

# **Women, Methadone, and the Politics of Supervised Exclusion**

**by  
Sylvia Parusel**

M.A. (Sociology), Simon Fraser University, 2005  
B.A. (Sociology), University of British Columbia, Okanagan, 2000

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# Approval

**Name:** Sylvia Parusel  
**Degree:** Doctor of Philosophy  
**Title:** *Women, Methadone, and the Politics of Supervised Exclusion*

**Examining Committee:** **Chair:** Kathleen Millar  
Assistant Professor, Anthropology

**Jane Pulkingham**  
Senior Supervisor  
Professor

---

**Dara Culhane**  
Supervisor  
Professor

---

**Susan C. Boyd**  
Supervisor  
Professor  
Faculty of Human and Social  
Development  
University of Victoria

---

**Parin Dossa**  
Internal Examiner  
Professor

---

**Colleen Dell**  
External Examiner  
Professor  
Department of Sociology  
University of Saskatchewan

---

**Date Defended/Approved:** March 27, 2017

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## **Abstract**

This study examines women's participation in methadone maintenance treatment (MMT) in British Columbia, Canada and concerns the intersections of addiction trajectories, clientization, and social exclusion. Drawing on life stories, physician interviews, and analysis of MMT (documentary) texts, the study explores how women experience MMT and other services in their efforts to improve life chances and social circumstances. Clientization in this case hinges on complex meanings of the body and care and can involve contestation of knowledge at various service sites. Five women's life stories, told from the vantage point of their mid-adult years, confront the normative progress story that MMT involvement suggests and illustrate how participants actively navigated program demands and service relationships, as well as challenged moralizing and individualizing notions of the woman MMT client. Physician perspectives and MMT texts show narrow understandings of the woman methadone client and reveal the glaring need for broader supports for women experiencing drug use troubles. I develop the term "supervised exclusion" to show how medical subjectivity in this case minimally alleviates the participants' experiences of social marginalization and complicates their economic and political marginalization. I argue that supervised exclusion is the intertwined process of "supervision" and "exclusion," and MMT as a supervised treatment asserts a contradictory care and control element which additionally disempowers women who have few resources due to their long-term social, economic, and political exclusion. Women's marginality persists in this context because although they actively challenge policies and discrimination at the level of MMT and broader service provision, they cannot dismantle such a complex problematizing of their lives without far more resources and political power.

**Keywords:** methadone maintenance treatment; women's social exclusion; addiction trajectories; clientization; politics of care

## Dedication

*To Camille, Debbie, Renee, Sarah, and Mariel for their  
grace and courage.*

*And to my mother, Hanna, for never giving up.*

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## List of Acronyms

AA	Alcoholics Anonymous
AIDS	acquired immune deficiency syndrome
ARC	Addiction Research Center
ARF	Addiction Research Foundation
BCAPOM	British Columbia Association for People on Methadone
CAMH	Centre for Addiction and Mental Health
CARBC	Centre for Addiction Research in British Columbia
CCENDU	Canadian Community Epidemiology Network of Drug Use
CCSA	Canadian Centre on Substance Abuse
CECA	Canadian Executive Council on Addictions
CPSBC	College of Physicians and Surgeons of British Columbia
DOT	directly observed therapy
DTC	Drug Treatment Court
DTES	Downtown Eastside (Vancouver, Canada)
HAT	heroin assisted treatment
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HLS	Heroin Lifestyle Study
MEU	multiple exclusion homelessness
MMC	Methadone Maintenance Committee
MMP	Methadone Maintenance Program
MMT	Methadone Maintenance Treatment
NA	Narcotics Anonymous
NAFBC	Narcotic Addiction Foundation of British Columbia
NIMH	National Institute of Mental Health
NMPOU	non-medical prescription opioid use
OPT	opioid pharmacotherapy
OST	opioid substitution treatment
PPA	physician peer practice assessment
PPMB	Persons with Persistent Multiple Barriers
VANDU	Vancouver Area Network of Drug Users
WHO	World Health Organization

## **Chapter 1.**

### **MMT and Everyday Experiences of Marginality**

Methadone maintenance treatment (MMT) is a physician-supervised program targeting chronic opioid use. The treatment is shown to reduce illicit opioid drug use, crime, and health care costs, and reduce the transmission of human immunodeficiency virus (HIV) and hepatitis C virus (HCV) (Ball & Ross, 1991; Gossop, Trakada, Stewart, & Witton, 2005; Nosyk et al., 2013). Opioid substitution also “facilitates access to HIV testing as well as access and adherence to antiretroviral therapy for HIV” (Nosyk et al., 2013, p. 1463).

There are diverse reasons why citizens become clients of the methadone maintenance program. In the province of British Columbia (BC), Canada, where my study takes place, 16,527 persons were registered in MMT in 2016 (College of Physicians and Surgeons of British Columbia, 2016a). Clients’ reasons for enrollment can include short-term management of opioid use problems due to inability to afford or access substances (Reist, 2010), being mandated into addiction treatment through court decisions (Boyd, 1999; Moore, 2007), or seeking relief from moral judgments about drug use (Keane, 2003). As this thesis shows, women’s involvement in MMT can also be about their efforts to remake a life in the face of experiencing multiple, converging troubles, whether these are of a legal, economic, physical, or sociopolitical kind.

Compared to those in the general population who use drugs, citizens participating in alcohol or drug treatment programs are far more likely to be economically marginalized (Room, 2005). In 2015/16, approximately 11,000 MMT patients in BC were on PharmaCare’s Plan C. This plan provides 100% coverage of eligible prescription costs for BC residents receiving disability benefits and income assistance through the Ministry of Social Development and Social Innovation (College of Physicians and Surgeons of British Columbia, 2016, personal communication). Latest available figures show that close to 65% of all MMT clients in the province are receiving some type of income assistance. To

describe the state of battling both addiction and advanced poverty as an experience of social suffering would not be an exaggeration. For instance, media recently reported that between 2008 and 2016, methadone treatment in British Columbia was unaffordable for approximately two-thirds of MMT patients in the province because their income assistance or disability assistance benefits are too meagre to pay for even a portion of the monthly \$60 dispensing fee (Omand, 2015; 2016).<sup>1</sup> This brief example in part illustrates the confluence of troubles and inequities rendering MMT clients and their social problems visible, with visibility, in this instance, implying intersecting client experiences of MMT and income assistance.

## **1.1. Why Methadone?**

Methadone maintenance treatment<sup>2</sup> is an opioid therapy that uses methadone, a synthetic pharmaceutical substance and mu ( $\mu$ ) opioid receptor agonist, to block the euphoric effects of other opiates and opioids and to prevent opioid withdrawal and cravings by acting on the peripheral and central nervous systems (Nosyk et al, 2013; Selby & Kahan, 2011). Methadone was first developed to treat pain but over time has also been utilized to medically treat dependence on morphine, heroin, and opioids such as hydromorphone, oxycodone, and fentanyl. As stated in information for physicians, “methadone has several properties that make it ideally suited as a treatment for opioid dependence—it is potent, has a slow onset and long duration of action, causes cross-tolerance and can be easily distinguished from heroin with urine toxicology” (Selby & Kahan, 2011, p. 28). Dosing guidelines, which are determined by health authorities in BC and are subject to changes, typically inform providers (medical physicians who supervise this treatment) as to the ranges of allowable daily doses. Guidelines for prescribing and dispensing are strict and physicians work with the most recent 2004 version of them. There are no clear guidelines for the third component, counselling (Reist, 2010). Clients must undergo directly observed ingestion by a pharmacist or other authorized person, and “carry privileges” or what is often referred to as “takeaways” are prescriptions for patients

<sup>1</sup> In July, 2016, rather than go to court, the government ended withdrawal of \$18.34 from monthly MMT income benefits. A class action suit still seeks reimbursements to clients for past payments (Omand, 2016).

<sup>2</sup> The program is sometimes referred to as opioid substitution treatment (OST).

who show enough stability to take home one or more doses between clinical appointments. MMT clients must also undergo testing to ensure for health safety reasons that the prescribed dose of methadone is the only opioid being ingested.

The clinical consulting and dosing routine surrounding methadone treatment participation places unusual constraints on clients' lives. Patients and others refer to the treatment as "liquid handcuffs" (Smith, 2011) and it is often seen to be a compassionate and effective approach to chaotic drug use (Keane, 2003). What is clear is that MMT is distinct among drug use treatments for the multiple meanings it evokes (Bourgois, 2000; Bourgois & Schonberg, 2009; Fraser & valentine, 2008; Järvinen, 2014). Bourgois (2000) argues from a critical anthropological perspective that approaches to heroin use since the 1960s arise from conceptualizing heroin and methadone according to political, populist, and economic aims. For example, heroin is regarded as an illegal pleasurable drug while methadone is promoted as a legal medicine blocking pleasure. Bourgois also notes that

for a significant minority of heroin addicts methadone maintenance stabilizes their lives and enables them to withdraw completely from street-based substance abuse. For the majority, however, the effects of methadone maintenance are much more mixed, and for some they are virulently counter-productive. (2000, p. 170).

MMT offers a pragmatic means to deal with chronic, life-changing opioid dependence (Keane, 2003) and the treatment "works" to some degree for many patients, given that the number of clients in Canada is rising. At the same time, there is little evidence that MMT leads directly to social inclusion (Fischer, Rehm, Kim, & Kirst, 2005).

## **1.2. Positioning MMT as One Harm Reduction Tool**

Addiction treatment has always been a complex, culturally constructed human service field but now specifically involves the following: 1) management of diverse "risky" populations; 2) classification of groups according to substance, habit, behaviour, and program experience; 3) dispersed sites of practices; 4) coordination of multiple treatment approaches and communities; 5) development of policy, and increased professionalization and capitalization of expertise; and 6) delivery evaluated to be economically efficient

(Bunton, 2001; Wodak & Moore, 2002). Addiction treatment programs, corresponding to health policies, are organized to classify people who use drugs, and to manage populations because of the risks that drug use behaviours pose for public health (Bunton, 2001).

BC's health authorities currently situate methadone maintenance treatment as a medical treatment under the umbrella of harm reduction. Harm reduction is broadly defined as a public health approach that seeks to reduce harm from drug use. This movement began in Liverpool, England in the 1980s, and the approach presently addresses a continuum of illicit and licit substance use practices but especially has been shown to reduce the harms arising from injection drug use practices. For example, needle exchange is a harm reduction program which helps to control the spread of HIV/AIDS (Coomber, McElrath, Measham, & Moore, 2013). MMT exists alongside programs such as supervised injection (Parusel, 2004), managed alcohol programming, the distribution of needles, crack pipes, and condoms, and client access to naloxone for overdose management. Defined in BC as a non-judgmental array of programming, harm reduction seeks to reduce mortality and the health risks associated with HIV and HCV seroconversion and to lower addiction-related health costs (Centre for Addictions Research BC, 2016).<sup>3</sup> The difficulty in succinctly defining harm reduction is due to its various shifting aspects, but it mainly concerns policy or programming “designed to reduce drug-related harm without requiring the cessation of drug use” and implies, among other goals, best practices of finding “a balance between control and compassion within a framework of respect for individual rights,” and pragmatically responding to the immediate needs of the marginalized person who chronically uses illicit substances (Centre for Addiction and Mental Health, 2002).

