Methadone as Social Control

Article *in* Qualitative Health Research · January 2012

2 authors:

Julie Harris
Ulster University
4 PUBLICATIONS   **51** CITATIONS

SEE PROFILE

Karen Mcelrath
Florida State University
16 PUBLICATIONS   **502** CITATIONS

SEE PROFILE

Qualitative Health Research

Methadone as Social Control : Institutionalized Stigma and the Prospect of Recovery

Julie Harris and Karen McElrath

The online version of this article can be found at:

Additional services and information for *Qualitative Health Research* can be found at:

Email Alerts: http://qhr.sagepub.com/cgi/alerts

Subscriptions: http://qhr.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.com/journalsPermissions.nav

Citations: http://qhr.sagepub.com/content/22/6/810.refs.html

>> Version of Record - May 2, 2012

OnlineFirst Version of Record - Jan 9, 2012

What is This?

Methadone as Social Control: Institutionalized Stigma and the Prospect of Recovery

Julie Harris[1] and Karen McElrath[1]

Abstract

Methadone maintenance treatment (MMT) is an intervention used to treat opioid (heroin) dependence. Several investigators have found that MMT is effective in reducing heroin use and other behaviors; however, a disproportionate number of MMT clients leave treatment prematurely. Moreover, MMT outcome variables are often limited in terms of their measurement. Utilizing an integrated theoretical framework of social control and stigma, we focused on the experiences of methadone maintenance from the perspective of clients. We pooled interview data from four qualitative studies in two jurisdictions and found linkages between social control and institutional stigma that serve to reinforce "addict" identities, expose undeserving customers to the public gaze, and encourage clients to be passive recipients of treatment. We discuss the implications for recovery and suggest recommendations for change.

Keywords

addiction / substance use; health care, users' experiences; recovery; social identity; stigma

Methadone maintenance treatment (MMT) is widely recognized as an intervention for treating opioid dependence (primarily heroin dependence). Researchers have described MMT in terms of its effectiveness for reducing heroin and/or other drug use (Fareed, Casarella, Amar, Vayalapalli, & Drexler, 2009; Simoens, Matheson, Bond, Inkster, & Ludbrook, 2005; Teesson et al., 2006), risk behaviors associated with HIV (Corsi, Lehman, & Booth, 2009; Gowing, Farrell, & Bornemann, 2008; Hartel & Schoenbaum, 1998), crime (Lind, Chen, Weatherburn, & Mattick, 2005; Sheerin, Green, Sellman, Adamson, & Deering, 2004), and fatal overdose involving heroin (Fugelstad, Stenbacka, Leifman, Nylander, & Thiblin, 2007).

Despite a vast research base into MMT, scholars have suggested that MMT outcome studies are limited because of methodological problems associated with program attrition, sample bias, and measures (Fischer, Rhem, Kim, & Kirst, 2005). For example, client retention in MMT is one outcome variable that has been used to gauge the effectiveness of MMT. Retention is deemed to be important because it reduces the likelihood of relapse into heroin use, and in turn, heroin overdose and injecting behaviors associated with blood-borne viruses. However, clients who have left treatment during the early stages of MMT are often excluded from retention studies (Fischer et al.). This omission can artificially boost the overall retention rate, i.e., making it appear higher than the true

value had early program leavers been included in the calculation. This form of sample selection bias is important, particularly because dropping out of MMT has tended to occur more frequently within the first few months of treatment (Farré, Mas, Torrens, Moreno, & Camí, 2002). In some studies, upwards of 40% to 60% of MMT clients were shown to leave treatment within 12 to 14 months (Kellogg et al., 2006; Liu et al., 2009; Nosyk, Marsh, Sun, Schecter, & Anis, 2010). In their review of the literature, Fischer et al. concluded that "patient retention . . . is the exception rather than the rule" (p. 3).

Compared to the large number of MMT outcome evaluation studies, less emphasis has been placed on MMT from the perspective of clients, although this line of inquiry is expanding. Scholars have identified important links between client satisfaction and retention in MMT (Villafranca, McKeller, Trafton, & Humphreys, 2006), and have linked client satisfaction at 3 and 12 months (Kelly, O'Grady, Brown, Mitchell, & Schwartz, 2010). Why do so many MMT clients leave treatment early, and what factors contribute to it? Although individual-level

[1]Queen's University, Belfast, Northern Ireland

Corresponding Author:
Karen McElrath, School of Sociology, Social Policy and Social Work, Queen's University, Belfast, Northern Ireland BT7 1NN
Email: k.mcelrath@qub.ac.uk

factors have been found to be associated with MMT drop-out (Mancino et al., 2010), many investigators have found that structural factors create the conditions for leaving MMT prematurely (Bao et al., 2009; Harris et al., 2006; Porter, 1999; Reisinger et al., 2009).

MMT clients have voiced concerns about daily collections of methadone (Holt, 2007), supervised consumption for stable clients (Stone & Fletcher, 2003), limited methadone collection times (Anstice, Strike, & Brands, 2009), lack of privacy in pharmacy settings (Anstice et al.; Fraser, Valentine, Treloar, & Macmillan, 2007; Matheson, 1998; Stone & Fletcher), lengthy wait times for collections (Fraser & Valentine, 2008) and the control of methadone over daily lifestyles (Reisinger et al., 2009). Dole and Nyswander (1980) highlighted structural and interpersonal factors, and noted the importance of mutual respect between treatment staff and MMT clients. They suggested that, without this respect,

> an adversary relationship develops between patients and staff, reinforced by arbitrary rules and the indifference of persons in authority. Patients held in contempt by the staff continue to act like addicts.... Understandably, methadone maintenance programs today have little appeal to the communities or to the majority of heroin addicts on the street. (p. 261)

More than 30 years ago, Newman (1976) observed that the rigid structure of MMT programs deviated substantially from the way that MMT was originally envisioned. In practice, MMT provision is highly regulated, characterized by intensive social control (Des Jarlais, Paone, Friedman, Peyser, & Newman, 1995), and yet still is considered to be a dominant modality for treating heroin dependence.

In this article, we link the theoretical concepts of social control and stigma to examine client experiences with MMT. We draw from the work of Cohen (1985), who described the societal shifts that incorporate the disciplining and regulating of deviance. He viewed social control as the "organized responses" to deviance (p. 3) that are deemed necessary to establish order, define moral boundaries, and monitor deviants in a panoptic world. Social control is fueled by power imbalances whereby those in positions of power can identify, track, control, and punish behavior; hence, power is a critical element of social control. The concept of power also features in stigma theory, because stigma derives from unequal power relations (Gilmore & Somerville, 1994); thus, social control and stigma are inherently linked through the concept of power. Link and Phelan (2006, p. 528) suggested that stigma is best understood as a multistage social process that begins with human differences that are labeled and stereotyped. Labelers (those with power) impose "them/us" distinctions, and

discrimination and loss of status are experienced by the individuals who are labeled (those without power). Once in place, stigma can spread and create additional power imbalances (Parker & Aggleton, 2003).

Stigma can be practiced by individuals, and within peer groups, communities, and agencies (Mill, Edwards, Jackson, MacLean, & Chaw-Kant, 2010; Yang et al., 2007). In the fields of mental health and HIV/AIDS, scholars have found that stigma negatively affects treatment entry, relationships with health care providers, and treatment retention (Link & Phelan, 2006; Varas-Díaz, Serrano-García, & Toro-Alfonso, 2005). Drawing from the literature on mental illness, institutional stigma (macro level) is differentiated from internalized stigma (micro level). The former refers to the "rules, policies and procedures of private and public entities in positions of power that restrict the rights and opportunities of people with mental illness" (Livingston & Boyd, 2010, p. 2151). Institutional stigma creates the conditions for people to internalize the stigma they experience (Campbell & Deacon, 2006). In turn, "they believe they are devalued members of society" (Livingston & Boyd, p. 2151). Not all individuals will internalize the institutional stigma that they experience; internalized sigma occurs when individuals "accept the social meaning" of the stigma (Lloyd, 2010, p. 43). In this article, we analyze data from four studies to explore how MMT clients experience the mechanisms of social control under MMT provision. We also examine the nature of institutionalized stigma in MMT delivery, and the ways in which this macro-level stigma reinforces spoiled identities. We link these issues to the prospects of recovery among MMT clients, and question whether the provision of MMT is consistent with the wider philosophy of contemporary treatment and harm reduction.

