Re-positioning Methadone Maintenance Treatment (MMT) within the context of criminalization

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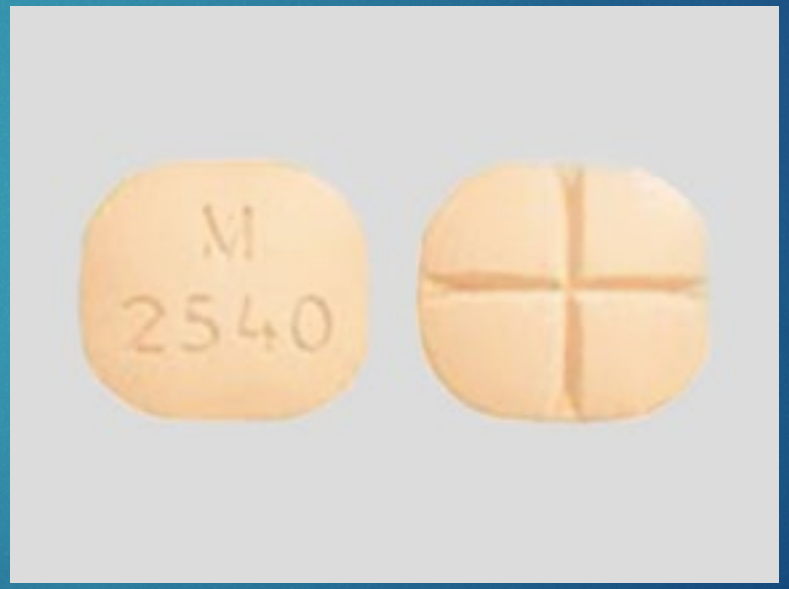
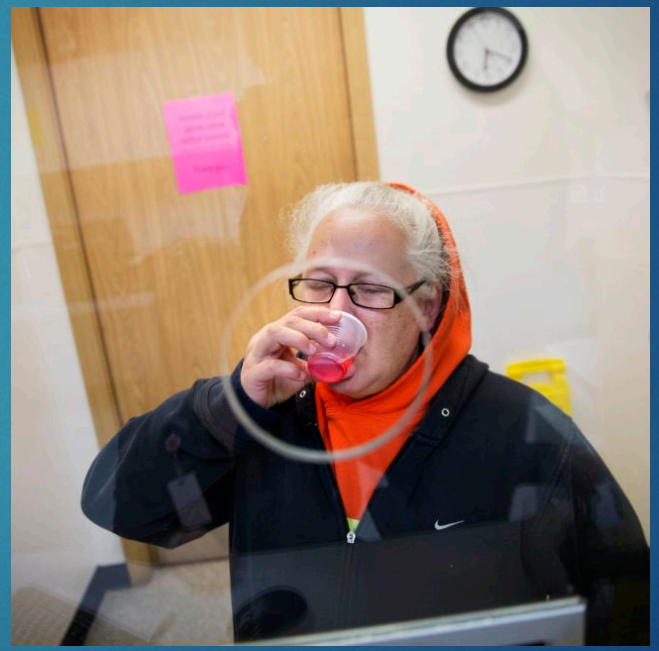
Background - Methadone

- Synthetic opioid
  - Cross-tolerant
- Longer half-life
  - Lasts longer
  - Less euphoric
    - But still euphoric



Background – Methadone Maintenance Treatment (MMT)

- Originated in NYC in the 1960's and 1970's
  - Dole and Nyswander
- Substitution-based treatment
- Maintenance-based
- Delivered in Opioid Treatment Programs (OTP), i.e., methadone clinics
  - Cannot be obtained in primary care
- Highly regulated



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Background – Methadone Maintenance Treatment (MMT)

- 'The Gold Standard'
  - Reduces rates of substance use; overdose; and transmission of blood-borne viruses[1]
- Low rates of patient satisfaction
- Low rates of use and retention
  - Only 10-15% receive medication for opioid use disorder(MOUD)
  - Approximately 50% of patients drop out every year

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Recovery-oriented MMT (ROMM)

- Recovery - "A voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship"[1]
  - Holistic model focused on changing the whole individual
  - Abstinence-oriented
  - Based on medical/moral model of addiction

[1]Betty Ford Institute Consensus Panel. (2007).