In Canada among recent developments directly impacting the MMT system are three that suggest new challenges for federal and provincial health authorities and renewed concerns about the health of persons using drugs. First of all, “non-medical prescription opioid use” (NMPOU) has grown over the past decade. Paradoxically, this term has broad meaning in that it concerns use of prescription drugs obtained in illicit

<sup>3</sup> See Roe (2005; 2010) who provides critical analyses of early harm reduction programming in Vancouver and the role of community activists in implementation.

markets or use of drugs obtained through typical medical consultation. The opioids of choice are increasingly oxycodone, hydromorphone, and fentanyl (Canadian Community Epidemiology Network on Drug Use [CCENDU], 2013; Fischer, Goldman, Rehm, & Popova, 2008; Fischer, Kurdyak, Goldner, Tyndall, & Rehm, 2016). As drug use activists and some inner-city health researchers point out, people often resort to buying opioids on the illegal market because of the unavailability of formal heroin assisted treatment (HAT) and other formal opioid substitutions, and this situation increases health risks associated with opioid drug use. NMPOU also indicates changing markets and implicates profit-motivated professional interests, such as aggressive pharmaceutical marketing and questionable physician prescribing that have contributed to increased dependence in recent years (Butler, 2016; Fischer et al., 2008; Fischer et al., 2016; National Advisory Committee on Prescription Drug Misuse, 2013; Reinarman & Granfield, 2015). Second, in Canada MMT client numbers have recently risen with the most dramatic increase being in Ontario, where the number of participants grew from 29,000 clients in 2010 to nearly 50,000 in 2014. Now 29% of all MMT clients in Ontario are under the age of 30, which relates to the rise of NMPOU to some extent (Fischer et al., 2016, pp. 1–2). Third, in 2015 BC authorities introduced alternative substances to methadone in opioid substitution treatment, namely, buprenorphine and specifically, buprenorphine/naloxone (trade name Suboxone®), the latter regarded as a “first line option” for new MMT participants. Buprenorphine is associated with reduced risk of overdose and inclusion of buprenorphine/naloxone in the MMT toolkit reflects emerging considerations about safety as methadone is implicated in one quarter of recent prescription opioid deaths in BC (Providence Health Care & Vancouver Coastal Health, 2015). Before this recent authorization of Suboxone® in substitution treatment, few clients in the province were treated with such alternate prescriptions. For instance, only about 1% of clients in the province aged 50 and older received permission for treatment with buprenorphine/naloxone in 2012 (CPSBC, 2012, personal communication). A broader rollout of alternative substances in MMT was protracted due to the government’s reluctance to fund a substance more expensive than methadone, and this situation illustrates how economic evaluations have underpinned specific harm reduction approaches over the years. The recent opioid use crisis in BC has led the Ministry of Health and CPSBC in July 2016 to facilitate easier access to opioid substitution treatment in British Columbia and as the CPSBC announced,

physicians will no longer be required to hold an exemption to prescribe methadone for opioid use disorder prior to being able to prescribe Suboxone® (sublingual buprenorphine/naloxone), or its generic versions. . . . To further remove barriers to patient access, the College will no longer maintain a central registry of patients registered in the methadone program. As a result, patient registration, transfer, and cessation forms are no longer required to be submitted. (Announcements, July 4, 2016, paragraphs 1 and 2)

Recent dramatic increases in opioid use and these policy changes therefore suggest increased participation in opioid substitution treatment.

In all, changes to MMT programming illustrate the shifting nature of the substitution treatment field. New knowledges have emerged from recent completion of two heroin assisted treatment (HAT) clinical trials in North America showing heroin's effectiveness for a minority of persons living in Montreal and Vancouver<sup>4</sup> who are not well served by methadone (Providence Health Care & Vancouver Coastal Health, 2015, p. 11). The future of heroin prescription for far more clients in the array of substances utilized for treatment for opioid use in Canada is unknown. It is likely to remain a contested issue in Canada, especially given the moralizing about heroin in general (Boyd, 1999; Malleck, 2015) and the tumultuous politics of substitution treatment (Fischer, 2000). As well, the recent overdose crisis in BC<sup>5</sup> suggests authorities may consider introducing heroin prescription. As it stands, recent reversal of a 2013 ban on doctors' access to diacetylmorphine has reinstated physicians' ability to request special access to prescribing heroin to a small select group of opioid users not well served by other types of substances allowed in MMT (Lupick, 2016).

As the above discussion suggests, MMT is not just a medical treatment but has broader sociocultural, temporal, gendered, and political dimensions. Critical sociological and anthropological literature shows clients' efforts to return to "normal" life through MMT over time (Rosenbaum, 1981) are challenged by negative representations of illicit

<sup>4</sup> The first HAT trial was located in Montreal and Vancouver. The second was based in Vancouver only.

<sup>5</sup> 622 citizens died from drug use overdoses in BC between January 1 and October 31, 2016 and fentanyl was detected in 60% of the deaths (Providence Health, 2016).

substance users as risky subjects unwilling to responsibly activate their citizenship in neoliberal terms (Bourgois, 2000; Fraser & valentine, 2008; Friedman & Alicea, 2001; Moore & Fraser, 2006). Also, studies reveal that MMT clients are highly stigmatized in society yet display agency in treatment settings through negotiations of identity (Fraser & valentine, 2008; Friedman & Alicea, 2001; Järvinen, 2014; Ning, 2005). There is little knowledge of how these issues factor into the experiences of women in MMT in BC and how they relate to protracted experience of exclusion.

This thesis enters critical debates about the MMT clinic's role in women's marginality (Fraser & valentine, 2008; Friedman & Alicea, 2001). Specifically, this research broadens the scope of critical inquiry of gendered MMT experience by examining links between five women's MMT client identity and their experiences of intersecting services related to health problems and drug use, poverty, and trauma. I examine the study participants' multiple client experiences, especially their MMT experiences, and analyze their life stories told from the vantage point of their mid-adult years. Their narratives richly illustrate the relationship between their MMT participation, multiple client experiences, and intense marginalization<sup>6</sup> in specific and complex ways, especially in relation to gender and social class. While racialization is another form of marginalization, participants' narratives do not support a fulsome analysis of women's MMT experiences and racialization, although I do examine the traumatic legacy of colonialism through one life story. The study also explores MMT texts and physician perspectives to illustrate practices and politics at the site of MMT, and expert knowledge of the MMT client experience and women's related challenges.

In this study, I develop the concept of supervised exclusion to help explain women's intersecting experiences of MMT and marginality. This approach seeks to account for various influences in the lives of women who turn to drug use treatment to improve their social circumstances. It addresses the contradictions that everyday medical supervision and longstanding redistributive neglect imply. Supervised exclusion also refers to multiple client experiences and women's need to navigate service sites and the

<sup>6</sup> Marginalization is defined as a multidimensional social process by which an individual or group is systematically prevented from accessing economic, social, or political resources, and positions of power (Wacquant, 2009).

politics of care to gain health and social resources. These experiences involve women's encounters with notions of risk in the treatment field that frame their MMT experience and identity. In the medical sense, risk is understood in negative terms and regards states or behaviours associated with exposure to danger. Epidemiological knowledge informs public health concerns about risk and examines risky behaviours (Inhorn & Whittle, 2001). I show in this thesis how these influences can obscure the complexities of drug use-related struggles.

### **1.3. Aims and Objectives of the Study**

The goal of the study is to critically analyze the everyday politics of care surrounding women's experiences of drug use, methadone maintenance treatment, primary health treatment, and income assistance and other services targeting the poor. One research objective is to broaden empirical knowledge of women's MMT participation relative to their ongoing experiences of social, economic, and political marginality. A second objective is to increase empirical understanding of how MMT is organized and practised in BC. The third objective is to sharpen theoretical focus on the reconstitution of marginality in the case of women in MMT.

### **1.4. Research Questions**

The study's broad research question is: What does women's participation in methadone maintenance treatment reveal about the politics of care surrounding their marginality? Additional questions are: What are the expert knowledges and practices of MMT in BC and how do they construct women as health subjects? How do women of mid-adult age experience MMT and other services? How do they navigate, negotiate, and challenge the intersections of MMT and other services over time? How do their experiences reflect the process of supervised exclusion?

## 1.5. Outline of Chapters

In Chapter 2, I examine the emergence of methadone and the medical research that promoted the use of this pharmaceutical substance in treatment for opioid addiction in North America by the mid-20<sup>th</sup> century. Early medical discussions about the “criminal addict” illustrate sociocultural and legal contexts of efforts to provide a medical-based treatment alternative to harsh drug laws. Health experts also promoted methadone as a means to socially rehabilitate the “street addict,” and this key claim continued throughout the politically charged development of methadone maintenance programming in Canada. Presently, mainstream knowledge of MMT tends to draw on risk discourse to explain women’s MMT involvement as a “special problem” concerning “behaviours”. This approach individualizes the connections between women’s drug use and health conditions, rendering complex experiences of social and political exclusion invisible to policy. Lastly, shifting definitions of addiction are also historically relevant to clients, largely because how drug use in a society is understood impacts the policies, practices, and experiences of treatment at any given time.

Chapter 3 examines strands of literature concerning sociocultural aspects of addiction, methadone maintenance treatment experience, and women’s social marginalization, and many of these studies emphasize how MMT can disempower clients. Through a critical discussion of governance literature, political economy theories of MMT, and phenomenological and ethnographic evidence, I argue that social control strategies and MMT knowledges reconstitute a multidimensional treatment regime that a woman methadone client must navigate. Women also negotiate their MMT-related identities, and their subjective, embodied meanings of MMT hold potential to inform understanding of women’s experience of this treatment. Furthermore, to develop my theory of “supervised exclusion,” which I explore more fully in Chapters 5 through 7, the discussion presents, in turn, four key concepts: addiction trajectories; clientization; the politics of care; and deep social exclusion. The theoretical discussion posits that MMT subjectivity can be multidimensional as well, involving problematization of life troubles, and clients’ obligations and experiences of both control and neglect.

Chapter 4 reviews the substantive and methodological literature, mainly narrative research and life story production, that informs this study. In this chapter, I consider how

established ethnographic tradition in qualitative drug studies in the U.S. have increased knowledge of the lived experience of drug use and treatment in that country. At the same time, few ethnographic studies have explored women's treatment experiences, especially in the case of MMT in Canada. Literature further shows how the study of marginalized groups must tread carefully, and suggests the need for reflexive methods and equitable production of addiction knowledges. I explain and justify my three research methods of life stories, qualitative interviewing, and content analysis of MMT texts. Furthermore, I provide details about the study participants, interview activities, and the texts I chose for close analysis.

Chapter 5 comparatively analyzes specific MMT texts and the narratives of four MMT physicians who practise in BC. Using a social constructionist framework, I discuss how regulation, expert knowledge, and MMT practices intersect and concern women's MMT experiences. I reflect on how both sets of data (content analysis and physician narratives) relate to clinical notions of risk, stability, and clients' readiness to change. As well, physicians' practical, health-related considerations about the woman methadone client must be understood according to how texts guide them in MMT practice and in light of the interpretive power that MMT texts and expert positions wield. Narratives show that mid-adult women's intersecting experiences of MMT and social marginalization remain only partially visible to providers and authorities.

Chapter 6 presents summaries of five women's life stories produced through multiple sequential interviews. Analysis draws on the concepts of addiction trajectories and clientization, showing women's diverse social locations and their experiences of drug use and life troubles. While their participation in treatment provided them relief from the worst effects of opioid use, their troubles persisted. Drawing from their life stories, I explore the links between participants' drug use troubles, client experiences, categorization, and social suffering. These especially concern the process of "supervised exclusion", and I discuss trajectories and effects in the context of local and provincial policies, such as harm reduction policies and dismantling of programming. Life stories show women's efforts to improve their life chances, and also the complexities and contingencies of addiction treatment subjectivity.