The Setting

The study sites included Northern Ireland (North) and the Republic of Ireland (South). The regions are divided by a land border, with separate governmental jurisdiction over health, education, social welfare, and other services. The availability of MMT provision in the North commenced in 2004, after several years of policy that proscribed any form of pharmacological-based maintenance for opioid dependence. Referrals to one of 13 specialist addiction treatment services are primarily made by a general practitioner (GP). The substitute prescribing scheme (MMT or high-dose buprenorphine) operates within these specialized services and under the context of shared care.

On 31 March 2010, 466 individuals were being prescribed methadone or high-dose buprenorphine in Northern Ireland (Department of Health, Social Services and Public Safety, 2010). Of this figure, 52% were in MMT in receipt of dosages that ranged from 5mg to

160mg per day (mean dosage = 66.6mg per day). Mechanisms of surveillance include the Addicts Index and the Northern Ireland Drugs Misuse Database (DMD). The Addicts Index is updated annually, and includes the names of individuals who have been officially identified as "addicts" by GPs and other health professionals, who are required by law to report patients whom they believe or reasonably suspect to be addicted to one of several opioids or cocaine. This information is supplied in writing to the Chief Medical Officer. These data also include patients who are referred to specialized addiction services; thus, MMT clients are included in the Addicts Index. The DMD includes information provided by statutory and voluntary agencies, and reflects individuals presenting for drug treatment. One major difference between the two surveillance systems is that individuals presenting for treatment are required to provide consent before their details can be included in the DMD database.

MMT has been officially available in the South of Ireland (largely Dublin) since 1992, although several changes in its provision have been implemented since then. The Methadone Treatment Protocol was implemented in 1998 and encompassed systematic procedures for prescribing methadone and for managing patients in receipt of methadone treatment (Butler, 2002). The Protocol sought to expand the number of people in methadone maintenance by encouraging community-based treatment in the context of primary care. General practitioners are required to complete at least one course of training (minimum 3 hours) if they intend to prescribe methadone. The level of addiction training and experience with treating MMT clients are the main factors that determine MMT caseload within primary care settings. A total of 259 GPs worked with the Methadone Treatment Protocol in 2008 (Health Service Executive, 2011), although only a small number had sufficient training to initiate methadone treatment in primary care settings. In 2008, two thirds of methadone clients were treated in clinics and one third were treated in community-based settings (Health Service Executive).

From the mid-1990s, the rapid diffusion of heroin extended beyond the geographic boundaries of Dublin; however, methadone provision was very limited in these nonurban areas. Although the availability of MMT has expanded to some areas outside Dublin city, the waiting time for treatment is extensive in some locales. Surveillance and tracking of MMT clients are conducted through the Central Treatment List, which included 10,213 MMT clients in 2008 (European Monitoring Centre for Drugs and Drug Addiction, 2010). In both jurisdictions, methadone is dispensed largely through community-based pharmacies, and most MMT clients undergo some degree of supervised consumption. Fixed durations of MMT provision are not specified in either region.

Table 1. Sample Characteristics of the Four Studies

Study	N	Heroin	MMT[a]	Average Age	Women
Heroin/IDU-NI[b]	54	100%	44%	32	33%
IDU-NI	90	97%	24%	31	30%
Problem Drug Use-ROI[c]	35	80%	36%	28	46%
Drug Misuse-ROI	36	39%	64%	25	29%

[a]Percentage maintained on methadone among individuals dependent on heroin
[b]Injecting drug use, Northern Ireland
[c]Republic of Ireland

Methods

In this article, we pool data from four studies that we conducted in one of two regions (Northern Ireland and the Republic of Ireland). Although our original studies did not focus exclusively on clients' experiences with substitute prescribing, in each of the studies we interviewed individuals who were dependent on heroin, a proportion of whom had participated in a methadone maintenance program. Two of the studies were conducted in Northern Ireland (Harris, 2011; McElrath & Jordan, 2005), and the remaining two were conducted in the Republic of Ireland (McElrath, 2008; 2009). We followed strict ethical protocol in each study, and ethical approval was granted by the Research Ethics Committee, School of Sociology, Social Policy and Social Work, Queen's University, Belfast. Harris received additional ethical approval from the Research Ethics Committee, Northern Ireland, and was cosponsored by Queen's University, Belfast and the Belfast Health Trust. Respondents who were interviewed by Harris provided written informed consent prior to data collection, and participants in the three other studies gave verbal informed consent. Respondents provided implicit consent for the interview data to be used in various articles. Direct and indirect identifiers that emerged during interviews were omitted during transcription. Digital and tape recordings were kept in secure storage in a university office. We transcribed interviews for the study with which we were affiliated, a strategy that reinforced confidentiality. Additionally, we protected typed transcripts through individual passwords. We did not have access to the full transcripts that were generated in the original studies in which we were not directly involved. We reimbursed all respondents for their time and travel expenses. We briefly describe the studies below, and provide sample characteristics in Table 1.

Study A (heroin use and injecting drug use, Northern Ireland). Harris (2011) focused on risk environments and their influence on route of administering heroin, initiation and transitions to and from injecting, and patterns of heroin use among 54 adult men and women who had used

heroin within the 4-week period prior to the interview. Data were collected between 2008 and 2010. A total of 44% of study participants were maintained on methadone at the time of the interview.

Study B (injecting drug use, Northern Ireland). McElrath and Jordan (2005) examined patterns of injecting, risk behaviors associated with injecting drug use, and experiences with drug services where relevant. The authors collected data over a 10-month period, ending in September 2004. In total, 90 adult men and women were interviewed by McElrath or by a privileged access interviewer. A total of 40% of the respondents were in contact with some treatment service at the time of the interview.

Study C (problem drug use, Republic of Ireland). McElrath (2009) explored drug service needs and experiences with drug treatment among adults experiencing problems with drug misuse—namely heroin, cocaine, and/or benzodiazepine. The study site was North County Dublin, and data were collected in 2008 and 2009. McElrath interviewed 10 individuals who were on methadone maintenance at the time of the study, and 25 individuals who were regular users of heroin, cocaine, and/or benzodiazepines and were not in contact with treatment services.

Study D (drug misuse, Republic of Ireland). McElrath (2008) analyzed people's experiences with drug treatment and related services, and identified gaps in service delivery. The study site was a large town on the east coast of Ireland and outside the Dublin metropolitan area; data were collected in 2008. McElrath interviewed 36 adult men and women, of whom 39% had used heroin (primarily through smoking), and 25% had current or previous experience with methadone maintenance in the area.

Our choice of the four study sites was based on two reasons. First, although we were principal investigators (PI) for the studies, we did not hold joint responsibility for any one study. As PIs, we conducted and transcribed interviews and analyzed the data; thus, we knew the data well. Second, we discussed and shared emerging findings over the previous several years, and we began to observe several similarities across the study sites in terms of how people experienced methadone maintenance.

Analytical Approach

The methodological strategy of pooling qualitative data from multiple studies has several advantages. For example, the approach makes efficient use of data, allows for checks on construct validity across research settings and time periods, and reflects a degree of triangulation (Hammersley & Atkinson, 1995). Our strategy evolved over a 3-year period, commencing with our discussions of the social worlds of people who use heroin. We were involved in separate studies but often shared preliminary research findings pertaining to the experiences of respon-

dents, including their stories about treatment services. As we shared and processed these experiences, we noted that respondents' social worlds were often shaped by intensive surveillance consistent with a social control framework. We began with a broad notion of social control and borrowed from the work of Cohen (1985) and his descriptions of surveillance of the deviant in a panoptic world. We remained open to other interpretations after several reads of the interview transcripts, noting themes and comparing data across these themes.

