of McKeganey et al. (2004)'s examination of whether drug users in treatment are seeking abstinence or harm reduction. Although that study is framed as demonstrating their preference for abstinence, the results show that individuals in MMT, as opposed to other types of substance use treatment, were the least focused

on achieving abstinence – only 42.5% reported seeking only abstinence (as opposed to harm

reduction only or a mix of abstinence and harm reduction). It is likely that the percentage is even

lower due to social desirability bias. Similarly, Fisher et al.'s examination of drug users'

perceptions of MMT emphasizes the pragmatic benefits people who use drugs accrue through

not having to participate in the illegal drug market (2002). Some of the participants' responses

sound remarkably similar to those in this study. For example, one stated, "As long as I don't

have to find or chase heroin, I would be able to function. Methadone is the solution for me."

(2002: p. 507) Similarly, many participants in that study were not pursuing complete abstinence

but used MMT as a way of minimizing (sometimes temporarily) the harms associated with

illegal opioid use such as withdrawal and having to commit crimes to avoid withdrawal (2002).

Similar to the participants on MMT, most of the advocates I spoke with also

conceptualized MMT as a means of reducing harm rather than as a means of achieving

abstinence-based recovery (though most felt that a good program should offer participants either

option, or anything in between). Many saw the harms that they encounter as directly caused by,

or related to prohibition/criminalization, and emphasized the pragmatic benefits associated with

using a legal, rather than illegal substance. In general, activists' accounts of how and why

people use MMT, as well as how they benefit from it, aligned with those of the MMT clients

themselves. Thus, among the three participant groups, only the clinicians/treatment providers

argued that MMT was primarily about recovery, and even some within this group admitted that it

was out-of-synch with how many people utilized the program.

Reliance on normativity

The recovery narrative's reliance on normativity and lack of appreciation for the

structural divisions in society also problematizes its ability to represent a highly diverse

community like people who use drugs. Although recovery is conceptualized institutionally as an uncomplicated (and even objective) diagnostic entity, since the definition includes things like work, school, and being perceived as a good citizen, it obscures the hierarchical nature of our society where access to monetary and other forms of capital are dispersed unevenly and often along racial and class lines. For example, since African Americans and Latinos are less likely than whites to be employed (US Dept. of Labor, 2016), they will be similarly disadvantaged in regards to assessments of recovery. Even things like accents, choice of clothing, or bodily comportment signify and reflect social hierarchies (Bourdieu, 1984) and can therefore affect assessments of recovery. Thus, by linking addiction to such vague and subjective markers as choice of friends, good citizenship, and/or maintaining the "right attitude", recovery becomes a powerful tool for the enforcement of norms, and the maintenance of social hierarchies.

Notably, some participants did describe their drug use experiences and treatment motivations through the lens of recovery. These individuals – who often identified as being in, or pursuing recovery – used medical language to frame their difficulties with drug use, and saw MMT as a form of medical treatment. However, many in this group relied upon subjective and culturally specific interpretations of "abstinence" and "drug" that problematized recovery's use of discreet and universal categories to delineate between people in recovery versus those who are not. For example, participants who occasionally drank alcohol tended to view that as within the bounds of recovery but rejected recreational marijuana use. Others smoked marijuana and argued for its acceptability while dismissing the claims of those who drink.

Although not everyone who identified as being in recovery defined it in exactly the same way, the divisions between those perceived to be in, or pursuing recovery versus those using MMT as a form of harm reduction, was a significant source of tension. Recovery-focused

participants felt pragmatically-focused clients were giving the program a bad name and potentially even jeopardizing its existence. In some cases, this led to a tense clinic atmosphere, sometimes involving clients reporting on one another for drug use or other activities that conflict with recovery. Since the recovery discourse is involved in expanding the jurisdictional boundaries of addiction-causing substances and behaviors, one can imagine how debates over substances like cigarettes, chewing gum, and sugar, or behaviors such as playing the lottery can further complicate the already tenuous boundaries between recovery and active addiction.