In Chapter 7, I again draw on the five women's narratives and use comparative thematic analysis to explore participants' experiences of MMT and other services. The women challenge dominant meanings of MMT and notions of progress, and the discussion explores clientization of their lives according to the themes of discrimination (stigma), health care, income assistance, and other formal and informal supports. In navigating the politics of care they encountered, participants displayed agency in seeking to improve their health and social circumstances. Throughout this chapter, I illustrate the distinct process of supervised exclusion, which implicates treatment organization and policies, and also a continued lack of formal social supports for women in BC who live in poverty.

In Chapter 8, I summarize the research findings. I argue that the process and experience of supervised exclusion arises from policies and practices that focus on risk behaviour. MMT can disempower women because it involves a contradictory neglect and control treatment scenario, and constructs woman clients while rendering their social, economic, and political needs invisible. I further argue that this case has significant implications for women who struggle to improve their life chances. I propose recommendations calling for renewed policy and research aims. As this thesis shows, in the context of gendered experiences of opioid addiction, women's need for tangible resources and political empowerment is crucial.

## **Chapter 2.**

### **The Origins of Methadone Maintenance and Development of the Treatment in Canada**

This chapter first examines experimentation with methadone in North America and early development of methadone maintenance treatment (MMT) in Canada. The origins of MMT illustrate the intersection of drug regulations and policies, medical research, professional opportunism, and shifting therapeutic strategies. Experts merged their understandings of both physical and social aspects of problematic narcotic drug use to claim that methadone, as a pharmacological substance, provided a licit ingested substitution for illicit narcotic drug use (e.g., heroin and morphine) which could socially rehabilitate “street drug users” in the process. While the claim gained policy attention in the 1960s, it did not displace dominant constructions of the “criminal addict.” In Canada, encounters with the law have long been part of the “street” experience of non-medical drug use; socially marginalized citizens were historically more likely to be imprisoned and forced into abstinence treatment than were middle- and upper-class users of illicit drugs (Boyd, 2014; Giffen, Endicott, & Lambert, 1991). Drawing on critical literature that examines the roots of social control of people who use drugs in Canada (Boyd, 1999; 2014; Fischer, 2000; Giffen et al., 1991; Malleck, 2015; Quirion, 2003), I trace the sociocultural, political, and institutional aspects of MMT’s emergence. I also examine medical claims about methadone’s role in treatment and social rehabilitation of persons using drugs, arguing that there is a long history of utilizing narrow constructions of the methadone client for political reasons.

The chapter then discusses the position of methadone maintenance in harm reduction developments. As risk management is now the dominant political and professional frame for MMT in Canada, this raises questions about the types of problems associated with drug use in mainstream knowledge. Evidenced by public health strategies and positivist research trends, increasing surveillance of drug-related risks contributes to narrow representations of the woman methadone client, de-contextualizes their treatment experiences, and represents them as lacking agency. Exploring the themes of control,

risk, and social rehabilitation expectations in this chapter facilitates scaffolding a theory of “supervised exclusion” that can help explain women’s experience of contemporary MMT.

## **2.1. North American Methadone Research: Substitution and Social Rehabilitation**

Methadone was first synthesized in Germany by Max Bockmuhl and Gustav Ehrhart at IG Farbenindustrie in the late 1930s, utilized during World War II as a substitute for morphine for German troops (Kleiman & Hawdon, 2011), and was rediscovered through U.S. investigation of wartime industries (Campbell, 2007). In 1947, medical scientists Harris Isbell, Abraham Wikler, Nathan B. Eddy, John L. Wilson, and Clifford F. Moran at the U.S. Public Health Service Hospital in Lexington, Kentucky were the first to document experimentation of methadone on human subjects in the U.S. when they set about testing the “addiction liability” of methadone’s analgesic properties. The setting was the “narcotic farm,” which existed between 1935 and 1976 and was one of two federal prison hospitals incarcerating felons with drug use histories.<sup>7</sup> The Lexington facility utilized “post-addicts”<sup>8</sup> for addiction research and its onsite research laboratory was renamed the Addiction Research Center (ARC) in 1948, in affiliation with the newly formed National Institute of Mental Health (NIMH) (Campbell, 2007).

The history of methadone research illustrates the types of scientific reasoning that animated the search for opioid substitutions (Campbell, 2007). Building on Himmelsbach’s laboratory logic of substitution (Campbell, 2007), Isbell and his team found that this synthetic drug relieved 15 male subjects of morphine withdrawal symptoms, and they concluded that methadone was indeed addictive and should be controlled (Isbell, Wikler, Eddy, Wilson, & Moran, 1947). Furthermore, methadone showed promise as a

<sup>7</sup> The prison hospital additionally housed voluntary citizens seeking treatment and some neuropsychiatric patients (Campbell, 2007). See also Courtwright, Joseph, and Jarlais (2013) who present an oral history of drug use in the U.S., drawing on numerous primary accounts that describe the Lexington facility, drug regulation, and early experience of methadone maintenance.

<sup>8</sup> The label “post-addict” appears in early medical literature on drug use and Campbell (2007) uses the term to describe people undergoing prison-based drug treatment.

maintenance drug for opioid dependence (Isbell & Vogel, 1949). From the late 1940s to the 1960s, other ARC studies were similarly reporting that methadone “substitutes readily for other addicting [morphine-like] substances” (Eddy, Halbach, & Braenden, 1957, p. 862). Later reflecting on his participation in early experimentation with analgesics which involved first testing methadone, then other synthetic drugs, Isbell explained the research activities and aims at the facility:

The synthetic flood almost overwhelmed our limited facilities at Lexington. We could no longer follow deliberately a path to dissociate physical dependence from analgesia but were struggling to evaluate the addictive potential in order to prevent the introduction of addicting new analgesics into general use without proper warning and control. . . . In short, a basic approach to dissociation of addictive liability had to be shelved and the program operated for reasons of public health. Lexington succeeded very well in this public health mission. No new analgesics with dependence liability were introduced in the United States without proper warning and control. (1977, p. 379)

Early experimentation reveals that the search for a *non-addicting* analgesic for opioid addiction began early at the research centre and was ultimately unsuccessful. As Isbell reflects,

the notion that finding a non-addicting analgesic would be a total solution to the problem of opioid addiction is and was naive. No matter what drugs are available for medical practice, *illegal heroin (and other drugs) would continue to be attractive to certain people*, and, since the illegal traffic in opiates is so lucrative sources of opium and heroin would continue to exist and new ones would be created. . . . However, no matter how naive the idea of developing a non-addicting analgesic as a solution to opioid abuse may have been, the development of such an agent would be *a major therapeutic triumph*. (Isbell, 1977, p. 382, emphasis added)

As a key researcher at Lexington, he nonetheless reports that the development of methadone was a major accomplishment of ARC. Here, he suggests that “certain people” illogically prefer illegal drugs but does not qualify his statement or provide evidence of such.

Early studies did not acknowledge the link between incessant illegal trafficking of opioids and political ideologies instituting criminalization of drug use over a century ago, creating the very conditions that contribute to social problems and proliferation of formal drug treatments<sup>9</sup> (Boyd, 1999; 2014; Reinerman & Granfield, 2015). Scientific discoveries of addiction are contingent and involve multiple knowledges, and Campbell (2007) further notes that “internal history must be handled with care so as to avoid overreliance on major figures at the expense of social structural factors” (p. 6). ARC researchers utilized institutions (i.e., the scientific laboratory, the penal system) and national addiction policy to inaugurate a style of thought—that abstinence from illicit drug use was at least theoretically achievable given the right scientific tools and knowledge applied to a growing narcotic use problem (Campbell, 2007). Overall, early production of neuroscientific theories of addiction drew on a steady supply of captive research subjects, arose from heightened interest in the study of individual health, reflected scientific enterprise and entrepreneurialism,<sup>10</sup> and was highly influenced by a growing pharmaceutical industry (Campbell, 2007). As I argue in this chapter, medical knowledge on MMT sought to broadly influence the lives of “criminal addicts” through narrow understandings of how marginalized citizens’ narcotic drug use implicates social processes and institutions.

In this context, researchers primarily observed methadone’s myriad physiological effects<sup>11</sup> and over subsequent decades, increasingly remarked on the psychosocial aspects of subjective experience of methadone in laboratory and hospital trials. Even the earliest experiments documented how subjects “re-establish[ed] ego interaction and normal social functioning, especially a steady paying job” (Isbell & Vogel, 1949, quoted in Bull, 2008, p. 124). Medical researchers in the 1960s would continue exploring methadone maintenance for its potential to reduce illicit narcotic use and socially rehabilitate heroin users (Bull, 2008; Campbell, 2007; Etzioni & Remp, 1973; Quirion, 2003). As the following shows, “the evidence in favour of the broadening of goals associated with the treatment

<sup>9</sup> I thank Susan Boyd for this insight.

<sup>10</sup> Kolb is an early example in this regard. He advanced his psychodynamic theory of addiction as well as his career by utilizing captive research subjects, institutionalizing his classification system, and linking dominant neurophysiological explanations with remnants of discredited theories of psychopathology (Campbell, 2007).

<sup>11</sup> Researchers pragmatically put methadone into use at Lexington to help many patients withdraw from opioids after they entered the facility and before placing them in the general prison hospital population (Campbell, 2007; Courtwright et al., 2013).

of drug use was as much supported by the social reintegration rhetoric as the bio-medical aspects of addiction” (Quirion, 2003, p. 251).

Social class differences figure strongly in the methadone treatment origin story. As in earlier decades and centuries when middle-class moral entrepreneurs targeted alcohol or drug use among the poor and working class, ostensibly on behalf of all populations (Acker, 2002), professional perspectives on methadone in the mid-20<sup>th</sup> century drew on middle-class values to reanimate arguments for medicalizing the “criminal addict.” The voices of people experiencing addiction were largely absent in the first decades of methadone treatment development. While studies in the U.S. found that many men and women who used narcotics were contributing to society (Bovelle & Taylor, 1985; Page & Singer, 2010), those who were structurally and politically marginalized through class and gender inequalities and racialization were being disproportionately removed from the populace at regular intervals through harsh criminalization of drug use and were singly targeted for rehabilitation.

### **2.1.1. Methadone Maintenance Experiments: Positing an Alternative to Abstinence Treatment**

Amid the minimal professional work challenging the construction of the “pathological criminal addict” (Boyd, 2014, p. 216), two projects stand out as seminal research in this regard. In Vancouver, Canada, under the auspices of the Narcotic Addiction Foundation of British Columbia (NAFBC), Robert Halliday began clinical methadone research in 1959 (Halliday, 1963; Paulus & Halliday, 1967). The approach was conceived as a short-term withdrawal program and involved administering methadone to patients over 12 days, optionally supplemented by tranquilizers. By 1963 Halliday continued the experiment as a longer maintenance program, the first in North America (Fischer, 2000; Quirion, 2003). Patients received maintenance treatment over an unspecified, lengthy period, involving a daily dose of 40 mg, which was low by today’s standards. Among the 815 patients treated between 1959 and mid-1964, Halliday interviewed 176 men and women who had taken part in ten or more of the clinic’s counselling sessions. The research goals are explained:

The aim of the study was two-fold: to compare the effects of prolonged versus regular withdrawal treatment, and to assess what criteria, if any, could influence rehabilitation. . . . Rehabilitation was defined as the achievement of specific measurable changes in a patient's life in accordance with the aims of the N.A.F. to: (1) detoxify the addict and teach him to function without the aid of drugs; (2) enable him to secure or maintain work in an appropriate occupation; (3) diminish his involvement in criminal activities; (4) change his companions to non-drug users and non-delinquents; and (5) guide him to act in a responsible way in his family. (Paulus & Halliday, 1967, p. 656)

The research, drawing on clinical and interview data, revealed 41% of patients in the regular withdrawal program and 47% in the prolonged maintenance program demonstrated decreased narcotic drug use and criminal involvement and increased employment. Based on these findings, Paulus and Halliday (1967) argued that there was a need for drug treatment programs improving narcotic users' health and social functioning rather than fixating unproductively on forced abstinence goals and "cure."