We identified emerging themes that pertained to different settings of MMT provision, interactions between MMT clients and service providers, and other experiences of MMT clients within the context of service delivery. The concept of institutionalized stigma surfaced in clients' stories about their experiences. We defined and examined outliers or deviant cases, and explored the conditions under which outliers might be explained. In general, the analytical approach involved largely inductive but also deductive reasoning.

A limitation of the analysis concerns the use of secondary data. None of the original studies focused specifically on experiences with methadone maintenance. This point raises the issue of data saturation. The sample sizes in the original studies were determined by funding agencies, although data saturation with regard to the original concepts was reached before final interviews were completed in those studies. Some of the themes we discuss in the present article emerged relatively quickly in the four original studies. However, had the original studies focused specifically on experiences with MMT, we would have likely recruited larger numbers of MMT clients to ensure that saturation relating to methadone experiences had been reached.

Results

Addict Identity as Master Status

Individuals who held power over methadone provision often framed client identities around the master status of "addict." Furthermore, MMT clients were treated as addicts regardless of their stage of recovery. The saliency of this identity was manifested through (a) rules and regulations that equated addicts with deviants and criminals, (b) contractual power differentials, (c) labels that incorporated a clean/dirty dichotomy, and (d) clients' lack of input into treatment decisions.

The addict as criminal. Stereotypical views about heroin addicts were closely tied to assumptions of deviance and crime. The majority of MMT clients in both jurisdictions visited on a daily basis pharmacies where methadone consumption was supervised by the pharmacy staff. Within these settings, clients from both jurisdictions were aware that they were watched closely and assumed to be deviant:

One time I was buying toothpaste—toothpaste, like. She [counter staff] thought I was trying to steal it. Why would I steal toothpaste? And if somebody was stealing toothpaste, why would they steal it from the chemist where they get their methadone? I know it's hard on the chemist too. Maybe they get ripped off [robbed] sometimes. But see being treated like that? Everyone needs to go through that to see what it's like.

They would literally watch you and follow you to the door, like you've just been caught shoplifting. That's how you would feel, which I think is just damn right rude. Now they've been told and told and told from [consultant psychiatrist], apparently, to stop.

Alleged fears that MMT clients would engage in shoplifting were reflected in rules and regulations that were imposed on clients in selected pharmacies. These additional regulations were particularly evident in the Republic of Ireland, where MMT clients from the two study sites reported that they were not permitted to enter the dispensing pharmacy with friends or adult relatives. A few MMT clients perceived that pharmacy staff assumed that clients' social networks were comprised only of other addicts, and that shoplifting could be curtailed by prohibiting groups of addicts in the pharmacy at any one time. These experiences were described by MMT clients in the South of Ireland:

Loads of pharmacists in town told meth [methadone] clients that they can't bring friends [with them into the pharmacy]. You can't bring friends unless they are buying something. What about other people picking up prescriptions for drugs? How come they bring friends?

The policy created difficulties when two or more clients happened to arrive at a pharmacy at the same time:

You see, we sign this contract, and we're not supposed to go in with other people. One time in [town], there were four of us who got there together. He [the pharmacist] said to me, "You're last in, you go out [and wait until the others have left the pharmacy]." I had my baby with me and it was raining, and then there was loads of us standing outside in the rain, and me with the baby. Now he [pharmacist] did apologize when he saw the baby.

It doesn't take a genius to know why you're in there. You had to sit in a chair. She had to call my name before I could go to the counter. You'd swear

I had leprosy. And you couldn't go in if someone else was in there getting their methadone. There was like a screen, and you could see the top of their head [someone else taking the methadone]. I'd wait outside 'til they finished.

Contractual power differentials. The continuation of MMT depended in part on how clients behaved. Some clients in the South were provided with a contract, but were not asked to sign them. The contracts listed various client behaviors that could result in penalties. Clients in the North were required to be punctual for appointments with key workers and prescribing doctors, and a 24-hour notice was required to change the time or date of appointments. Although the contract was signed by the client, the prescriber, the dispenser, and the key worker, the behaviors outlined in these contracts related to the client only. Our review of the contractual language suggests an emphasis on controlling client behavior through rules that reinforce addict and deviant identities. Clients in the North faced "possible discharge" or the withholding of methadone for "consistent tardiness," for missing two consecutive appointments, and for "inappropriate" behavior in pharmacies. Clients in the South reported similar rules that regulated clients' behavior in these settings:

Respondent (R): I think they [pharmacy staff] just need to treat people better from the start. They look at us like dogs, [as if we are] robbing and all. You see that paper [list of rules; contract] they give us when we start? We're not supposed to even look around the room.
Interviewer (I): What room? The whole pharmacy?
R: Yeah, we're just supposed to look straight ahead, not look around at all. And we have to sit there.

"Clean/dirty" dichotomy. Speech associated with heroin dependency includes references to "clean" and "dirty," and these words equate with good and bad behavior.[1] Individuals are "clean" when in recovery, or when they have abstained from using heroin even for a brief time. MMT clients who are clean are often rewarded by treatment services. For example, they might be entitled to reduced visits to the clinic, and might be granted unsupervised methadone consumption in the form of take-home doses. The "unclean" clients undergo more regular surveillance in the form of supervised consumption, daily collections of methadone, frequent meetings with drug workers, and the dreaded urinalysis testing for psychoactive substances other than methadone. If former addicts are clean, then by comparison, addicts are "unclean" or "less clean." This dichotomy and the associated system of reward and punishment serve to reinforce the distinction between good and bad behavior, and amplify the addict identity.

The tool of urinalysis is justified as a means to determine treatment compliance and to prevent overdose. The results of urinalysis are also dichotomized, whereby urines are either clean (no evidence of recent use of psychoactive substances) or dirty (recent consumption of psychoactive substances other than methadone), and dirty often reflects use of heroin. The psychoactive effects of methadone and its associated dependence are deemed by service providers to be acceptable in the name of treatment. Methadone clients are clean, whereas heroin use is considered to be dirty. Yet the effects of methadone have the potential to socially and physically incapacitate MMT clients (Bourgois, 2000). Nevertheless, consistent "cleanliness" is likely to be rewarded (although not praised), whereas clients who provide "dirty" urines are subjected to warnings, reprimands, and sometimes punishment.

Prior to 2008, MMT clients in the North were subjected to program dismissal when three consistent urine samples showed dirty results. A change in policy in 2008 meant that clients who consistently (e.g., three times) provided dirty urines are referred to an "enhanced clinic" where they no longer have contact with their key worker; rather, use of heroin and other nonprescribed substances is monitored by a consultant psychiatrist. Similar procedures were in place in one study site in the South of Ireland, where one participant noted, "Stablized people go on Wednesday. That's me. One dirty urine, and they could put me back to Thursday." The dirty are separated from the clean, and this segregation is justified in terms of preventing the dirty from influencing the clean. The dirty are believed to have the power to influence the relapse of the clean.

As a mechanism of social control, urinalysis represents a powerful and intrusive form of surveillance. Clients in both jurisdictions reported procedures whereby urine samples were required under the watchful scrutiny of staff. Collecting and handling urine samples were heavily regulated under the assumption that addicts are deviant. For example, procedures were in place to deter clients from substituting their own urine with another's clean urine, or to prevent urine dilution with toilet water. Surveillance of urine sample provision differed across services located in the North. In particular, the regulations of one clinic were described as punitive:

> [Addiction service] is far better. Just the way they get on [do things; provide the service]. They're not all having a go at you 'cause you're giving dirty samples and all. They don't stand over you and watch you go to the toilet like in [other addiction service]. They let you go in privacy and stuff like.