It is important to keep in mind that individuals in MMT are operating within an institutional environment that rewards acceptance of recovery and punishes deviation from it. Scholars have pointed out the capacity of such institutions to promote the internalization of their own norms and values (Foucault, 1973; Goffman, 1968; Szasz, 1961). Thus, while not denying the lived experience of individuals who see their experience as medical treatment, recovery in MMT engenders an institutional process whereby "addicts" learn to describe their newly reconstituted life stories utilizing the linguistic rules of the disease/recovery discourse (Reinarman, 2005). Sociologist Helen Keane points out that medical categories are particularly imbued with this type of power, stating:

> "Therapeutic authorities work in the service of liberty and personal choice, which ironically makes them more profoundly subjectifying than other more obviously oppressive forms of authority. Therapeutic authorities seem to emerge from inside ourselves, from our desires for happiness and striving for fulfillment. The understanding of freedom as a regulative norm provides a useful insight into recovery discourse, which urges troubled individuals to attain autonomy and find happiness through open-ended projects of self-examination and self-improvement" (Keane, 2002)

Conclusion

Most participants conceptualized, and utilized MMT, primarily as a way to moderate or potentially eliminate the harms and difficulties of *illegal* opioid use and not as an abstinence-based program of self-change. This not only contrasts with the recovery narrative, but with disease-focused, and pharmacologically deterministic theories of addiction generally. Instead of acting at the behest of a substance or mental illness, participants' experiences can be better described as those of highly criminalized individuals (often with additional intersectional forms marginalization and/or oppression) who are often forced to make strategic decisions under difficult circumstances. For some, this meant utilizing MMT to permanently reduce a variety of risks without having to discontinue opioid use (methadone) - essentially swapping an illegal drug for its decriminalized cousin - though most would not frame their activities in that way since discourses that position MMT as a form of 'substitution' are culturally associated with anti-methadone arguments. For others MMT functioned as a temporary means of survival during particularly difficult circumstances. In either case, their actions demonstrated a rational form of strategic adaptation to oppression – a narrative that sharply contrasts with the medically-based tenets and claims of recovery.

Thus, one important finding of this study is that the narrative of recovery-based treatment is not universal to all people on MMT. Although many are undoubtedly seeking recovery, many clearly are not, and these already marginalized individuals become increasingly marginalized by having to conform to its tenets. This is particularly important in light of the long history of silencing, and ignoring the voices of people who use drugs in regards to their own perceptions of, and needs for treatment (Chen, 2011; Friedman et al., 2007; White, 2001).

How, if at all, has the shift towards conceptualizing MMT as recovery-based treatment affected issues of agency and control among individuals in the program?

An individualist model?

Although treatment providers and individuals working for administrative offices like Substance Use and Mental Health Services Agency (SAMHSA) and New York Office of Alcohol and Substance Abuse Services (OASAS) consistently described recovery as a flexible or "individualist" model that was easily adapted to meet a variety of needs, interviews with participants from the MMT-client group refuted this claim. Rather, most described clinics as decidedly top-down institutions that maintained strict rules and used punishment to back them up. Although they pointed out that clinics have always been authoritarian in structure, recovery expanded their jurisdictional boundaries, allowing them to intervene in more aspects of their clients' lives. Moreover, it provided a strong ideological motivation/justification - through the disease model of addiction - for them to do so.

The ability of individuals in MMT to participate in or otherwise structure their treatment depended on how clinic staff perceived them in regards to recovery. Clients whose treatment goals aligned with the recovery model reported few if any problems dealing with their clinics, and often saw their counselors as allies in their recovery. However, participants whose treatment goals contrasted with recovery, for example individuals utilizing MMT for harm reduction and not abstinence, reported numerous difficulties. This is particularly important considering that most participants' (from the MMT-client group) descriptions of how they used and benefited from MMT, aligned far more closely with the open-ended, and pragmatically-oriented harm reduction model than with the strictly delineated tenets of recovery.

Clinicians generally saw individuals who were not pursuing recovery as either unready for treatment or as taking advantage of the program and hurting those who were using it "correctly". Twenty years ago Koester et al. rejected this all-or-nothing interpretation in their qualitative study of what motivates people who use heroin to enter MMT (1999). Instead, they characterize MMT as a pragmatic strategy utilized in multiple ways by a highly criminalized population with limited options. More recently, Harris & Rhodes point out that within the context of numerous constraints that restrict people who use illegal drugs and people on MMT, even activities generally understood as rule-breaking or crime, such as diverting methadone to the illegal market, can be understood as "indigenous harm reduction strategies" that help people who use drugs to "manage their drug use, prevent withdrawal, cement social relationships, and inadvertently protect against hepatitis C transmission." (2013: p. 43)