Further challenging conventional abstinence goals and exploring methadone's potential physical and social benefits, Dole and Nyswander (1965; 1967) began a methadone maintenance research trial at Rockefeller University Hospital in New York in February 1964, treating a total of 304 men and women over the next three years. In their first report, Dole and Nyswander (1965) make a distinction between their work and previous medical maintenance models which existed between 1919 and 1923, arguing that maintaining addicts on morphine or heroin is not practical given the frequent need to administer injections of those short-addicting drugs. Methadone provided longer efficacy of 24 hours, which required less medical oversight and allowed for a regular daily social routine, such as implied by employment and family obligations. The first intake of patients in the study was given methadone at a dose of 50–150 mg. over one to 15 months. Twenty-two male patients between the ages of 19 and 37 participated on an outpatient basis after spending their first week in the clinic. Hospital staff helped monitor the mainly unconfined patients who also needed assistance "in obtaining jobs, housing, and education" (Dole & Nyswander, 1965, p. 648). The authors conclude that methadone eliminated drug hunger and blocked the effects of heroin, facilitating normative life routines.

By 1967, patients were being given a dose of 80–120 mg/day and the program did not have a counselling component. The authors argued that heroin users' disordered metabolism gives rise to problematic drug use and disorder in their social lives, and that methadone is a pharmacological blockade for "drug hunger" (Dole & Nyswander, 1967, p. 21), which in turn reduces addicts' criminality and increases their social productivity and employability overall. Accordingly,

approximately 70% of the patients who have been in the program for six months or longer are employed or in school; the remaining patients, although not yet socially productive, have at least ended heroin usage and the related antisocial behavior. (Dole & Nyswander, 1967, p. 19)

The authors described the results as positive beyond their expectations, finding participants' cessation of illicit drug use and their increase in social productivity and status were straightforward benefits. This research challenged dominant century-old psychogenic understandings of addiction that linked addiction to character weakness and inherent sociopathic personalities. Dole and Nyswander's argument that drug use concerns physiological problems and not psychiatric ones was a key claim for expanding drug substitution therapy in the U.S.

There were few differences between how these two North American studies conceptualized social rehabilitation, basically understood as responsible engagement with formal work, family, and community, and cessation of both criminal activity and fraternizing with delinquents. Brief remarks about gender differences in the Vancouver study outcomes assert that

this treatment approach is instrumental in changing the hitherto hopeless lives of many addicts into more constructive ones; for the women especially this affords a chance to contract marriage and meaningful family ties. These give them some measure of personal and financial security, and keep them from slipping back into the use of drugs so persistently. (Paulus & Halliday, 1967, p. 658)

Women who use drugs are typically absent in discussions of methadone trials. When briefly remarked upon, as in the above quote, they are represented as deviant from

domestic spheres, rather than from instrumental roles. Paulus and Halliday failed to report the number of women who participated in their research, even as they drew associations between women's social rehabilitation and return to the norms of marriage and family life via methadone treatment. References to sex work are absent in early methadone literature, but the term "these give them some measure of personal and financial security" alludes to it. While culturally conditioned expectations about societal roles were evident in this early literature, both studies are unique for attempting to contextualize opiate users' experiences of living with addiction, however narrowly understood, unclearly communicated, or weakly hypothesized through middle-class, medical perspectives. Without a doubt, practices at the two clinics display these early researchers' deep concern for the suffering that persons using drugs were experiencing in North American society and were willing to assert the rights to help them.<sup>12</sup>

For methadone treatment proponents, treatment success hinged on facilitating addicts' normative behaviours. Dole and Nyswander clarify their view on the role of methadone in this regard:

Perhaps the limitations of medical treatment for complex medical-social problems were not sufficiently stressed. No medicine can rehabilitate persons. 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. But to succeed in bringing disadvantaged addicts to a productive way of life, a treatment program must enable its patients to feel pride and hope and to accept responsibility. This is often not achieved in present-day treatment programs. Without mutual 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, and the overcrowded facility becomes a public nuisance. Understandably, methadone maintenance programs today have little appeal to the communities or to the majority of heroin addicts on the street. Methadone maintenance, as part of a

<sup>12</sup> See Courtwright et al. (2013) whose compilation of first person accounts of criminalization and drug use treatment in the U.S. includes individual interviews with Vincent Dole and Marie Nyswander.

supportive program, facilitates social rehabilitation, but methadone treatment clearly does not prevent opiate abuse after it is discontinued, nor does social rehabilitation guarantee freedom from relapse. (1980, p. 261)

According to these authors, there are limits to how biomedicine can affect complex social problems related to addiction. However, methadone proponents sought to socially rehabilitate through pharmacology those addicts “living as criminals on the fringe of society,” even as conventional treatment goals and practices may have spoiled the ground for the expansion of methadone treatment. Supportive methadone maintenance programs, they argued, offer patients hope and facilitate users to act responsibly as opposed to unsympathetic treatment practices which deter opiate users from seeking or staying in treatment. While scientists and physicians avoided direct criticism of harsh North American drug controls, they often weighed in on various social issues. Isbell suggested the issue of addiction mainly concerns incessant supply of and demand for illicit drugs. Paulus and Halliday in Canada and Dole and Nyswander in the U.S. infer that medicalization of addiction gave the narcotic user opportunities to integrate into society through the display of productive behaviours. Dole and Nyswander (1965) argued in their first report on their experimentation that “this treatment requires careful medical supervision and many social services. In our opinion, both the medication and the supporting program are essential” (p. 646).

Also, there was frequent use of the label “criminal addict” in methadone literature.<sup>13</sup> Indeed, references to the “criminal addict” or “street addict” in early treatment literature reflected an inaccurate belief that criminality typically preceded drug use (Giffen et al., 1991). The term also obscured the fact that citizens from all classes were presenting with narcotic addictions to physicians while professional scepticism of addicts’ motives continued to circulate. Early methadone literature, presented as common sense reasoning, was certainly not politically neutral. In a sense, methadone proponents began to exert influence over how narcotic addicts were represented in society, while actual treatment introduced a new standardization of control of opioid drug use, as the daily

<sup>13</sup> See Dole, Nyswander, and Warner (1968) for a prominent example.

observed ingestion of methadone and regular surveillance of MMT clients' behaviours show.

As shown thus far in this chapter, the standard received history of methadone treatment has accentuated medical experts' role in its development, rather than clients' experiences of it. Perhaps too much can be attributed to the activities of key methadone proponents and yet as Campbell (2007) shows, these provide evidence of the sociocultural and political dimensions of medical addiction treatment developments. As the next section shows, experts' efforts to establish methadone treatment in Canada were highly curtailed in some decades. Debates centred on how programming should be available to the Canadian public and organized to maximize control. Policy changes had dramatic effects for opiate users, especially the most marginalized among them. Furthermore, social rehabilitation remained a figurative goal and political tool in further discussions of this treatment.

## **2.2. The Controversies of Methadone Maintenance Treatment (MMT) in Canada**

Instituting publicly funded drug treatment sympathetic to clients was difficult in Canada due to punitive policies and discourses (Boyd, 2014; Fischer, 2000). The state's criminalizing of narcotic drug use had involved a succession of government acts and amendments since 1908.<sup>14</sup> The Opium and Drug Act of 1911 distinctly "consolidated and strengthened a broad-based drug-control regime that had begun at the provincial level over a half a century before, and initiated the break from medical control and the advent of judicial control," which thus set in motion the eventual criminalization of drug possession that occurred by the 1920s (Malleck, 2015, p. 247). By the mid-20<sup>th</sup> century, incarceration of persons using narcotics was common, and they were increasingly forced into abstinence-based treatment programs behind prison walls where knowledges there constructed a person's drug use as a "psychiatric disorder as well as a criminal activity"

<sup>14</sup> The key drug control acts Canada passed during the early 1900s were the Opium Act (1908), the Opium and Drug Act (1911) (1920), and the Opium and Narcotic Drug Act (1923) (Malleck, 2015).

(Boyd, 2014, p. 216). These included prison treatment programs for women, such as the Ontario Women's Treatment Centre at the Mercer prison complex, which the Ontario Department of Reform Institutions launched in 1955 (Guzzo & Underhill, 2012), and the Narcotic Drug Treatment Unit established as part of the Women's Division at the Oakalla Prison Farm in Burnaby, BC (Butterfield, 1958).

By mid-century, the response to illicit opiate addiction began to shift when the medical paradigm of drug treatment began to demonstrate some influence on policies surrounding addiction. Fischer (2000) describes the medical model of addiction as a professional treatment movement that drew on the growing influence of psychiatry. However, medical-based treatment for illicit drug use did not displace punitive approaches to addiction, and a polarizing of attitudes toward opiate addiction can be traced to this period (Fischer, 2000; Giffen et al., 1991). With the 1961 Narcotic Control Act (NCA), "legislative changes gave Canada the distinction of enacting some of the harshest drug laws of any Western nation" (Boyd, 2014, pp. 216–217). As professional discourse and policy debates about control show, few experts were challenging the prison treatment model and general distrust in the community of people who use drugs continued through the postwar period (Giffen et al., 1991). At this time, the Canadian government and law enforcement authorities were still strongly opposing the argument for opiate substitution and despite some tentative ministerial consideration of medical arguments it wasn't until 1961 that both paradigms were legally recognized.

In 1963, the Addiction Research Foundation opened Canada's second methadone clinic in Toronto, held a conference during which enforcement and treatment professionals debated treatment concerns, and finally turned to the Canadian Medical Association for advice (Giffen et al., 1991). This led to the formation of a special committee of the Association, which in 1965 proposed guidelines for physicians encountering patients requesting withdrawal or maintenance. The guidelines stipulated that private physicians conduct a thorough examination and case history of the patient; carefully write prescriptions to prevent "double doctoring"; with patient consent, provide information to the Department of Health and Welfare that identifies the patient as a narcotic user under treatment; and consult with colleagues for additional physical or psychological assessment or treatment (Ferguson et al., 1965).

Guidelines referred mainly to the 3000 or so “street addicts” in Canada, as distinct from the believed (but unspecified) far lower numbers of “professional addicts,” such as doctors, nurses, or veterinarians illicitly using narcotics, and “medical addicts,” such as patients addicted through prescriptions (Ferguson et al., 1965, p. 1040). The latter category, “medical addicts” or rather, patients with iatrogenic addiction, were commonly found in the medical system in the 19<sup>th</sup> and early 20<sup>th</sup> century due to physicians’ liberal prescribing of opiates (Reinarman & Granfield, 2015; Malleck, 2015). The following quote refers to so called street addicts and reveals medical doubts that they could be socially rehabilitated through the available treatments after release from prison:

[The Narcotic Control Act] provides for continuing supervision under the Parole Act after release of the addict, during which time "treatment" can be continued. Workers in the health sciences and social sciences have yet to develop conspicuously effective methods of treatment, which means, in essence, persuading and assisting street addicts to become relatively useful citizens; but they are trying. Bystanders should not, however, expect spectacular results in a hurry. (Ferguson et al., 1965, p. 1041)

Medical authorities deemed treatment methods effective when “persuading and assisting street addicts to become relatively useful citizens.” Medical professional discussions about methadone provision represented people who used drugs as risks to the social body and rarely mentioned the structural barriers such citizens could face. Also, references to social re/integration in early Canadian medical discussions were often rhetorical and fostered the notion that most users of drugs were at the very least socially unproductive, if not also inherently criminal.