Methadone Maintenance Treatment

MY OWN EXPERIENCE

My research

- MMT and buprenorphine
- Primarily qualitative and ethnographic studies
- Focused on how well institutional narrative (of addiction and recovery), and practices that are linked to that view, aligned with the needs and goals of patients.
- Centered the voices and experiences of patients and people who use drugs

Theoretical framework

- Medicalization
  - Looks at how human issues and problems come to be seen as medical
  - Critique of bio-medical determinism
- Situated Knowledge[4]
  - Critique of "disembodied scientific objectivity"
  - Stresses researcher positionality, partiality, and reflexivity
  - More comfortable with social-justice research

Theme 1 – Misalignment between ROMM and patients' goals

PATIENTS' NARRATIVES DID NOT ALIGN WITH INSTITUTIONAL APPROACH

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Institutional narrative versus patient responses

ROMM

- Ideological and medical
- Stresses narrative of addiction and recovery – bad/sick to good/recovered
- Harms of drug use are individually-based (addiction)
- Requires abstinence only (from all drugs)
- Treatment as holistic behavioral modification

Patient responses

- Pragmatic
- Stresses reducing or eliminating harms and difficulties of illegal substance use
- Harms of drug use are linked to the context of criminalization
- Most did not want abstinence. They did want stability
- Just wanted easier access to methadone and protection from harms

Circumventing criminalization

"The criminalization and all that goes along with it. Absolutely. That was the main reason [I got on MMT]" because, you know, you get very, very sick and very ill and that's why I feel like I did a lot of stuff that people don't usually do to get the drugs, you know what I mean? Because of the effects of not having it."

Angela, 32 white female, currently on MMT

Tired of the hustle

"I'm tired of the chaos. Tired of losing people I love. Tired of the lifestyle."

Martin, 29, Latino male, currently on MMT

"I got on Methadone so that I wouldn't feel sick. It was strictly so that I wouldn't feel sick. So, I was like, "You know what? I'm never gonna get sick again."

Steve, 37, white male currently on MMT

Harm reduction, not abstinence

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

Barry, 33, White male

Fentanyl, overdose, and an increasingly unstable supply

"I think it was because the Fentanyl was coming out and I had to do something in terms of like OD'ing. You don't know what's in it [opioids bought from the illicit market], and then, and I wanted to get fentanyl tested but who's -- I'm not -- who's going to go over through all that to get, for a bag of dope? I'm not going to start testing it and doing all of that. Now, it becomes a project. But that's the beauty of methadone."

Sandra, 55, white female currently on MMT

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Finding 2 – ROMM as barrier to patients' goals

ABSTINENCE-BASED AND PUNITIVE POLICIES LEAD TO DROPOUT AND AVOIDANCE

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How does addiction/recovery narrative affect the way that MMT is practiced?

- Treatment becomes all about behavioral modification not harm reduction
  - Counseling, drug-testing, 12-steps
- Highly regulated and punitive
  - Patients have no power
- Abstinence-only (even from alcohol and marijuana)
  - No take-homes
  - Could lead to discharge
  - Makes it hard to hold a job or go to school

"Liquid handcuffs"

"I hate it [MMT] because it's like liquid handcuffs. Say you want to go somewhere for a few days, you need take-homes and if they won't give them to you, there's nothing you can do. The outside world, or people that are not on MMT don't really understand what that's like…. Take-homes are the biggest problem, everyone has trouble with them, whether it's losing their job, or they can't go out of town, or they're just late, or sick."