Although some treatment providers emphasized that their clinics' focus on recovery was non-coercive, this position seems untenable. Firstly, recovery-oriented goals and principles are often built institutionally into programs (SAMHSA, 2015; SAMHSA, 2009) as well as conveyed through the client/counselor relationship. This was evidenced by the interviews with SAMHSA and OASAS employees who stressed the organizations' focus on recovery-based treatment, and who described a number of recently implemented recovery-based programs and grants. Secondly, the belief that individual clinics can provide a non-coercive focus on recovery also misunderstands the highly unequal power dynamic between individuals on MMT and treatment providers. People on MMT are often terrified of being discharged from programs, which makes any official doctrine on how to conceptualize drug use and treatment, coercive. Moreover, some treatment providers were upfront in their belief in the disease/recovery model, and that people in

their programs were encouraged to adopt it and describe their drug use through those concepts and language.

Surveillance & Punishment

Individuals in MMT who were not in, or were not pursuing recovery associated the shift towards recovery-based policies with an increased focus on policing their drug use. Although clinics have always maintained rules against substance use (SAMHSA, 2015; Joseph, Stancliff & Langrod, 2000), the culture of recovery involved a greater emphasis on abstinence. Thus, while in the past, clinics may have tolerated their clients' substance use, seeing MMT as, in part, a form of harm reduction, this is less and less common (or acceptable) in the environment of recovery. Since clinics have significant autonomy and policies often vary by individual clinic, a clinic director or counselors' views on recovery versus harm reduction, can significantly affect their rules and policies.

Some administrators even directly mentioned harm reduction as something that would no longer be tolerated. Moreover, since recovery conceptualizes addiction as a holistic, or whole-person problem, clinics are increasingly focused on clients' non-opioid substance use which had, in the past, often been seen as outside the purview of MMT.

Punishments most commonly took the form of reducing or eliminating individual's take-home doses. Since this meant having to attend the clinic every day (with the possible exception of Sunday when most clinics are closed), it was a serious penalty that made life much more difficult for such individuals. Moreover, the highly limited, early morning dosing hours exacerbated this problem. Thus, such policies inevitably forced individuals to spend a considerable amount of time (often during standard working hours) at their clinic, making it

extremely difficult for these already marginalized individuals to maintain regular employment. This is particularly problematic when considering that most people reported using MMT to stabilize and/or normalize their lives, a nearly impossible outcome under such circumstances.

Not surprisingly, the punitive structure for take-home doses was among the most contentious issues (particularly for those not receiving them) and many reported it as the main reason for having left a particular clinic, or treatment in general. Studies demonstrate that individuals who leave MMT often return to more risk-involved forms of street opioid use (Fugelstad et al. 2007; more). For example, Fugelstad et al. found mortality rates from unnatural deaths (usually overdose) of 44.3% for individuals discharged from MMT programs as opposed to rates of 2.1% for those currently in MMT (2007). Emphasizing this relationship, one participant in this study died shortly after being consistently refused take-home doses and eventually leaving treatment as a result[16].

Recovery was also associated with an effort to expand the number of services offered (and sometimes required) by clinics. This shift is reflected in clinicians' increasing preference for the term Opioid Treatment Program (OTP) instead of the more specific Methadone Maintenance Treatment Provider (MMTP). Clinicians emphasized that the program was not simply a means of providing individuals with methadone, but rather a holistic treatment for addiction, which was described as a whole-person pathology, requiring a variety of psych-social-spiritual interventions. Examples of recently introduced services included: on-site 12-step meetings; peer-based recovery groups; and various classes centered on promoting 'healthy

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[16] Although it was not completely clear how this participant died, the proximity of his death to his departure from MMT (within a month), as well as his comparatively young age (early 30s) suggests that the two events were at least partially related. Research has demonstrated increased risk of overdose, suicide, and a variety of negative health outcomes associated with discontinuation (particularly involuntary discharge) of MMT (Clausen, Anchersen & Waal, 2008; Capplehorn et al. 1996).

living' such as exercise or 'more nutritious' eating. Clients reported that such services were often included as parts of their treatment plans and that they felt pressured to attend whether it was officially required or not.