By the end of 1972, 23 methadone programs had been established, serving 1700 patients in Canada, and the Commission of Inquiry into the Non-Medical Use of Drugs (informally named the Le Dain Commission) enthusiastically recommended further methadone program expansion<sup>15</sup> (Fischer, 2000; Giffen et al., 1991). While the Le Dain Commission also called for improved monitoring of methadone provision by established

<sup>15</sup> In acknowledging that some clients were not well served by methadone treatment, the Commission additionally and unsuccessfully proposed that a heroin maintenance trial be developed as a last resort treatment, limited in availability (Fischer, 2000).

clinics that could ensure therapeutic components were in place, resistance to this treatment was growing across a number of political fronts, evidenced by legal advocacy for abstinence programs and documented fears about increased demand for methadone.

The federal Department of Health formed a Joint Committee of “health, law enforcement officials, and Representatives of the Canadian Medical Association to investigate the problem situation,” reflecting legal and health service anxieties about why private physicians were the dominant prescribers of methadone and how the substance was being diverted to the street, as both factors were believed linked to several overdose deaths (Fischer, 2000, p. 193). The committee recommended urinalysis testing, expanded documentation, and further guidelines for physicians, all of which became legally enforceable through Narcotics Control Act amendments in 1972. Federal regulation of physicians’ prescribing privileges can be traced to this time (Fischer, 2000). These treatment restrictions and a fivefold increase in convictions for heroin offences between 1966 and 1973 led to drastically decreased numbers of methadone clients, and by 1975 the total number had fallen by one-third (Fischer, 2000, p. 197). Beginning in the mid-1970s, there was further decline in client numbers and by 1980 methadone dosages across Canada were low with some regional differences (Fischer, 2000; Quirion, 2003). Client numbers began to climb again in the 1980s and by mid-decade, 75% of clients were receiving their prescriptions from private physicians while authorities were developing further restrictive guidelines (Fischer, 2000). Overall,

the regulatory restrictions of methadone treatment in Canada as introduced in the early 1970s present a formidable case study of how pervasive regulation can hinder treatment implementation and provision almost to the point of extinction. Instead of enhancing methadone treatment availability, the federal guidelines imposed in 1972 appear to have made methadone treatment rather unattractive to physicians and thus dramatically less accessible to addicts, producing a drastic decrease in the numbers of treatment places in the following years. (Fischer, 2000, p. 205)

When the federal government decided to download the administration of MMT to the provinces in 1996, Ontario and British Columbia treatment and authorization guidelines became less restricting. As a result, the percentage of clients in BC grew by almost 450%

from 1995 to 1999 to a total number of 12,000 patients (Fischer, 2000). As of 2016, BC's MMT program serves over 16,000 clients.

In summary, early methadone treatment knowledge was based on biomedical experimentation and drew attention to individuals' non-normative behaviours. Fischer (2000) shows that support for the treatment oscillated following the first thin bloom of facilities. Overall, Canada's MMT system served less than 10% of opiate users for some time, a percentage that compared unfavourably to Australia, Switzerland, and the Netherlands, which provided methadone to 40–50% of their opiate-using populations (Fischer, 2000).

As Quirion (2003) argues, documents from the “primary phase” (1963–1979) and the “resurgence phase” (1980–2001) of methadone treatment in Canada further reveal that goals had shifted from addressing individual needs to risk management of groups. In the resurgence period, clinical and evaluative documents reiterated social reintegration goals but also began actively monitoring the costs of addiction and the impact of addiction on communities and public health. In the case of MMT, employment and criminality are difficult states to measure with current health research tools that do not address legal frameworks and changing policing practices and employment patterns (Fischer et al., 2005). Early methadone literature suggested the treatment promised citizens who use drugs a reprieve from the overt moralizing they encountered through criminalization of drug use. This has not been shown, nor have methadone's social rehabilitation effects been definitively proven. The links between MMT and employment and improved social functioning are not well substantiated despite persistent mainstream discussions on these public health goals for methadone patients. For instance, Nosyk et al. (2013) speculatively state that “substitution treatment may be even more advantageous if potential increases in workplace productivity are realized, resulting in additional economic benefits outside of the health care sector” (p. 1464). I argue that workplace productivity can be a non-issue for women methadone clients depending on their social circumstances and other factors such as age and geographical location. Furthermore, economic considerations are narrow responses and draw attention away from the social disadvantages that many clients experience.

Overall, neoliberal governance led to changes in MMT governance, replacing vague humanistic goals with intent to control high-risk drug using populations at a time when increasing numbers of citizens were turning to MMT due to relaxed regulations and growing opiate supply.<sup>16</sup> The default response to illicit opioid drug use until the late 1990s was largely punitive due to the government's favouring of criminological views of addiction and rejection of recommendations which would have improved clients' access to treatment and lives overall. From its marginal position in the Canadian addiction treatment field until the 1990s, MMT more recently symbolizes best practices harm reduction programming, which, in effect, stands for medicalizing and managing risks surrounding opioid use and reducing crime and public costs (Fischer et al., 2005; Quirion, 2003). While risk assessments within clinical practices (i.e., case management) have a long history (Bull, 2008), these were accentuated in British Columbia in the last years of the 20<sup>th</sup> century when provincial authorities began to construct people who use illicit drugs as risks to public health and as potential addiction health patients. Furthermore, health risk research tends to emphasize the short term and is not equipped to consider the myriad policies and practices that contribute over time to a person's social disadvantages and drug use.

### **2.2.1. When Marginalized Women Become Visible Through Health Risk Focuses**

Little is known about women who participate in MMT in the province. Epidemiological research renders some women in MMT in BC visible, examining their lives through a health risk lens. For instance, research on marginalized women in Vancouver's Downtown Eastside examines correlations between their MMT involvement, injection drug use, and sex work (Spittal et al., 2003). Health research, which draws mainly on quantitative data and multivariate risk analysis, tends to narrowly misrepresent women's lives and struggles and lacks attention to political and structural contexts (Inhorn and Whittle, 2001). For instance, health variables such as gender and race are defined as attributes of the individual, rather than constitutive of larger institutionalizing forces such as gendered social and economic discrimination and racialization (Marshall, 2005). Medicalization of addiction disrupted some egregious aspects of criminalization of

<sup>16</sup> Both harm reduction and risk management are components of a larger global managerial model that anticipates continuous supply of illicit substances (Quirion, 2003).

addiction in the 20<sup>th</sup> century. However, drug use in the 21<sup>st</sup> century is still regarded as an individual problem and pathology, especially when associations between addiction and social class, poverty, “race,” gender, and risk of disease are drawn. Also, addiction knowledges, which are constructed through a positivist lens, search for cause and effect at the expense of understanding the complexities and social contexts of drug use. Additionally, positivist science (whether bioscientific, medical, or public health oriented), accommodates powerful ideologies and existing policies and practices and serves to maintain the status quo (Campbell, 2000; 2004). We see that these knowledge constructions typically frame the study of women’s addiction health.

Inhorn and Whittle (2001) remind us that early epidemiology attended to issues of history, politics, and other factors influencing public health whereas now, prevailing epidemiological approaches display de-contextualization in observing individual behaviours and exposure to risk factors. These authors find current mainstream epidemiological approaches in public health research problematic because, first, they contribute to policies that blame subjects for their lifestyles and choices; second, they ignore how meanings can contribute to behaviours; and third, they lack attention to political economies, both local and global. Fourth, epidemiological studies “leave unquestioned social hierarchies of gender, race, and nation by ignoring how these relationships mediate an individual’s power, personal agency, and available choices relating to their health” (Inhorn & Whittle, 2001, p. 554). In a discussion about HIV seroincidence and syringe exchange policies and practices in Vancouver, BC in the mid-1990s, Ciccarone and Bourgois argue that

behavioral epidemiology, especially during epidemics of stigmatized illnesses, needs to become a more “social” epidemiology, incorporating expansive understandings of the differences between risk and risk taking and between structural forces and logistical administrative rules. A structural risk environment approach (Bourgois & Hart, 2011; Burris et al., 2004; Rhodes, 2009) allows for improved contextual understandings of the social, cultural, historical, economic and political risks imposed on persons in a “risk group.” It also permits attention to administrative logistics and infrastructure (needle exchange quotas, abandoned alleys, decrepit SROs, gentrifying cities, drug purity and price, etc.). Vulnerable

individuals in this group may or may not express additional risk behaviors that compound that structurally-imposed risk. (2016, p. 41)

Overall, mainstream understandings of women's drug use which emphasizes risk, social behaviours, and women's reproduction obscure how social and gender inequalities, identities, and women's complex social and cultural locations are highly relevant issues (Boyd, 1999, 2008; Friedman & Alicea, 2001). Raimondo (2007), who studies women's health concerns related to the HIV/AIDS crisis, argues that women's social and political realities have been actively "written out" of research and policy while their behaviours are increasingly scrutinized and rendered more visible and problematic for society than men's behaviours. A public health emphasis on individual women's behaviour promotes a dichotomous "invisibility/hyper-visibility" paradigm of women's health that obscures the gendered politics of health, women's multiple locations, and "differences within broad categories" (Raimondo, 2007, p. 391).

Rather than calling into question what MMT means for women, positivist research further highlights correlations between MMT status, aging, experiences of stigma and depression, and poor health and treatment outcomes, and proposes increased pharmaceutical and psychosocial therapy for older and menopausal clients (Connor & Rosen, 2008; Tuchman, 2007, 2010). Neo-positivist studies accommodate existing policies and reveal little about women's embodied experience of addiction policies and discourses (Campbell & Ettore, 2010; Ettore, 2004). Women's experiences of MMT in BC and their social situations are too diverse and complex to fit into public health or psychosocial frames. Dominant knowledges about women and drugs support existing systems of health care but should be responding to women's foremost concerns (Ettore, 2004; VANDU Women CARE Team, 2009).

### **2.3. The Concept of Addiction**

Addiction suggests habituation (Coomber et al., 2013) and is a highly-contested concept often reflecting reductionist thinking about the regular consumption of a substance or experience (Reinarman & Granfield, 2015). Literature defining addiction as a brain disease, disorder, an irrational compulsion, dependency, or craving constructs clients for

cellular, clinical, or therapeutic intervention (O'Malley & Valverde, 2004; Reinarman & Granfield, 2015). While the sciences have long dominated understandings of drugs and associated problems, addiction itself is a relatively recent social construction (Campbell, 2007; Fraser & Moore, 2011; Fraser & valentine, 2008; Reinarman & Granfield, 2015). As Fraser and Moore explain,

the constructionist position argues that what makes a given condition a problem is the process of “collective definition” of that condition as a “problem,” in other words, the level of concern within society about a condition or issue. In this approach, social problems do not exist objectively, as is assumed by the objectivist position but are constructed by discourse, practice and politics. (2011, p. 2)

The problem of addiction did not exist before its discovery, and the history of the concept shows active reconstruction of its meaning. Addiction emerged in the 17<sup>th</sup> century as an explanation for intoxicated deviant behaviour, over time was linked to “disease of the will,” and by the early 20<sup>th</sup> century, the “addiction as disease” concept was increasingly used to explain criminalized opiate use (Boyd, 2014; Reinarman & Granfield, 2015). The World Health Organization (WHO) and others further developed definitions of addiction to account for the changing use of illicit drugs, which moved from “drug habituation” to “drug dependence” and so on, to the current psychiatric term of “substance use disorder.” Thus, addiction definitions have become less precise over time, revealing “addiction” to be an elastic term used to explain a range of everyday behaviours, such as shopping, gambling, and social media addictions (Reinarman & Granfield, 2015). Discussing the American Psychiatric Association’s contributing definition of “drug abuse” in 1972, Reinarman and Granfield find that

most of these terms are normative, not scientific, and the definition itself rests on a troubling circularity: When lawmakers write drug laws they justify them in terms of medical expertise on drug abuse, but here the medical scientists defined drug abuse in terms of the law . . . the fundamental concepts and categories that many assume to be clear, objective, and universal indicators of addiction are in fact fuzzy, fluid social constructions that reflect the beliefs of a particular group of experts at a particular time and place. (2015, p. 5)

Fraser and Moore (2011) further state that “addiction and modern society have made each other, and they continue to rely upon each other for meaning” (p. 7). Definitions of addiction have significant power to shape the lives of people who use drugs. How society defines addiction affects how clients are categorized and regarded, and how laws and policies develop or withhold treatment and justify controls (Reinarman & Granfield, 2015; Fraser & Moore, 2011).