Recovery from drug dependence is a process. However, as a means of social control, the clean/dirty distinction served to dichotomize recovery and reinforced spoiled identities. In turn, the dichotomy restricted opportunities for developing client identities that incorporated incremental steps of the self in recovery.

Lack of input in treatment decisions. MMT clients in all four studies recalled feelings of powerlessness over treatment decisions that were determined by service providers. Some of these decisions were based around methadone dosage, although we found only limited evidence of inadequate dosages. The majority of MMT clients from Study A reported satisfaction with their methadone dosage at the time of interview. However, some respondents recalled difficulties in negotiating a suitable level of dosage, i.e., a level that would "hold" them, diminish cravings and the effects of withdrawal. Northern clients raised concerns about the power of addiction services to define the amount of methadone needed for stabilization. Clients resisted the uniform dosage policy—the "one size, fits all" approach after several months or years on MMT. Indeed, one respondent (the only study participant who had initiated an extant complaints procedure) had been very proactive in challenging the dominant discourse relating to suitable methadone dosages. He reported that his current dosage exceeded 150mg:

> They [addiction service] were saying that 120[mg] was the limit and that they weren't gonna put me up any higher. Eventually I ended up putting in a complaint to the Health Board, and eventually I got a test done on how the methadone was metabolized by my blood plasma. I researched it myself and found that there's cases where some people—their metabolism can affect the methadone. They metabolize it at different rates. But then I actually got moved up [dosage increased] . . . it more or less takes me through until about 8.00 in the morning, and then I feel a bit rough for about an hour, which is an awful lot better compared to what I was.

In Study D (Republic of Ireland), some respondents perceived their current methadone dosage to be too low. A woman respondent indicated that her current daily dosage of methadone (i.e., 50mg) was insufficient, and had reported this problem to addiction services on several occasions. At the time of interview, her dosage level still had not been increased. As a result, she was "topping up" with heroin periodically to avoid withdrawal and cravings. In the same locale, adjustments to dosage levels and withholding methadone altogether were at times used as punishment: "I was three minutes late one time—three minutes, and they took me down five mg [decreased the methadone dosage level]." Another client reported, "Some chemists in town—if you're late, they'll pour methadone down the sink. Pour it down, I swear. There's you—using heroin again." Dosage penalties were also recalled by MMT clients in the North:

When they see people who are still using heroin and using their methadone it's not just because they want to get extra stoned [intoxicated]. Maybe there's an underlying reason why ... the methadone isn't holding them enough so they need extra doses. With [addiction service], if you're caught using [heroin], it seems to be that you're given a warning, and then given another warning, and then you're struck off [forced to leave treatment]. I've heard cases of that happening. One thing that I'll say for [consultant psychiatrist] is that he was always fair. If you were using he wouldn't condone it, but he would think that it was better maybe using once or twice and being on the methadone, once or twice in a week, as opposed to maybe using once or twice a day every day, so harm reduction.

In these instances, dosage penalties (and threats of dosage penalties) were perceived as mechanisms of social control that were used to encourage clients to conform to the rules of the clinic and pharmacy. Although proper dosing is important for preventing overdose, insufficient dose levels can contribute to relapse into heroin use.

The lack of client input in treatment decisions also was revealed through clients' concerns over progress. In the Republic of Ireland, clients' preferences for reducing methadone dosage levels over time did not appear to be an option at the two study sites (Study C and Study D). Two men from Study D were interested in having their methadone dosage level reduced gradually, in hopes of eventually coming off methadone completely. One client reported being depressed because he believed that his goal was ignored by addiction services: "I'm afraid of methadone. The years are flying by and I'm still on it. They won't let me come down [reduce dosage]."

Similar concerns were voiced by respondents in Study C. Despite abstaining from injecting drug use for several years, MMT clients were unable to see the progress they had made because they saw themselves as still being opioid dependent. They reported that gradual detoxification from methadone was rarely mentioned as an option for them: "Do you know anybody who's been on methadone for a few years? Got off the methadone and not on heroin again? People can't get off methadone, and if they do it's right back to the heroin." Other clients voiced similar concerns: "I think of all the people who have used heroin. Loads of them, and I only know a few people who got off it. I know people who've been on methadone for years. That scares me."

Some respondents in the North voiced their concerns over what they perceived to be a blanket policy to retain people on methadone with no option of reducing. One respondent reported,

Methadone's a cure but methadone isn't a long-term cure. Methadone is there to cure you in the short term, but they're doing it wrong here. They're putting people on methadone for years and years and years .... If you go and say to them, "Could you put my methadone up?" they say to you, "You don't need it to go up." But see if you go in and say to them, "Could you start to take me down off my methadone?" they turn around and tell you that you need to go up. But if you go in and say that you need to go up they'll say you don't .... [Addiction service] is a load of shit, to be honest with you.

Over time, a few respondents were able to negotiate low dosages of methadone, which they believed kept the withdrawal symptoms and cravings at bay. These individuals envisioned a time when they would not be using heroin or methadone. Although methadone prevented withdrawal symptoms, they feared long-term use of the treatment more than heroin itself (see Bourgois, 2000). Overall, treatment was determined largely if not solely by addiction staff, with limited input from clients. For the most part, MMT clients were passive recipients of treatment, and this provision reinforced power imbalances between service providers and clients. We suggest that encouraging client passivity in treatment serves to reduce the likelihood of self-empowerment in recovery.

Undeserving Customers

Several clients perceived that they were treated as undeserving customers in pharmacies and clinics. This theme was reflected by (a) limited privacy and lengthy wait times, and (b) poor facilities.

Limited privacy in pharmacy settings. In the context of methadone provision, pharmacy settings are important because MMT clients come into contact with "normals" (Goffman, 1963) within these venues (Lloyd, 2010); thus, addict identities become visible to the public gaze. Clients' perceptions of the gaze were heightened because they were placed well down the list of preferred pharmacy customers. The public wait was described as "embarrassing" or "agonizing":

Sometimes I have to wait half an hour to get my meth. She has to serve everyone first, even people who come in after me. I'm waiting there, and people looking at me like I've got two heads. She's getting paid for helping us, but you feel like you have to kiss her toes.

In the present study, space restrictions within pharmacies might have been one factor that contributed to

settings that were devoid of privacy. For instance, some MMT clients reported regular consumption of methadone behind temporary screens that had been set up for that purpose. A few others reported that consumption occurred within photo booths that were located inside pharmacies. For other respondents, however, methadone was consumed in the presence of other customers. In both the North and South of Ireland, lack of privacy was of great concern to clients because they perceived this setting to be characterized by a stigmatizing public gaze:

> You can ask to go in there [separate and private room], but you have to make a point of it. I ask [for privacy], as there's members of my old work and others [present] … there's always people standing there, and I get really embarrassed.

> Private? It's not really that private. They walk out with the cup [of methadone] like. And plenty of time there's some people in there—especially at lunch hour. Walks out with the cup, and says, "C'mon [client]." And I go into the room—not really a room; that's where they take the photos. And everyone knows what's in the cup.

Very few clients complained directly to the pharmacist or other service provider about the difficulties they (clients) had experienced in the pharmacy setting. MMT clients lacked a voice ("Who'd believe a junkie?"), and often feared that methadone provision would be discontinued if they voiced complaints. This perceived threat was enough to encourage clients to "keep their heads down," mind their manners, and avoid "rocking the boat."