Much of the research on MMT is critical of how excessive rules and regulations affect treatment outcomes (Stancliff et al., 2002; Des Jarlais et al., 1995; Dole & Nyswander, 1976). Stancliff et al. cite the restrictive nature of MMT as potentially explaining why so many people who use drugs view it negatively (2002). Similarly, physicians Dole and Nyswander - who did the foundational research leading to MMT in the mid-1960s - also rejected the use of strict rules and regulations, which they cite as the most common reason for "addicts" to reject treatment. Others point out, that MMT is incapable of providing "individualized" treatment while maintaining a rigid system of rules (Des Jarlais et al., 1995; more). As Des Jarlais et al. argue "The highly restrictive regulations also serve to undermine patient morale in MMT. The complexity and rigidity of the regulations work against the idea that treatment is individualized according to the needs of the specific patient" (1995: p. 1581). Moreover, aside from the ethical, and morale-based problems associated with such policies, there is no evidence that they are effective (Ward, Hall & Mattick, 1999).

Medical model as a form of social control

The disease model also functioned to legitimize the increasing control demanded by clinics over their clients. In particular, the disease model established the pathological nature of drug use/rs, as well as the hierarchical social context that positions doctors and clinicians as more knowledgeable (and better able to determine treatment needs) than drug users themselves. Scholars focusing on the trend towards medicalization have consistently noted its ability to restrict the agency of "sick" individuals, ostensibly for their own good (Conrad and Schneider,

2010; Zola, 1972; Rosenfeld and Faircloth, 2009). Thus since the disease model constructs "addicts" as inherently flawed individuals' who are incapable of acting in their own interests, the use of authoritarian and paternalistic tactics seems justified (Acker, 2002; Szasz, 1961).

Clinic counselors knew that such policies – particularly the expanded focus on non-opioid drug use – would negatively impact many of their long-term, and older, clients. However, they conceptualized the shift as an inevitable result of top-down policy changes. Moreover, and in line with recovery discourse, they also saw the changes as positive opportunities for "addicts" to "treat their disease", meaning to accept recovery. Thus, clinicians' attitudes were informed by discourses of addiction that utilize both medical and punitive elements. Here making the proper treatment choices was conceptualized as both an opportunity and a responsibility, and difficulties that arose for individuals who were not pursuing recovery, were seen both as a product of their disease and also as their own fault. Similarly, (and evidencing how clients' internalize such narratives) clients also tended to view punishments as 'their own fault' rather than as the result of punitive and unfair polices. Although medical and punitive approaches are often conceptualized as mutually exclusive, scholars point out that they are better understood as parts of the same institutional and cultural structures for controlling people who use drugs, and often work in support of one another (Tiger, 2013; Smith 2012; Keane, 2002).

Participants reported occasionally voicing their concerns over such policies, however they were consistently rebuffed using the same discourses of pathology. For example, SAMHSA and OASAS employees described clients' requests for harm reduction-based treatment as "their disease talking" and declared that, if allowed, "addicts" will always try to "lie and manipulate". Thus, the medical model established an epistemological dynamic whereby drug users' views

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were not only devalued and silenced, but positioned as inherently in-authentic and malicious products of their disease.

Stigmatization

Although one of the most oft-cited defenses of disease, or medically-based theories of drug use is the claim that such models reduce stigma (White and Mojer-Torres, 2010; more), participants' descriptions of recovery-based treatment refuted this view. As discussed (earlier in this chapter), individuals who used MMT as a form of harm reduction were often stigmatized by recovery-focused clients and clinicians, who sometimes sought to remove them from treatment programs. Thus, while not necessarily stigmatized for their disease as such, their decisions regarding it were morally scrutinized. Arguing from a similar perspective, medicalization scholar Irving Zola points out, that even if diseases, in and of themselves, do not inherently represent moral signifiers, once the conversation moves to exploring how one acquired or treated a particular malady, "then the rational scientific veneer is pierced and the concern with personal and moral responsibility emerges quite strikingly." (1972: p. 472).

In *Addiction stigma and the biopolitics of liberal modernity* Sociologist Susan Fraser describes stigma as means of mobilizing political power rather than a static marker of difference (Fraser, 2017). She argues that "we must consider addiction not so much as a stigmatized state but as a linguistic and taxonomical mechanism by which *stigma is materialized*. (2017: p. 8) and that "addiction is a means by which contemporary liberal subjects are schooled and disciplined in the forms of conduct and dispositions required to belong, and to count as fully human" (p. 8).

Hence, these results align with research that problematizes claims of medicalization as a liberatory force in people who use drugs' lives (Kvaale, Haslam & Gottdiener, 2013; Kaye,

2012; Tiger, 2013; Keane, 2002). Rather than reducing levels of stigma, many respondents – particularly, those who utilized MMT for harm reduction – described high levels of stigma based on who was seen to be using MMT 'correctly'. Thus, while the recovery discourse did establish a hierarchy that may have reduced stigma for certain individuals, it was at the expense of others who were increasingly marginalized for their views.