## **2.4. Conclusion**

A brief history of methadone treatment development in this chapter explored how scientific experimentation with analgesic substances and narcotic substitutions paved new avenues for clinical discoveries. Methadone maintenance research built on emerging addiction knowledges, applying a medical paradigm to the social problem of criminalized narcotic drug use. By challenging abstinence discourse, concentrating their attention on drug use behaviour, and drawing productively on social rehabilitation language, researchers laid claim to a “common sense” approach to narcotic addiction. According to Paulus and Halliday (1967) and Dole and Nyswander (1965, 1967, 1980), among others, impoverished “narcotic drug users” were outsiders who had strayed from normative gendered roles such as the male employee or the woman homemaker. Also, within the ethos of discovery found in the methadone story (Campbell, 2007), we find new assertions about the value of scientific expertise and the utility of proper medical oversight in controlling the “outsider, criminal street addict.” Critical re-interpretations of the origins of methadone maintenance and the role of pioneers reveal the various historical contingencies and structural forces related to developments, rendering context more visible (Boyd, 2014; Bull, 2008; Campbell, 2007; Fischer, 1999, 2000; Quirion, 2003). In Canada, policy support for the treatment fluctuated, which limited the expansion of public clinics and the number of physician providers and restricted access for many who had sought out the treatment before the mid-1990s.

MMT expanded in the 1990s when provincial authorities in BC gained control of the system and positioned the treatment as a harm reduction program. Harm reduction has gained status in inner city communities and among health professionals in the

province in recent years. It is comprised of various programs designed to treat multiple, shifting public health problems, with methadone maintenance treatment being one approach that targets opioid dependence. Contemporary addiction policies construct new expectations of people who use drugs, who are expected to self-manage, to be prudent, and to continually re-constitute their risk manager identity. At the same time, public health knowledge expands to increasingly monitor drug use populations to identify the “public at risk” (Bunton, 2001, p. 227). However, mainstream knowledge of women’s experiences of MMT remains narrow at the expense of understanding the broader sociopolitical contexts of treatment involvement. Overall, dominant Western knowledge and treatment of addicted women have become increasingly biomedically oriented. Dominant health knowledge of drug use intensifies the pathological gaze at marginalized women’s bodies and behaviour and obscures their identities and complex locations in society. Social constructionist understandings of addiction reveal how medical knowledge helps to construct the use of opioids as a social problem. Moreover, “addiction” definitions have everyday effects, shaping client categorization and experiences, treatment policies, and laws (Reinarman & Granfield, 2015; Fraser & Moore, 2011). It is significant that the current disease paradigm, as the dominant approach to addictions, exists in tandem with ongoing regulation of illicit drug use, rather than replaces it.

In the next chapter, I situate my study in the sociocultural literature on MMT and social control, health and MMT client identities, and in the literature on narrated embodiment. I then explore, in turn, the themes of addiction trajectories, clientization, the politics of care, and social exclusion, which hold potential for informing a theory of supervised exclusion.

## **Chapter 3.**

### **The Multiple Dimensions of MMT and “Supervised Exclusion”**

This chapter discusses a range of studies that provide insight into the multiple dimensions of MMT. First, it examines research that considers MMT as a form of social control or governance perpetuating “othering” in society. Second, the chapter addresses poststructural literature that explores the fluidity of MMT identities and how they may be navigated and resisted. Third, it considers research about power/knowledge and the body, and using literature on biopolitics and illness narratives, examines the relevance of narrated embodiment in MMT experience. The second part of this chapter discusses four concepts—addiction trajectories, clientization, politics of care, and social exclusion. These concepts help to develop the term “supervised exclusion,” used in this analysis.

#### **3.1. Social Control and Governance**

A strand of sociocultural literature views MMT as social control of marginalized persons chronically using substances and examines how it disciplines clients to conform to normative roles and behaviour (Boyd, 1999; Bourgois, 2000; Bourgois & Schonberg, 2009; Bergschmidt 2004; Campbell, 2004; Friedman & Alicea, 2001). In-depth anthropological and sociological studies of drug use and treatment further explore specific links between MMT and economic marginalization in the U.S., drawing on ethnographic methods (Bourgois, 2000; Bourgois & Schonberg, 2009; Fraser, 1997), and feminist and sociohistorical lenses (Campbell, 2004; Friedman & Alicea, 2001; Rosenbaum, 1981; Rosenbaum & Murphy, 1990). This critical research collectively illustrates how MMT exacerbates structural constraints in clients’ lives. Studies drawing on governmentality theory especially call attention to clinical-level practices, such as the regular testing and daily dosing regimens that disempower participants. Philippe Bourgois and Jeff Schonberg (2009) succinctly conclude that MMT in the U.S. is a “conflictive, humiliating apparatus of governmentality” aligning with neoliberal goals (p. 284). These studies richly contextualize

the MMT client experience and overall challenge the individualizing and responsabilizing medical model of treatment.

Two key ethnographies discussing women's MMT experiences in the U.S. are Marsha Rosenbaum's *Women on Heroin* (1981) and Jennifer Friedman and Marixsa Alicea's *Surviving Heroin: Interviews with Women in Methadone Clinics* (2001). Drawing on 100 women's life histories and employing liberal feminist theory and phenomenological and symbolic interactionist perspectives, Rosenbaum argues that gender inequalities, poverty, and stigma place women at risk for poor treatment outcomes:

On methadone, the few social options open to women who have been addicted are further reduced: The woman remains addicted and unable to lead a normal life; the methadone routine ties her to the drug world and the other addicts; and her health problems increase dramatically.

If it is necessary to concede that addicts cannot remain opiate-free and that they must, therefore, be maintained on a narcotic in order to reduce drug-related crime, it is necessary to use a drug that is at least no more physiologically, psychologically, and socially harmful than heroin itself. (Rosenbaum, 1981, pp. 126–127)

Rosenbaum and Murphy (1990) later identify three stages to women's experience of MMT—surrender to control, then stabilization, and then eventual disillusionment with the disciplinary clinical regime and its effects. They conclude that treatment outcomes are class dependent and the poorest of women seemed to remain on MMT for long periods. They argue for women-sensitive treatment that acknowledges employment barriers and childcare to help move women from deviant drug cultures to relative autonomy and better health.

Drawing on interviews with 37 women in 1990–1994, Friedman and Alicea (2001) also provide a detailed gender and class analysis of women heroin users in treatment but emphasize the governance aspect of this treatment, arguing that MMT subversively, rather than just coercively, disciplines women who use heroin to adopt gender norms and shapes them into socially and economically productive neoliberal subjects. This text theorizes

heroin use as defiance but finds that MMT weakens women's resistance to normative roles through the clinical gaze, "psy" knowledges, and overall promotion of self-discipline and responsabilization. Significantly, governance of marginalized women through MMT increases their stigmatization across networks and institutions and serves as another oppressive influence perpetuating women's disadvantages in neoliberal times (Friedman & Alicea, 2001).

Neoliberal discourses, "psy" knowledges, expansion of technologies, and the continued legal punishment of drug use represent a diffusion of strategies for controlling people who use drugs (Campbell, 2004; Friedman & Alicea, 2001; Moore, 2007). Late modern MMT is arguably a physically and mentally intrusive policy response to chronic drug use due to the surveillance and governance aspects of this treatment which place it among an array of coercive technologies (Campbell, 2004). For instance, biosurveillance in the U.S. is a growing industry expanding social controls across workplaces, healthcare sites, and schools. Certain technologies, such as urine or blood testing, often target racialized and marginalized groups for screening for drug use, and thus, distrust and "coercive compassion" have become structured, which especially creates a "climate of suspicion" of vulnerable groups, such as poor women and mothers (Campbell, 2004, p. 81). However, research shows that women of all social classes who participate in MMT can encounter problematic control strategies in treatment.

Boyd (1999) examines the experiences of 28 British Columbian mothers who use drugs, noting that laws along with social control policies and practices perpetuate the erroneous belief that women who use drugs are by default unfit mothers. The control approach can lead to excessive institutional surveillance of women's bodies and their caregiving practices, and frequent apprehension of their children. While poor and racialized women disproportionately experience health and legal surveillance over their drug use, all participants of Boyd's study who had encountered MMT, and who came from various class positions, found the treatment to be disempowering and would have preferred heroin maintenance had it been available to them. According to Reist, some MMT clients in the province are not well served:

The voices of clients suggest that MMT in BC is sometimes experienced as dehumanizing and less than optimal. Some of this relates to egregious practice by

particular physicians, pharmacists and other service providers, but some results from systemic stigma within current health and social service systems. (2010, p. 20)

Client narratives point out that problems with MMT can involve interpersonal and systemic aspects. Overall, studies emphasizing the disciplining and surveillance aspects of MMT, including the use of “psy” knowledges, locate it among intrusive policy responses to chronic drug use, all of which perpetuate “othering” in society. While MMT organization and regulations in Western liberal societies can differ somewhat across and within countries and have changed over time, it is significant that women experience surveillance, lack of privacy, and infantilizing, paternalistic treatment in the program (Boyd, 1999; Fraser & valentine, 2008; Friedman & Alicea, 2001; Rosenbaum & Murphy, 1990). Socially marginalized women who enter drug treatment are already marked as deviant and can face further stigmatization through their exposure to disciplining features of MMT (Boyd, 1999; Friedman & Alicea, 2001). My research explores women’s specific experiences of social control in the context of MMT participation and BC’s income assistance services.

### **3.2. Multiple Identities and Exploring the Limits of Negotiation**

Rather than centre attention on how MMT clients resist or capitulate to surveillance and control, another strand of literature draws on poststructural theories to examine how clients navigate the MMT clinic and negotiate identities that are co-constructed through treatment practices and experiences (Fraser & valentine, 2008; Järvinen, 2014; Ning, 2005; Smith, 2011). MMT identities and ideologies are multiple and unstable, and furthermore, clients strategize for better treatment by drawing on these identities but may discard them in other care settings (Ning, 2005; valentine, 2007). Experiencing MMT in Australia as either a dissatisfied customer, a stable user, an imperfect agent, or a lay carer illustrates the process of “making up people” from “below” (people’s actions) and “above” (expert discourses) which generates new identities (valentine, 2007, p. 499). Research on MMT in Denmark finds the program stabilizes clients but paradoxically increases their

vulnerability, even as clients especially resist the institutional identities they find in this treatment (Järvinen, 2014; Järvinen & Miller, 2010).