Several clients attempted to minimize the stigma associated with the public gaze of the addict. For example, some arranged for early morning visits to pharmacies, when fewer customers were present. Other clients reported waiting outside the pharmacy until other customers had left, or had occasionally purchased a pharmacy item so as to appear like "normal" customers while waiting for others to be served. MMT clients residing in small towns, villages, or particular housing estates appeared to be more affected by the local public gaze. This finding pertained to MMT clients in both jurisdictions:

> I would be nervous going in there. There's a few reasons. Your ordinary people come and get their prescriptions. Could be your mom's mate, someone down the lane, someone in the UDA [Ulster Defence Association, a loyalist paramilitary group in the North of Ireland].

It might be packed with people. Maybe your next-door neighbor. You got to get a cup of water and your methadone, and drink it. There's a wee [small] private area, but people [other customers] know what's going on back there.

To some extent, Belfast respondents voiced less concern about the public gaze in pharmacies. The urban environment might have provided the perception of anonymity within the Belfast pharmacies. Some clients negotiated a change to another pharmacy, in hopes of minimizing this stigma. A change in pharmacy was often beneficial for clients, and finding the right pharmacist appeared to increase clients' self-esteem on the slow road to recovery:

> Gentleman like [pharmacist]. He's stood by me, looked after me when I was down in the dumps and all. Gives you time, know what I mean? He would talk to you and you can go round the shop with him. "Have you twenty minutes?" [And he says] "I have, aye." I mean, we've talked so much and he knows when there's something wrong with me like …. So if there is anything wrong I would go and talk away to him.

Poor facilities. The physical appearance of clinics differed across the two regions. In particular, our observations of some clinics in the South of Ireland showed very grim, depressing, and near-dilapidated external facades that were characterized by barbwire and high barricaded walls, surrounded by litter-strewn entrances. In the North, the majority of facilities appeared similar to doctors' offices and other "respectable" health centers. At the time of the studies, the interior design of most northern clinics suggested a somewhat welcome atmosphere, with organized reading material available in waiting rooms, simple but fairly new décor, and the appearance of cleanliness. In contrast, the two southern study sites were characterized as being more "clinical" and less welcoming in appearance. In one southern site, toilet facilities were described by MMT clients as particularly demeaning. One respondent reported, "There's one toilet and there's urine all around the toilet bowl. It's disgusting." A woman client had accessed addiction services at the same site:

> I hate going to the toilet there. There's urine everywhere, and can you get something from someone else's piss? Can you get AIDS? I try and clean up the urine before I go, and then I wash my hands like mad.

MMT clients in this locale perceived that treatment staff thought them undeserving of clean toilets. Rather,

the assumption was that "dirty" toilets are appropriate for "dirty" people. None of the respondents in Study D had ever complained to treatment staff about the condition of the restrooms. MMT clients were voiceless under the powerful constraints of treatment and those who held power over it.

Barriers to Reintegration

If one objective of drug treatment is to encourage and perhaps facilitate reintegration into mainstream society, then clearly, participating in meaningful employment is part of this process. However, the conditions under which MMT is provided can act as barriers to finding suitable employment and staying employed. Some respondents in Study D were searching for meaningful work, yet were conscious of the need to collect methadone frequently, and perceived that this lifestyle routine could affect relationships with employers. In this locale, seeking employment was deferred for another day. A man participant from the North reported similar difficulties:

> It's too much hassle. I got a phone call, says would I like to have a job. I was interested. It started at 8.00 in the morning and finished around 5.30. How could I get the [methadone] script [prescription]? I needed to be in town at 9.00 or 9.30 [pharmacy opening hours], or else be back by 4.30 or 5.00 [closing hours]. I need to find work that allows me to get my script.

Although some MMT clients in the North (Study A) reported that they had worked while being dependent on heroin, none were searching for work at the time of interview. We attributed this finding to the regulations and routines of MMT:

> I was working when I was on the heroin, when I had a pretty big habit. I was able to hold a job—no problem—whereas on the methadone at the minute, there's no way that I feel like I could hold down a job. I'm waking up in the morning feeling rough. Three days a week I have supervised consumption. Four days a week I have it [methadone doses] home with me. So there's not gonna be very many employers who go, "That's okay. Sure, come in an hour or two after you get your methadone," you know?

In one of the four study sites (Study C), nearly all of the MMT clients who participated in an interview worked in part- or full-time employment, consistent with county-wide data claiming the highest rate of labor force participation in 2006 (Central Statistics Office, 2006). MMT

clients in that study noted the difficulty associated with collecting methadone during working hours. A man reported,

> The woman [counter staff] there looks down on you—all the time. Well, she's not there all the time. But when I see her, I go, "Oh God—here it comes." I was working, every day. See that chemist? It's always packed. I had [a] half hour for my lunch break, and it would take me half an hour to get my methadone … loads of times she'd keep me waiting 'til everyone had gone. And me getting back to work late. You'd have to sit there 'til everyone was away. Then they'd get your methadone. I'd be late for work after lunch, like. And they [coworkers] don't know I'm taking methadone.

Some respondents in Study C disclosed their MMT involvement to their employers or a trusted coworker. Others tended to carefully guard their treatment participation for fear of losing their jobs or being treated differently at work. Strategies to avoid potential stigma were incorporated into daily lifestyles. Indeed, some respondents described how they saw but never took possession of the business card that contained information about the study, used in an effort to recruit participants. They voiced apprehension that their drug use history might be disclosed if another party observed the card in their possession. A woman respondent and MMT client worked in a financial institution at the time of interview. Distancing herself from a drug user identity was paramount to her self-image and how she perceived others might view her: "I got the card, but I couldn't carry it with me. Thought maybe work might find out. Didn't want to leave the card at work."

A respondent in Study C had held the same job for several years, but had never disclosed his MMT involvement to his employer. He had long ago negotiated take-home methadone doses so that his work routine would not be affected. The respondent attributed meaningful employment to his involvement in MMT: "I've been with them for eight years, and it's the longest time that I've had a job. And that's due to the methadone."

Discussion

Methadone provision in both jurisdictions was characterized by social control and institutional stigma, which served to reinforce spoiled identities, expose "undeserving customers" to the public gaze, and create barriers to reintegration. We observed more similarities than differences across the study sites, but noted the contrasts in terms of the physical structure of the clinics (facilities in the North were more likely to resemble

mainstream health centers) and pharmacy regulations that prevented MMT clients being accompanied by friends during pharmacy visits (southern sites). We conclude that social control is multifaceted and layered within and across the contexts in which MMT is provided. The layers of social control derive from the official registers or lists of MMT clients. In the official quest to identify and track MMT clients, informed and voluntary consent to be part of these lists is deemed to be unnecessary. The layers of social control expand from the official registers to the settings of clinics and pharmacies, and extend further to regulations and surveillance within these settings. In the clinics, for example, social control features in drug testing through urinalysis, dosage decisions, clean/dirty distinctions, and sanctions over missed appointments. Layers of social control within pharmacies are reflected in the wait experienced by "undeserving customers," the watchful gaze of pharmacy staff, and the rules that govern client behavior (e.g., contractual obligations).

These layers of social control are tied closely with institutional stigma. The label of addict emerged as a salient identity among MMT clients, and was imposed by service providers. Moreover, addicts were interpreted to be untrustworthy and part of a "dangerous class." Opsal (2011) described the social control of parolees with "felon" identities. Respondents in her study "lived under a system of surveillance that bounded their behavior" (p. 142). She noted for example, the practices of regular drug testing, frequent meetings with agents of social control (i.e., parole officers), rules that prevented association with other felons, and the power over the body (i.e., parole officers had discretion over recommendations for parole revocation). These methods of regulating felon behavior are strikingly similar to the experiences of MMT clients in the present study, where spoiled identities equated addicts with criminals. Frequent exposure to institutional stigma across various settings served to reinforce spoiled identities of MMT clients.