Harm reduction, drug user rights, and recovery movements

Efforts to promote or implement harm reduction-based treatment have also been affected by the political landscape of drug treatment services and activism. Although harm reduction overlaps, and is historically aligned with the drug user rights movement, it has also become increasingly accepted within mainstream medicine, potentially shifting the movements' focus. Many of the advocates I spoke with, who still identify as harm reductionists, were critical of the shift and worried that it has led to a less radical version of the movement. Specifically, they were concerned that today's more mainstream harm reduction is necessarily more focused on normative outcomes like abstinence and less willing to support active drug users. They argued that a political critique of criminalization, which had always been a part of the movement, is increasingly ignored. Advocates linked the ability of harm reduction organizations to access mainstream funding sources to a focus on quantifiable outcomes like reduced levels of drug use. Thus, they characterized the trend as one of an outsider movement, becoming increasingly part of the mainstream and, therefore, less equipped to be critical of it.

This shift is also reflected in drug use scholarship where some advocate merging abstinence-based and harm reduction treatment models (Futterman, Lorente, M., & Silverman, 2004; Kellogg, 2003). Such programs usually call for "building a therapeutic continuum between the harm reduction and abstinence-oriented treatment worlds" (Kellogg, 2003: p. 241).

Although proponents often describe such hybrids as incorporating the best of each model, opponents argue that a "continuum" necessarily preserves the hierarchical relationship between abstinence and drug use, which harm reduction traditionally opposes. Thus, most hybrid models relegate harm reduction to a means of initiating (and maintaining) contact with marginalized drug users, in order to encourage them to pursue abstinence, which is always seen as the true goal.

Conclusion

Results demonstrate that conceptualizing MMT as recovery-based treatment has a variety of potential negative effects for individuals using MMT for harm reduction and not recovery. Participants described an increasing ability for clinicians to intervene in areas of their lives previously seen as outside of the purview of MMT. This included increased surveillance of their drug use, and notably, a focus on monitoring use of non-opioid substances. Participants who were not pursuing recovery often experienced the shift as intrusive and punitive, and changes associated with recovery accounted for at least one participant abandoning treatment (and subsequently dying).

The disease model of addiction was used as a justification for increased surveillance and punishment of people who use drugs as well as a strategy for silencing dissent amongst those who requested forms of harm reduction treatment. Similarly, participant responses suggest that rather than a means of reducing stigma among drug users, the recovery model merely re-arranges how, and to whom stigma is applied – in this case, those who resisted recovery were consistently marginalized. Thus, the shift towards recovery-based treatment in MMT did not increase agency and control for people in the program. Moreover, for those positioned as deviant by the recovery discourse, the change was associated with a significant reduction in their ability to structure their

treatment, in many cases leading to discontinuation of treatment (either voluntarily or involuntarily).

How does conceptualizing MMT as recovery-based treatment affect how drug use, drug treatment, and drug control are understood?

Obscuring structural and institutional oppression

Although medical models of drug use and treatment like recovery are often positioned as progressive alternatives to more overtly punitive models, the results of this study demonstrate a more complicated relationship. Rather than an alternative to criminalization, the recovery discourse in MMT provides implicit support for it by obscuring its role both as a source of harm in drug users' lives, and as a motivation for their engaging with treatment (MMT). First, recovery positions the harms people who use drugs encounter as resulting from individual pathology, i.e. the disease model of addiction, rather than through the structural-legal difficulties imposed on them by criminalization. Although nearly all participants linked the difficulties they encountered using drugs to their illegality, the recovery discourse frames such problems as resulting individually, from addiction. Thus, the role of heroin's illegality in the harms and difficulties drug users encounter is positioned outside of the model and free from critique. Similarly, the recovery discourse also constructs drug users' decision to use MMT as motivated by a desire for abstinence-based recovery, and not as a refuge from the harms of criminalization. This constrains discussions of drug users' harms, and of MMT's benefits, to the biological/pharmacological, rather than structural-legal domains, thereby depoliticizing drug users' treatment decisions.