Smith (2011) finds MMT in Toronto, Canada to be a segregating co-construction of stigmatized identities, bodies, and urban space. Ning (2005) argues that MMT in the same city is a site of multiple truths about addiction treatment and recovery<sup>17</sup> whereby individuals adapt to, resist, or comply with institutionalized practices. Clients utilize “mainstream, institutional, and subculture discourses” in response to the contradictory promotion of abstinence at this site (Ning, 2005, p. 374). Thus, staff and client narratives reveal both complicity and resistance to therapeutic management and biomedical discourses. Ning and Smith’s research explores MMT in the context of Ontario, Canada, and both reveal the presence of multiple ideologies, alternate meanings of recovery, multiple identities, and often contradictory instances of client resistance at the site of MMT, finding fluid negotiation of identity and more client agency than social control or governance studies have shown. Ning (2005) argues that dominant ideologies are less relevant than previous literature suggests and categories that influence client identity tend to shift in accordance with clinic demands and acts of resistance. Literature discussing identities illustrates that MMT clients have agency and can navigate this site of treatment in inventive ways. These studies challenge to some extent the program’s design and practices but do not provide much context for understanding variation among clients’ identities.

Fraser and valentine (2008) examine MMT in Australia and broadly conceptualize it as a social and cultural phenomenon and a co-construction of pharmaceutical substance, human and non-human actors, policies, social practices, experiences, and discourses. In arguing that methadone is both substance and substitution, the authors locate this research in science and technology studies and feminist science studies. The research draws on 87 semi-structured interviews with 50 MMT clients, 8 policymakers, and 29 health care workers (doctors, nurses, and pharmacists), and also on news media analysis. They posit that MMT involvement is less an example of capitulation to forces

<sup>17</sup> Recovery is a process by which an individual finds a solution to a problem or returns to a positive physical or mental state. Knowledges favouring the disease model of addiction understand recovery as transformative for the individual (Coomber et al., 2013).

than signalling new ways in which dependence in society is discursively and materially produced, as well as governed through risk management. MMT also illustrates increasing regulation of those unable to become responsabilized and autonomous. Many, although not all, MMT clients display a dependence on both drugs and income assistance, and thus the dismantling of social welfare policies in recent years is relevant for representation of MMT clients and regulation of their lives through MMT. Broadly speaking, dismantling and privatizing social welfare supports has negatively impacted service quality and clients' (and service providers') lives.

Control, again, plays a significant role in MMT organization, just as the usual stereotyping of clients as “errant children” and the notion of liquid handcuffs illustrate some of the ways in which clients are perceived or how they can perceive themselves (Fraser & valentine, 2008; Järvinen, 2014; Smith, 2011; Vigilant, 2005). Like Friedman and Alicea (2001), Fraser and valentine (2008) provide breadth and depth in their study of the MMT experience in the Australian context, especially gendered aspects of identity. They argue that substitution therapy “feminizes” clients and treatment providers regard women clients as doubly inferior. Indeed, methadone has become a society-wide metaphor for “inauthenticity, disorder and the feminine” (Fraser, 2006, p. 669). Regular methadone dosing, like compulsive drug use, signifies repetition and passivity, thereby “feminizing” clients. Both men and women are conceptualized as lacking agency in this treatment, and yet women in MMT are also conceptualized as “the target of abuse and disadvantage, rather than as agents . . . female clients can be said to be doubly subjected through treatment, both to partners and to service providers, and this impacts on treatment delivery” (Fraser & valentine, 2008, p. 161). Increasing permission for takeaways would not significantly improve the low status of the treatment (connoting as it does inauthenticity) or combat ubiquitous notions of powerlessness surrounding chronicity or repetition that particularly stigmatize women (Fraser, 2006; Fraser & valentine, 2008).

Thus far, this chapter considered how women's experiences of drug use and treatment differ from men's in ways that concern power/knowledge, embodiment, and identities (Boyd, 1999; Campbell & Ettore, 2010; Ettore, 2004; Fraser & valentine, 2008; Friedman & Alicea, 2001; Garcia, 2008; Rosenbaum & Murphy, 1990). Poststructural studies reveal how classification and experts' risk-managing knowledges and practices can shape diverse everyday experiences of this treatment. Notably, clients can draw on

identities to resist harmful drug and recovery discourses. Literature reveals that identities at this site are fluid, gendered through repetition, and can be navigated and resisted. As I discuss in Chapters 6 and 7, MMT-related identities also involve socioeconomic contexts and link to experiences of clientization across sites.

### **3.3. The Subjects and Bodies of Medicine**

Althusser (1971) first sowed the seeds of theoretical exploration of identity and social positions in arguing that social beings are embodied agents of ideology. The sociocultural conditions and political concerns that once spurred him to question how institutions live through the body and *vice versa* have since shifted. In the context of neoliberalism and our increasingly pharmaceuticalized society, questions endure regarding the role of institutions in shaping the subjectivities and meanings of women's everyday embodied experience of drug use and treatment.

In discussing the parameters of the "biopolitics of life itself," Rose (2007) argues that emerging examination of life at the level of the cell or molecule has not yet replaced the medical gaze of the molar body with its attendant pathologies (p. 10). He further notes, "there are [health] strategies for the management of high risk groups. And, increasingly, there are strategies based on identification of, and preventive intervention for risky individuals" (Rose, 2007, p. 70). For example, classification underpins expert knowledge about people who use drugs (Järvinen, 2014; Campbell, 2007; Rose, 2007; Fraser & valentine, 2008; valentine, 2007). Citizens who struggle with addiction and possess a visible and highly problematized body have become targets for classification and other activities aimed at knowing and normalizing health states (Rose, 2007). Indeed, Foucault (1978) had earlier identified that classification of bodies was a particularly successful technique for modernity projects aimed at normalizing the life of populations. While Western citizens face the possibility of being increasingly known as biomedical subjects (Rose, 2007), poststructural analyses of MMT consider the role of classification in limiting treatment development (Fraser & valentine, 2008; Ning, 2005). Informed by Rose (2007), Järvinen (2014), and Fraser and valentine (2008), I explore in Chapter 7, categorical identities which emerge from risk management approaches in MMT in BC and how these compete with narrated experience of the body.

A strand of research in medical anthropology argues that stories of chronic illness reveal how meanings are enabled or restricted relative to the structures and discourses surrounding specific health care experiences (Saris, 1995; Steffen, 1997). Constructions of chronic illness highlight that narratives and interpretations are often thought of as microcontextual but nevertheless are related to larger social influences. While Steffen (1997) examines meanings surrounding addiction ideology, Saris (1995) utilizes a life history to show how institutions influence experiences, narratives, and interpretations. Here, the label of schizophrenia emerges through both institutional framing and medical interpretation. Saris (1995) argues that life histories often lack attention to structuring influences, such as technologies, discourse production, and “as importantly, erasures and silences” (42). His analysis of the individual’s history finds that the institutional defining of a medical condition can be resisted to some extent using embodied knowledge. In this case, the life history narrator both railed against and incorporated into his identity the label of chronic schizophrenic. At the time, Ireland was facing a significant rise in heroin use (in the 1980s and early 1990s), and the narrator’s extremely marginalized position made it difficult to transcend his representation and resist treatment.

In the context of drug use, literature drawing on feminist theories discusses to various degrees the dismissal of women’s embodied knowledge at the site of treatment (Campbell & Ettore, 2010; Ettore, 2004; Fraser & valentine, 2008; Friedman & Alicea, 2001). Ettore (2004) argues that the “classical” disease model of addiction represents drug use as embodied and deviant, requiring control and containment of users. Like Ning (2005), Ettore argues that a one size fits all drug treatment model is problematic as it lacks attention to drugs users’ perspectives and social differences, such as gender, class, ethnicity and ability.

Drawing on Saris (1995) and Garcia (2008), my research explores how institutionalized identities can be powerful frames in one’s life, especially when they relate to chronicity and clienthood. Further drawing on Ettore (2004) and Järvinen (2014), my study explores through narrative construction, the study participants’ use of their embodied knowledge.

### **3.4. Constructing the Theoretical Frame of Supervised Exclusion**

In this study, to demarcate the parameters of supervised exclusion, I draw on the notions of addiction trajectories, clientization, the politics of care, and social exclusion. The term “addiction trajectories” relates to paths to and through treatment and further concerns how addiction knowledges, therapeutic practices, and treatment experiences come together in fluid ways. This lens is useful for exploring the contingencies of drug use and treatment experiences, and the longitudinal aspect of drug use narratives. Clientization is another conceptual lens for exploring client experiences and social problem constructions from the ground up, across multiple sites. Next, the politics of care is a framework for exploring negotiated and contested meanings of the body and dependency found in a range of sites related to the marginalized drug user. Lastly, social exclusion is a broad concept useful for keeping the issue of multi-dimensional, intense disadvantages front and centre in this study.

#### **3.4.1. Addiction Trajectories**

The term “addiction trajectories” has multiple meanings. It can refer to drug use and treatment experiences during the life course (Hser, Longshore, & Anglin., 2007). In another specific use, Prins (2008) utilized the term in the 1990s to explore what drug biographies revealed about social suffering over time. He theorized social suffering to mean that people who used drugs can experience psychological pain arising from lack of social attachment. Prins sought to test Winick’s (1962) thesis that persons typically mature out of hard drug use, and his findings revealed a mixed picture. While Prins’ work incorporated psychological perspectives, his research informs my attention to longitudinal and biographical evidence of drug use and suffering, at least in the broader sense of structural and political disadvantages. Similarly, Garcia (2008) explores the local experience of drug use in northern New Mexico, the associated appropriation of territory and culture through institutional violence, and the logic of chronicity that shapes the subjective experience of treatment. Residents’ affective experiences of struggling with loss is at once “intergenerational and intersubjective,” and has produced over time a community of “melancholic” subjects (Garcia, 2008, p. 726).

Taking up the specific notion of addiction trajectories, Raikhel and Garriott's (2013) edited collection of essays locates the notion within anthropological study of the commodification and cultural shaping of substance use, and in the sociopolitical relationship between substances and global and local markets. These authors recognize the recent shifting meanings of "addiction," defined here as an "object of knowledge, intervention, identification, and contention" (Raikhel & Garriott, 2013, p. 6). For example, addiction is currently more likely to be identified as a problem addressed by pharmacological treatments, such as buprenorphine. At the same time, biomedical understandings of addiction have not displaced the harm reduction technologies or the self-help therapies, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), which co-exist as treatment modalities. Furthermore, both the medical model and disease model of addiction are subsumed under a highly capitalistic organization of licit and illicit drugs and dismantling of social supports in general. Raikhel and Garriott suggest that addiction studies echo many issues in the contemporary world, such as "consumption and production, sickness and health, . . . belonging and alienation" (p. 7). The authors further distinguish aspects of trajectories, calling attention to the following:

The *epistemic trajectories* traced by categories and concepts of addiction as they change over time and move across institutional domains; (2) the *therapeutic trajectories* of treatments as they move through distinct cultural and organizational settings; and (3) the *experiential and experimental trajectories* of lives constituted through the terrains of addiction and subjectivity. (2013, p. 2, emphasis in original)

These three focuses—institutional knowledges, therapeutic treatment, and experiential phenomena—broaden the view of present day provision and experience of addiction treatment. Furthermore, by perceiving trajectories as multiple and located in the domains, settings, and terrains of social relations, I perceive that "addiction is sociologically contingent and indeterminate" rather than a linear or causal pathway of neurobiology (Reinarman & Granfield, 2015, p. 16). In my study, trajectories can also refer to both space and time, indicating movement of institutions, categories, and people. Furthermore, I draw on this socially situated "organizing rubric" of addiction trajectories in order to contextualize and historicize study participants' drug use and treatment experiences while exploring both broad and specific influences and contradictions (Raikhel & Garriott, 2013, p. 8). The

notion of addiction trajectories helps to theoretically situate construction of addiction and clients' treatment experiences across both "supervision" and "exclusion" aspects of MMT.