Samantha, 32, white female previously on MMT

A barrier to stability

"So basically, the idea is to get back to living your regular life. But, in a way, it kind of deters you from doing so sometimes. And especially at first. I had to go even on Saturdays. I mean, how the hell would I do a regular job like that? How could I get a nine to five. I don't know that I could definitely be on time."

Dean, 29, black male, currently on MMT

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A barrier to treatment initiation and retention

"That's going to probably be the number one reason people don't want to get on Methadone. You have to go stand there in the morning, wait to get dosed, and it just sounds like a real pain… I lived in Pennsylvania, and at the worst time, I would have jumped on treatment in a second. But the closest clinic was in Lancaster and that meant that I would have to drive up there every day, which it was a little over two hours each way so, I would have to do that every single day."

Edward, 30, white male, never been on MMT

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Harm production

"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

Withdrawal

- Current study shows the withdrawal is a catalyst for MOUD participation and for taking risks.
  - Should not be underestimated as vector of risk
  - MMT's ability to stop that is a great treatment outcome

MMT does a lot of good regardless of abstinence

- Allows PWUD to access opioids outside of the context of criminalization
  - Reduces frequency of opioid use
  - Reduces OD, transmission of disease
  - Eliminates the need to hustle and commit crimes
  - Reduces/eliminates withdrawal
  - Provides agency over substance use
  - Allows people to work, go to school, become stable

- **But not if people dropout of treatment and/or avoid it**

Overdose Crisis

- Opioid-involved overdose deaths in the U.S. have sharply risen from 21,088 in 2010 to 68,630 in 2020
- During the 12-month period ending April 2021, there were more than 100,000 drug overdose
- At the same time (2010-2019), estimated rates of acute annual HCV infections increased by 387%, also driven in part by the opioid epidemic and linked to injection drug use deaths in the U.S., a 28.5% increase from the prior year
- HIV outbreaks continue to emerge among people who inject drugs

Clinic Policy Changes

- Harm reduction
  - Neutral position on drug use – concern with harms
  - Patient autonomy - allow for a variety of treatment goals rather than just abstinence
  - Respect incremental change
  - Pragmatic – risks should be seen in context
  - Non-coercive/non-punitive
- Clinicians need to conceptualize MMT in context of WOD
  - Treatment should reflect the reality that many people are involved for harm reduction NOT the pursuit of abstinence.

Problems - discursive

- ROMM obscures the role of policy (criminalization) as a source of harm
  - Positions the causes of drug use harms individually
  - Positions success on MMT as the result of addiction treatment

Re-thinking MMT

- Theorize the harms of drug use and benefits of treatment in context of the WOD and other structural forces
  - Recognizing the role of the War on Drugs as a force of oppression for people who use drugs, and that their treatment decisions are made in that setting.
  - MMT 'treats' the problems of criminalization
- Conceptualize MMT as harm reduction
  - Acknowledge MMT's role as a form of decriminalized opioid use
  - Acknowledge MMT's role as a form of safe supply
  - Acknowledge MMT's role as a way of avoiding withdrawal, overdose, disease transmission, improving quality of life, stability, etc.

What's wrong with addiction

- Focused on the individual at the expense of structure
- Diagnostic and etiological problems
  - Who defines "harm"?
  - What causes the harm?
- A moral narrative masquerading as science
- MMT problematizes "addiction"
  - If "addicts" get better when you provide them with their drug of choice outside of the context of criminalization, what does that say about "addiction"?

Take-aways

- MMT is not working
  - The current approaches to MOUD do not align with the actual needs and goals of people who use MOUD
- This leads to high rates of dissatisfaction and dropout and ultimately poor health outcomes including overdose
- Healthcare and addiction scholars need to be more critical about the theoretical frames for understanding the etiology of drug use harms and treatment's benefits
- Harm reduction is a more practical, and more ethical, way of addressing and understanding treatment
- Importance of experiential knowledge

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THE END

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