The false dichotomy between drugs and medicine

This obfuscation is accomplished in part by the recovery model's reliance upon the false dichotomy between "drug" and "medicine". By positioning methadone as a medication, with little to no relationship to illegal opioids like heroin, the recovery discourse describes positive treatment outcomes as the result of a pharmacological intervention: switching from a "drug" to a "medication" rather than from an illegal substance to a legal one. This construction not only renders the treatment more politically acceptable, but also enables positive treatment outcomes to be seen as the result of a medically-based pharmacological shift, while obscuring the more meaningful differences resulting from legal as opposed to illegal drug use.

While many participants adopted this rhetorical strategy when describing their treatment experience (an unsurprising outcome considering the institutional dominance of the disease model in MMT), others challenged this view by emphasizing the similarities between methadone and illegal opioids. Some participants even directly rejected the pharmacological distinction between heroin and methadone, describing them instead as *legal* versus *illegal* opioids. However, participants from the MMT-client group were often reticent to express that view and admitted to social pressure from family and others to position methadone as a medicine, separate and distinct from illegal opioids like heroin.

Public health initiatives like recovery are often criticized for their tendency to focus on individual behavioral change at the expense of structural analyses (Salas, 2015; Walls, Peeters, Proietto & McNeil, 2011; Merzel & D'afflitti, 2003; Reinarman & Levine, 1997). Reinarman and Levine argue convincingly that the moral panic surrounding crack cocaine use functioned to protect the power structure by positioning the structural and institutional issues of urban decay as resulting from poor moral choices i.e. crack cocaine use (1997). Sociologist Deborah Lupton argues that public health discourses often mobilize concepts of risk in order to "blame the victim,

to displace the real reasons for ill-health upon the individual, and to express outrage at behavior deemed socially unacceptable" (1993: p. 425).

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

Limitations

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

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on a representative sample, the results cannot be generalized to the larger population of individuals on MMT.

Similarly, since the majority of study participants were located in New York City (NYC), the results may reflect that community. NYC is a center of drug use, research, and activism, and participants may therefore be more informed about recovery, harm reduction, and/or the politics of drug use issues. Similarly, the clinic I attend (and did the majority of my ethnographic research at) is also the location of Medication Assisted Recovery Services (MARS), one the primary organizations working to promote recovery-based principles in MMT. Although this had no direct effect on the study, the clinic environment (posters, announcements, etc.) may focus on recovery more so than other clinics. For these reasons, I spoke with participants from outside the state and also visited other clinics (in the NYC area).

Recommendations

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

Increasing focus should be given to 'low-threshold clinics' and other forms of harm-reduction-based treatment. Low-threshold clinics are those that "seek to break down barriers to the treatment of opioid dependence by reducing entry and retention criteria and by accepting individuals who continue to use drugs without threat of expulsion from the program" (Millson,

Challacombe, Villeneuve & Strike, 2007: p. 125). Although treatment providers may object to

such clinics on the basis that individuals on MMT who use other substances may be at increased

risk of overdose, studies have found that low-threshold clinics actually reduce the risk of

overdose (Van Ameijden, Langendam & Coutinho, 1999) as well as injection-related HIV risk

(Millson, Challacombe, Villeneuve & Strike, 2007) and improve health related quality of life

among participants (Millson et al. 2006). Moreover, like many critiques of harm reduction

treatment, such claims are based on the falsehood that individuals who wish to continue using

drugs while in MMT will be dissuaded by the possibility of punishment and comply with the

rules. In actuality (and like one participant in this study) many simply abandon treatment and

return to illegal and unregulated – and thus, more risk-involved - opioid use.

However, when such options are unavailable, people who use drugs and like-minded

activists should be open to operating outside of the system. As critical Anthropologist C.B.

Smith points out "Prior to being institutionalized as public health policy…. harm reduction

originated as an illegal activity where activists and politicized front-line workers risked arrest by

distributing clean syringes" (2012, p. 210). Similarly, participants in this study who used MMT

for non-recovery reasons, were most successful when they utilized deception to convince

clinicians that they were, in fact, pursuing recovery. In the oppressive context of criminalization

and the War on Drugs, using deception in order to maintain access to a stable, reliable, and legal

supply of opioids is comparable to underground syringe exchange organizations, illegal safe

consumption spaces, and other forms of traditional harm reduction work.

Most importantly, the culture and institutions involved with MMT must allow for

alternative discourses that position criminalization as oppressive to drug users and acknowledge

the role of treatment (particularly MMT because clients are not required to discontinue opioid

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

Appendix 1: References (Introduction)

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