MMT is most often utilized among people presenting with heroin dependence, and heroin is often viewed as the least-acceptable drug, even among individuals who are "heavy" users of other illicit drugs (McElrath & McEvoy, 2001). In a previous study, Radcliffe and Stevens (2008) found that individuals whose addiction was associated with drugs other than heroin dropped out of treatment in an attempt to disassociate themselves from "junkies." Similar to people's assumptions about HIV (Miles, Isler, Banks, Sengupta, & Corbie-Smith, 2011; Worthington & Myers, 2003), heroin dependence is perceived to be linked to lifestyle rituals that are associated with deviance, e.g., injecting drug use (Simmonds & Coomber, 2009), and conditions that are presumed to be dangerous, e.g., blood-borne viruses. Moreover, heroin dependence

is perceived to be intertwined with criminal activity (Radcliffe & Stevens); hence, MMT provision is situated between the ideologies of medicalization and criminalization (Vigilant, 2004).

We recognize that various drug treatment modalities can be stigmatizing (Luoma et al., 2007), but we suggest that in comparison to other interventions, MMT is characterized more by social control and institutional stigma that reinforce and perhaps create spoiled identities. We believe that this difference has its roots in how heroin dependence is perceived and stereotyped, and how these perceptions are connected to individuals who experience heroin dependence. Moreover, clients involved with other types of drug treatment are generally not exposed to the public gaze in pharmacies. Still, it would be useful to compare social control mechanisms across a diverse range of modalities that are designed to treat individuals with heroin dependence.

Perceptions about MMT clients are in some ways consistent with statutory MMT protocols (e.g., drug testing, supervised consumption of methadone, contracts) that permit and sometimes require some of the rules and regulations that characterized provision in these jurisdictions. Institutional stigma is reflected in some of these protocols; thus, "stigma plays a key role in producing and reproducing relations of power and control" (Parker & Aggleton, 2003, p. 16). The implication of these findings is that institutional stigma has the potential to discredit and negate self-recovery, particularly when individuals internalize the stigma. (Re)developing nonaddict identities is important for recovery (Biernacki, 1986), and positive self-identities are likely to surface in the absence of institutionalized and internalized stigma. Institutionalized stigma disempowers MMT clients, whereas recovery requires empowerment. Internalized stigma can contribute to leaving treatment prematurely (Lloyd, 2010), which has been linked to increased likelihood of mortality (Fugelstad et al., 2007; Magura & Rosenblum, 2001). Moreover, when individuals are devalued by the treatment process itself, how can recovery be achieved?

MMT might be the most regulated and controlled intervention that operates under the guise of treatment. By comparison, Fischer et al. (2005) noted that patients being treated for diabetes and AIDS are not "penalized by the treatment provider for not complying with the prescribed treatment" (p. 3). We compare the social control of MMT with long-term use of benzodiazepine, prescribed by physicians. Benzodiazepine dependence is well-documented in Ireland. Intended for short-term relief for anxiety, repeat prescriptions in the country have been described as commonplace (Department of Health and Children, 2002). However, patients in receipt of repeat prescriptions do not consume the medication in the

presence of specialist providers, and are not required to submit to urinalysis testing. These controls are not in place, despite benzodiazepines being implicated in overdoses when combined with alcohol (Koski, Ojanperä, & Vuori, 2002; Tanaka, 2002), and being diverted to illicit markets (Fountain, Griffiths, Farrell, Gossop, & Strang, 1996; Inciardi, Surratt, Cicero, & Beard, 2009). This contradiction in pharmacological delivery must be explained by the spoiled identities of heroin "addicts" who remain, even after several years, on MMT.

Under the current service provision in North and South Ireland, methadone maintenance is best viewed as an intervention rather than a treatment modality. The pharmacological potential of methadone is undermined by clients' experiences of MMT provision, which is inconsistent with contemporary visions of treatment and harm reduction. MMT provision is characterized by highly regulated social control mechanisms and institutional stigma that (a) reduce the likelihood of developing trusting relationships between providers and clients, (b) reinforce spoiled identities of clients, and (c) view clients as passive recipients of treatment. Unlike individuals who seek other health provision, MMT clients are not treated as patients (Vigilant, 2001), but as suspects. MMT is more about controlling behavior than treating disease (Bourgois, 2000; Saris, 2008), and the control of clients' behavior is justified because of stereotypical assumptions that addicts are a deviant and to some extent dangerous class.

Suggestions for Change

We suggest that social control and institutional stigma create the conditions for poor outcomes with MMT. So how can stigma-free MMT be provided in the context of multifaceted social control? First, there is an urgent need to reframe MMT provision so that clients are viewed as customers (Fraser & Valentine, 2008) or consumers (Reisinger et al., 2009) in the various contexts of service delivery. This ideological change represents an important step for reducing social control and institutional stigma. In regions where service users are not organized collectively, MMT programs can develop autonomous groups of service users and commit to dialogue for resolving complaints. Patterson, Backmund, Hirsch, and Yim (2007) argued that interventions designed to reduce stigma must consider macro-level changes. They offered the example of hospital advisory groups consisting of service users who could contribute to the development of antistigma interventions. They also suggested that advisory members should be compensated for their work. Broadening the voice of MMT clients to directly influence MMT programs has the potential for improving service delivery, boost retention,

and benefit recovery. Although the Irish and British governments have recently called for service user involvement in the provision of health care, it remains to be seen whether the voice of the service user will have substantive impact.

Second, although relocating drug treatment services to mainstream health centers might reduce the stigma of treatment (Radcliffe & Stevens, 2008), some general practitioners have voiced resistance about treating patients with drug problems (Matheson, Pitcairn, Bond, van Teijlingen, & Ryan, 2003), which could result in the displacement of institutional stigma from clinics to physicians' offices. Instead, White (2010, p. 46) recommended that MMT clinics alter their "institutional identities" and be referred to as "addiction recovery centers" that are reflected by "strong cultures of recovery." Service users should be encouraged to develop a stake in ownership by participating in meaningful program aspects. These centers should actively involve individuals who were once heroin dependent but have since gained employment, education, training, or other meaningful life change. It is important that MMT clients know and learn from empowered others who also have experienced heroin dependence. Additionally, "clean" and "dirty" discourses should be avoided, and replaced with language that does not demonize or create hierarchies of MMT clients.

Third, there is an urgent need to rectify the institutional stigma that occurs in pharmacies. This issue represents significant challenges, because methadone is often dispensed in private pharmacies that lie outside the gaze of auditing. We suggest that antistigma training be required of pharmacists and counter staff, and that regular feedback meetings be held between pharmacists and collective groups of service users. Finally, we do not necessarily oppose the use of contracts, but believe that contracts should be balanced and power differentials eliminated by including specific responsibilities for prescribers, dispensers, treatment staff, and customers. Contracts should include the importance of privacy and confidentiality, and how these issues will be protected. Feedback from clients should be collected on a regular basis, and without threats to methadone availability or provision.

Declaration of Conflicting Interests

Funding

Note

1. Clean and dirty discourse was first raised by a drug outreach worker in discussions with the second author. We acknowledge Michelle Jordan's insights here.

References

Anstice, S., Strike, C. J., & Brands, B. (2009). Supervised methadone consumption: Client issues and stigma. *Substance Use and Misuse*, *44*, 794-808. doi:10.1080/10826080802483936

Bao, Y.-P., Liu, Z. M., Epstein, D. H., Du, C., Shi, J., & Lu, L. (2009). A meta-analysis of retention in methadone maintenance by dose and dosing strategy. *American Journal of Drug and Alcohol Abuse*, *35*, 28-33. doi: 10.1080/00952990802342899

Biernacki, P. (1986). *Pathways from heroin addiction: Recovery without treatment*. Philadelphia: Temple University Press.

Bourgois, P. (2000). Disciplining addictions: The bio-politics of methadone and heroin in the United States. *Culture, Medicine and Psychiatry*, *24*, 165-195. doi:10.1023/A:1005574918294

Butler, S. (2002). The making of the methadone protocol: The Irish system? *Drugs: Education, Prevention and Policy*, *9*, 311-324. doi:10.1080/09687630210148465

Campbell, C., & Deacon, H. (2006). Unravelling the contexts of stigma: From internalization to resistance to change. *Journal of Community and Applied Social Psychology*, *16*, 411-417. doi:10.1002/casp.901

Central Statistics Office. (2006). *Persons, males and females, aged 15 years and over in each province, county and city, classified by labor force, employment status and labor force participation rate*. Retrieved from http://census.cso.ie/census/ReportFolders/ReportFolders.aspx

Cohen, S. (1985). *Visions of social control: Crime, punishment and classification*. Cambridge: Polity.

Corsi, K. F., Lehman, W. K., & Booth, R. E. (2009). The effect of methadone maintenance on positive outcomes for opiate injection drug users. *Journal of Substance Abuse Treatment*, *37*, 120-126. doi:10.1016/j.jsat.2008.11.004

Department of Health and Children. (2002). *Report of the benzodiazepine committee.* Dublin: Author. Retrieved from http://www.dohc.ie/publications/benzodiazepines_good_practice_guidelines.html

Department of Health, Social Services and Public Safety. (2010). *Statistics from the Northern Ireland substitute prescribing database: 31 March 2010*. Belfast: Author. Retrieved from http://www.dhsspsni.gov.uk/substitute_prescribing_report_2009-10.pdf

Des Jarlais, D. C., Paone, D., Friedman, S. R., Peyser, N., & Newman, R. G. (1995). Regulating controversial programs for unpopular people: Methadone maintenance and syringe exchange programs. *American Journal of Public Health, 85*, 1577-1584. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1615684

Dole, V. P., & Nyswander, M. E. (1980). Methadone maintenance: A theoretical perspective. In D. J. Lettieri, M. Sayers, & H. W. Pearson (Eds.), *Theories on drug abuse: Selected contemporary perspectives* (pp. 256-261). NIDA Research Monograph 30. Washington, DC: U. S. Government Printing Office. Retrieved from http://archives.drugabuse.gov/pdf/monographs/download30.html

European Monitoring Centre for Drugs and Drug Addiction. (2010). Estimated number of clients in methadone treatment and of all clients receiving any opioid substitution treatment (OST), Table HSR-3. *Statistical Bulletin 2010.* Lisbon: Author. Retrieved from http://www.emcdda.europa.eu/stats10/hsrtab3b

Fareed, A., Casarella, J., Amar, R., Vayalapalli, S., & Drexler, K. (2009). Benefits of retention in methadone maintenance and chronic medical conditions as risk factors for premature death among older heroin addicts. *Journal of Psychiatric Practice*, *15*, 227-234. doi:10.1097/01.pra.0000351884.83377.e2

Farré, M., Mas, A., Torrens, M., Moreno, V., & Camí, J. (2002). Retention rate and illicit opioid use during methadone maintenance interventions: A meta-analysis. *Drug and Alcohol Dependence*, *65*, 283-290. doi:10.1016/S0376-8716(0)00171-5

Fischer, B., Rehm, J., Kim, G., & Kirst, M. (2005). Eyes wide shut? A conceptual and empirical critique of methadone maintenance treatment. *European Addiction Research*, *11*, 1-14. doi:10.1159/000081410

Fountain, J., Griffiths, P., Farrell, M., Gossop, M., & Strang, J. (1996). *A qualitative study of patterns of prescription drug use amongst chronic drug users.* London: Department of Health.

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

Fraser, S., Valentine, K., Treloar, C., & Macmillan, K. (2007). *Methadone maintenance treatment in New South Wales and Victoria: Takeaways, diversion and other key issues*. Sydney, NSW, Australia: National Centre in HIV Social Research. Retrieved from http://nchsr.arts.unsw.edu.au/media/File/Methadone2007.pdf

Fugelstad, A., Stenbacka, M., Leifman, A., Nylander, M., & Thiblin, I. (2007). Methadone maintenance treatment:

The balance between life-saving treatment and fatal poisonings. *Addiction*, *102*, 406-412. doi:10.1111/j.1360-0443.2006.01714.x

Gilmore, N., & Somerville, M. A. (1994). Stigmatization, scapegoating and discrimination in sexually transmitted diseases: Overcoming 'them' and 'us.' *Social Science and Medicine*, *39*, 1339-1358. doi:10.1016/0277-9536(94)90365-4

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.

Gowing, L., Farrell, M., & Bornemann, R. (2008). Substitution treatment of injecting opioid users for prevention of HIV infection. *Cochrane Database of Systematic Reviews*, Issue 2, Art. No. CD004145.

Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in practice* (2nd ed.). London: Routledge.

Harris, J. (2011). Risk and enabling environments: Influences on initiations into injecting drug use and heroin use, transitions to and from injecting drug and patterns of use. Doctoral dissertation, in progress, Queen's University, Belfast.

Harris, K. A., Arnsten, J. H., Joseph, H., Hecht, J., Marion, I., Juliana, P., & Gourevitch, M. N. (2006). A 5-year evaluation of a methadone medical maintenance program. *Journal of Substance Abuse Treatment*, *31*, 433-438. doi:10.1016/j.jsat.2006.05.018

Hartel, D. M., & Schoenbaum, E. E. (1998). Methadone treatment protects against HIV infection: Two decades of experience in the Bronx, New York City. *Public Health Reports*, *113*, 107-115. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1307733

Health Service Executive. (2011). *The introduction of the opioid treatment protocol.* Dublin, Ireland: Author. Retrieved from www.drugs.ie/pdfs/2010/Opioid_Treatment_Protocol.pdf

Holt, M. (2007). Agency and dependency within treatment: Drug treatment clients negotiating methadone and antidepressants. *Social Science and Medicine*, *64*, 1937-1947. doi:10.1016/j.socscimed.2007.01.011

Inciardi, J. A., Surratt, H. L., Cicero, T. J., & Beard, R. A. (2009). Prescription opioid abuse and diversion in an urban community: The results of an ultrarapid assessment. *Pain Medicine*, *10*, 537-548. doi:10.1111/j.1526-4637.2009.00603.x

Kellogg, S., Melia, D., Khuri, E., Lin, A., Ho, A., & Kreek, M. J. (2006). Adolescent and young adult heroin patients: Drug use and success in methadone maintenance treatment. *Journal of Addictive Disease*, *25*, 15-25. doi:10/1300/J069v25n03_03

Kelly, S. M., O'Grady, K. E., Brown, B. S., Mitchell, S. G., & Schwartz, R. P. (2010). The role of patient satisfaction in methadone treatment. *American Journal of Drug and Alcohol Abuse*, *36*, 150-154. doi:10.3109/00952991003736371

Koski, A., Ojanperä, I., & Vuori, E. (2002). Alcohol and benzodiazepines in fatal poisonings. *Alcoholism: Clinical and Experimental Research*, *26*, 956-959. doi:10.1111/j.1530-0277.2002.tb02627.x

Lind, B., Chen, S., Weatherburn, D., & Mattick, R. (2005). The effectiveness of methadone maintenance treatment in controlling crime: An Australian aggregate-level analysis. *British Journal of Criminology*, 45, 201-211. doi:10.1093/bjc/azh085

Link, B. G., & Phelan, J. C. (2006). Stigma and its public health implications. *Lancet*, *367*, 528-529. doi:10.1016/S0140-6736(06)68184-1

Liu, E. Liang, T., Shen, L., Zhong, H., Wag, B., Wu, Z., & Detels, R. (2009). Correlates of methadone client retention: A prospective cohort study in Guizhou province, China. *International Journal of Drug Policy*, *20*, 304-308. doi:10.1016/j.drugpo.2008.09.004

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science and Medicine*, *71*, 2150-2161. doi:10.1016/j.socscimed.2010.09.030

Lloyd, C. (2010). *Sinning and sinned against: The stigmatisation of problem drug users*. London: UK Drug Policy Commission. Retrieved from www.ukdpc.org.uk/resources/Stigma_Expert_Commentary_final.pdf

Luoma, J. B., Twohig, M. P., Waltz, T., Hayes, S. C., Roget, N., Padilla, M., & Fisher, G. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors*, *32*, 1331-1346. doi:10.1016/j.addbeh.2006.09.008

Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine*, *68*, 62-74. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11135508

Mancino, M., Curran, G., Han, X., Allee, E., Humphreys, K., & Booth, B. M. (2010). Predictors of attrition from a national sample of methadone maintenance patients. *American Journal of Drug and Alcohol Abuse*, *36*, 155-160. doi:10.3109/00952991003736389

Matheson, C. (1998). Privacy and stigma in the pharmacy: Illicit drug users' perspectives and implications for pharmacy practice. *Pharmaceutical Journal*, *260*, 639-641.

Matheson, C., Pitcairn, J., Bond, C. M., van Teijlingen, E., & Ryan, M. (2003). General practice management of illicit drug users in Scotland: A national survey. *Addiction, 98*, 119-126. doi:10.1046/j.1360-0443.2003.00263.x

McElrath, K. (2008). Drug misuse and drug service provision in Dundalk: Improving the community's response. Dundalk (County Louth, Ireland): Drugs Advisory Group.

McElrath, K. (2009). *Drug use in Fingal and associated need for support services.* Swords (Fingal, Ireland): North Dublin City and County Regional Drugs Task Force.

McElrath, K., & Jordan, M. (2005). *Drug use and risk behaviours among injecting drug users.* Belfast: Department of Health, Social Services and Public Safety. Retrieved from http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health/stats-drug-alcohol.htm#dacurpubs

McElrath, K., & McEvoy, K. (2001). Heroin as evil: Ecstasy users' perceptions about heroin. *Drugs: Education, Prevention and Policy*, *8*, 177-189. Retrieved from www.drugsandalcohol.ie/ 6876/1/McElrath_4060_Heroin_as_Evil.pdf

Miles, M. S., Isler, M. R., Banks, B. B., Sengupta, S., & Corbie-Smith, G. (2011). Silent endurance and profound loneliness: Socioemotional suffering in African Americans living with HIV in the rural south. *Qualitative Health Research*, *21*, 489-501. doi:10.1177/ 1049732310387935

Mill, J. E., Edwards, N., Jackson, R. C., MacLean, L., & Chaw-Kent, J. (2010). Stigmatization as a social control mechanism for persons living with HIV and AIDS. *Qualitative Health Research*, *20*, 1469-1483. doi:10.1177/ 1049732310375436

Newman, R. G. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction*, *71*, 183-186. doi:10.1111/j.1360-0443.1976.tb00077.x

Nosyk, B., Marsh, D. C., Sun, H., Schecter, M. T., & Anis, A. H. (2010). Trends in methadone maintenance treatment participation, retention, and compliance to dosing guidelines in British Columbia, Canada: 1996-2006. *Journal of Substance Abuse Treatment*, *39*, 22-31. doi:10.1016/j.jsat.2010.03.008

Opsal, T. D. (2011). Women disrupting a marginalized identity: Subverting the parolee identity through narrative. *Journal of Contemporary Ethnography*, *40*, 135-167. doi:10.1177/0891241610384995

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine*, 57, 13-24. doi:10.1016/S0277-9536(02)00304-0

Patterson, B. L., Backmund, M., Hirsch, G., & Yim, C. (2007). The depiction of stigmatization in research about hepatitis C. *International Journal of Drug Policy*, *18*, 364-373. doi:10.10 16/j.drugpo.2007.02.004

Porter, J. (1999). The street/treatment barrier: Treatment experiences of Puerto Rican injection drug users. *Substance Use and Misuse*, *34*, 1951-1975. doi:10.3109/10826089909039434

Radcliffe, P., & Stevens, A. (2008). Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatised identities. *Social Science and Medicine*, *67*, 1065-1073. doi:10.1016/j.socscimed.2008.06.004

Reisinger, H. S., Schwartz, R. P., Mitchell, S. G., Peterson, J. A., Kelly, S. M., O'Grady, K. E., . . . Agar, M. H. (2009). Premature discharge from methadone treatment: Patient perspectives. *Journal of Psychoactive Drugs*, *41*, 285-296. Retrieved from http://www.tandfonline.com/doi/abs/10.1080/0279107 2.2009.10400539

Saris, A. J. (2008). An uncertain dominion: Irish psychiatry, methadone and the treatment of opiate abuse. *Culture, Medicine and Psychiatry*, *32*, 259-277. doi:10.1007/s11013-008-9089-z

Sheerin, I., Green, T., Sellman, D., Adamson, S., & Deering, D. (2004). Reduction in crime by drug users on a methadone maintenance therapy programme in New Zealand. *New Zealand Medical Journal*, *117*, U795. Retrieved from http://www.nzma.org.nz/journal/ 117-1190/795/

Simmonds, L., & Coomber, R. (2009). Injecting drug users: A stigmatised and stigmatising population. *International Journal of Drug Policy*, *20*, 121-130. doi:10.1016/j.drugpo. 2007.09.002

Simoens, S., Matheson, C., Bond, C., Inkster, K., & Ludbrook, A. (2005). The effectiveness of community maintenance with methadone or buprenorphine for treating opiate dependence. *British Journal of General Practice*, *55*, 139-146. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1463190/

Stone, E., & Fletcher, K. (2003). User views on supervised methadone consumption. *Addiction Biology*, *8*, 45-48. doi:10.1080/1355621031000069873

Tanaka, E. (2002). Toxicological interactions between alcohol and benzodiazepines. *Clinical Toxicology*, *40*, 69-75. doi:10.1081/CLT-120002887

Teesson, M., Ross, J., Darke, S., Lynskey, M., Ali, R., Ritter, A., & Cooke, R. (2006). One year outcomes for heroin dependence: Findings from the Australian Treatment Outcome Study (ATOS). *Drug and Alcohol Dependence*, *83*, 174-180. doi:10.1016/j.drugalcdep.2005.11. 009

Varas-Díaz, N., Serrano-García, I., & Toro-Alfonso, J. (2005). AIDS-related stigma and social interaction: Puerto Ricans living with HIV/AIDS. *Qualitative Health Research*, *15*, 169-187. doi:10.1177/1049732304272059

Vigilant, L. G. (2001). *"Liquid handcuffs": The phenomenology of recovery on methadone maintenance.* (Doctoral dissertation, Boston College). Retrieved from WorldCat database (OCLC: 48134549).

Vigilant, L. G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society*, *28*, 403-418.

Villafranca, S. W., McKellar, J. D., Trafton, J. A., & Humphreys, K. (2006). Predictors of retention in methadone programs: A signal detection analysis. *Drug and Alcohol Dependence*, *83*, 218-224. doi:10.1016/j.drugalcdep.2005.11.020

White, W. L. (2010). *Long-term strategies to reduce the stigma attached to addiction, treatment, and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/recovery).* Retrieved from http://www.comproviders.com/files/stigma-william-white-101309.pdf

Worthington, C., & Myers, T. (2003). Factors underlying anxiety in HIV testing: Risk perceptions, stigma, and the patient-provider power dynamic. *Qualitative Health Research*, *13*, 636-655. doi:10.1177/1049732303013005004

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: Adding moral experience to stigma theory. *Social Science & Medicine*, *64*, 1524-1535. doi:10.1016/j.socscimed.2006.11.013

Bios

Julie Harris, MA, is a PhD student in the School of Sociology, Social Policy and Social Work, Queen's University, Belfast, Northern Ireland.

Karen McElrath, PhD, is a reader in the School of Sociology, Social Policy and Social Work, Queen's University, Belfast, Northern Ireland.