### **3.4.2. Clientization: Construction of Problems, Solutions, and Clients**

Clientization is a social process constructed through human service encounters and is part of the broader landscape of increased rationality and dependency that Western citizens now navigate (Gubrium & Järvinen, 2014). Gubrium and Järvinen specify that while troubles are part of the human condition, they can be vague, personally noticed, and when brought to the attention of professionals, the "expert gaze" constitutes troubles into observable social problems. In this sense, clarifying and problematizing are intertwined activities, involving the "expert gaze" in a loosely step-wise process. At the same time, "troubles are subject to the challenges of old, new, and dissenting problem categories and related social policies" (Gubrium & Järvinen, 2014, p. 3). Of course, expertise is an expanding concept and phenomenon, and using social movements as an example, Gubrium and Järvinen conclude that "whether troubles center on the body, behavior, mind, relationships, or groups, the mission is two-pronged: to establish the taken-for-grantedness of a problem in what is otherwise vaguely understood, and to marshal proof for making that evident" (p. 3–4). Classification and texts such as the *Diagnostic and Statistical Manual of Mental Disorders* can play a central role in the clientization process, as can social policies (Järvinen, 2014). Neoliberalism has changed the style of service provision (and with some egregious effects) for the most vulnerable members of society, and still the process of clientization ensues. While clientization refers to the relational, "on the ground," front-line service process, there are also broader issues to consider, such as local cultural and policy trends that inform clinical and therapeutic practices and can shape clients' program experiences at sites.

Clientization suggests practices that are multi-directional and happen (or do not happen) because of a range of influences, such as discourses, contexts, negotiations, and resistances. The term further allows for interpreting client experience as navigation, and for representing clients as having more agency and more complex identities than mainstream understandings acknowledge. My research draws on a fluid conceptualizing of clientization as it explores women's MMT involvement and experience of other services,

including health services in BC, some of which can be overtly coercive or governing. Clientization likewise implies the need to understand the influence of applied expert knowledges in women's MMT experiences, and how women can negotiate and resist expert practices. Clients' documented and narrated struggles for autonomy and improved life chances can hinge on complex or intertwined late modern understandings of the body and care, involve policy and human service interventions, and include clients' contestations of expert knowledge.

### **3.4.3. The Politics of Care**

Conceptualizing care as a public issue and a "primary building block for social life," Fine (2007, p. 173) also points to its contested meanings and multiple forms. By politics of care, I mean the processes and practices of providing and receiving care and their political dimensions (Fine, 2005, 2007). Fine outlines the history of the concept, discussing how it developed out of specialization of occupations (medicine, nursing, social work, etc.) in the 19<sup>th</sup> and 20<sup>th</sup> centuries, and through accelerating bureaucratization and industrialization of human service provision. Construction of a postwar welfare state and feminism's influence in raising women's status and increasing their formal employment were also significant developments in the politics of care in contemporary society. More recently, neoliberal restructuring of the welfare state and a care deficit broadly influence availability of formal and informal care. The care deficit refers to the increased demand for care among populations at the same time as families are shrinking in size and less able to provide informal care, facing as they are new risks in an increasingly service-based economy. Promotion of individual responsibility underpins stark reductions of government funding for care (Fine, 2007) and growing poverty increases financial and labour burdens on the most marginalized citizens' families and networks (Offer, 2012). Furthermore, while critical debates about care in the 20<sup>th</sup> century have primarily troubled the respective roles of man as breadwinner and woman as unpaid caregiver, care is now increasingly marketized while gendering of care continues in ever more complex ways.

If ideas about care are shifting and contested, they also include considerations about how to move toward a more caring society, given dominant individualizing and responsabilizing ideologies, the dismantling of the welfare state, increased marketization

of care, and risk-management policies and practices (Fine, 2007). By incorporating the body as a materiality that cannot be ignored in social constructions of care (Fraser & valentine, 2008), Fine accentuates the fact that care infers attention to physical, social, and political vulnerabilities. Care, while it involves the physical and social, cannot be reduced to sociobiological determinism, but is “a social response to bodily need” and “dependency” (Fine, 2007, p. 194). As well, informal care emphasizes the issue of reciprocity. Once considered to involve an economy of obligations and interdependencies, reciprocity is now a “force of fragmentation,” burdening the poorest among citizens who have inadequate resources (Offer, 2012, p. 790).

The role of families is relevant to this study of women in MMT, as is Fine’s reference to “domesticity” in debates about individualization of care. During times of heavy drug use, informal network scenarios can be absent, insufficient, or problematic in everyday lives. For example, at times when individuals are imprisoned or experiencing homelessness, informal care from or for others may be limited or absent and can animate medical understandings of care. Furthermore, at times when drug treatment services, prisons, and/or denigrated public spaces become the principal domains of an individual’s everyday life, such circumstances tend to render severe social exclusion visible and signify a need for multiple services and innovative forms of health care (Bourgois & Schonberg, 2009; Elliott, 2007; Roe, 2010). As I argue in Chapter 2, harm reduction policies and programming have additionally made the politics of care more visible, and it is useful to consider women’s experiences in this light.

Miller in Australia (2001, p. 175) describes harm minimization theories as “idealistic” and “passive,” as they rarely impact policy. He finds the discourse advances the medical model, epitomizes and activates dominant economic rationalist arguments, and obscures the structural inequalities leading to drug use. Alternately, Keane (2003) finds harm reduction provides a necessary respite from moralizing drug paradigms. Furthermore, “there is the danger of a kind of political romanticism in which the everyday, practical achievements of programs, such as needle exchanges, are minimized by being measured against a goal of perfect freedom,” when what is required are “concrete practices of liberty” (Keane, 2003, p. 229). Furthermore, Roe (2005) argues that the increased medicalizing and professionalizing of harm reduction cannot address the social marginalization which people who use drugs often experience. In tracing shifts of

governance around harm reduction in Vancouver, Roe finds it an increasingly top-down organization of treatment, which establishes new scientific notions of what is harmful and not harmful in society without confronting how systems feed into the need for treatment. These and other critical perspectives on harm reduction display tensions between viewing the harm reduction paradigm as a collection of short-term approaches or as a possible facilitator of social rehabilitation over the long term. Efforts to critically examine the possibly devalued position of the harm reduction client in this supervised milieu of services continue while Moore and Fraser (2006) posit there is no “pure location from which to construct the “ideal” subject of harm reduction” (p. 3045). I would also add that there is little knowledge of what harm reduction means to women when they are at different stages of treatment involvement (i.e., early to prolonged participation).

My study concerns care that ranges in public visibility, and drawing on Fine and Offer, I explore the politics of care that women in BC’s MMT system encounter, similarly questioning the blurred individual and social dimensions, but nevertheless tracking the process across both formal and informal activities, from pragmatic harm reduction to encounters with medical treatment to care from and for family members and friends. The politics of care is a central theme for women in MMT who draw on multiple services or at least at times have need of them.

#### **3.4.4. Locating Intense Social Exclusion**

The term “social exclusion” originated in France in the 1970s, expanding in meaning in the 1980s to become a concept for explaining growing poverty and social dislocation among citizens (Byrne, 2008). Political change has led to diverse meanings but the tendency to narrowly define social exclusion as economic deprivation and lack of labour market participation has obscured the multiple drivers and levels of this experience (Neale, 2006; Levitas et al., 2007). A complex range of circumstances contributes to experiences of social exclusion; social exclusion through disability, poverty, sexual orientation, racialization, or health status (alone or in combination) are various ways that individuals experience social disconnectedness (Taket, Foster, & Cook, 2009). Although social exclusion and drug dependency do not always co-exist (Vitellone, 2004), when concomitantly experienced in some advanced liberal societies, these circumstances can

become more visible to policymakers. Examples of broad institutionalized responses to deep exclusion or multiple disadvantages include last resort methadone maintenance treatment in Denmark (Järvinen & Miller, 2010; Järvinen, 2014) and U.K. initiatives targeting multiple exclusion homelessness (MEH) (Fitzpatrick, Bramley, & Johnsen, 2013).

Levitas et al. developed a working definition of the concept that further recognizes the increased relevance of deep exclusion:

Social exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole. *Deep exclusion refers to exclusion across more than one domain or dimension of disadvantage, resulting in severe negative consequences for quality of life, well-being and future life chances.* (2007, p. 9, emphasis added)

Deep exclusion in this regard connotes severe social, economic, and political disadvantage and reference to “more than one domain or dimension” indicates multiplicity. This notion of multiplicity is found in earlier efforts to explain intense social disadvantage. valentine (2016) discusses how social policy literature took up two tropes within the last 50 years to explain the experience of being multiply disadvantaged, whereby identification of some groups’ “complex needs” and “wicked problems” spurred interdisciplinary efforts over several decades to develop definitions and measurements that aimed to inform policy. Finding multiplicity in this respect involved classifying particular groups, thus constructing “multi-problem families” and increasingly, “people with complex needs.”

Locating citizens’ multiple disadvantages has also been a case of “making up” people, which has had deleterious political effects for some of them (Järvinen, 2014; valentine, 2016). As Järvinen (2014) argues, classification has become a key tool in constructing human service clients in the addiction treatment field. In Denmark, this involves streaming persons over the age of 30 who chronically use drugs into long-term substitution therapy which clients then resist as it signifies severe dependence (Järvinen,

2014). Recent public censuring of multi-problem families in the U.K. is another instance of problems with classification (valentine, 2016). There is potential for policy to respond to complex social problems, but with classification there is also a “risk that we project the complexity of our systems of knowledge onto the lives of disadvantaged people, and attribute our failure to provide good support to the complexity of their needs” (valentine, 2016, p. 247). Yet as my research shows, the inverse state of being invisible to policymakers poses the risk that inadequate and inequitable policies remain unchallenged. Acknowledging connections between severe disadvantage and substance use can counter moralizing, call attention to addiction politics, and account for differences in drug use domains (Fraser & valentine, 2008).

The various terms discussed in this chapter—deep exclusions, multiple disadvantages, complex needs, advanced marginality—reflect evidence of intensifying experiences and shifting contexts of social disadvantage, and signal recent policy targeting of particular groups, including groups experiencing visible marginalization relating to drug use. Also, positivist representations of marginalized people who use drugs tend to reconstitute these citizens as “Others,” positioning them outside the social (Singer & Page, 2014) and given ongoing gender inequalities, more critique of the “cultural conditions and political and social effects of this othering” is needed (Vittelone, 2004, p. 130).

Wacquant (2008) argues that the post-Fordist phenomenon of advanced marginality is expanding in Western countries, even as our collective wealth is increasing. In Canada, the notion of multiple disadvantages is mainly absent in policy language, although preliminary descriptions refer to intersecting exclusions. While some provincial legislators and policymakers in Canada have developed a few integrated policies to address poverty and social exclusion, the province of British Columbia has not, and the federal government still resists developing a comprehensive action plan to ameliorate these especially visible social problems (MacKinnon, 2008). Two Senate reports, *In from the Margins: A Call to Action on Poverty, Housing and Homelessness* (2009), and *In from the Margins, Part II: Reducing Barriers to Social Inclusion and Social Cohesion* (2013), both drawing on community and advocacy consultations, discuss various economic and social aspects of exclusion (Standing Senate Committee on Social Affairs, Science and Technology, 2009). Although the two reports mention links between substance use and

economic/social disadvantages, only one of the reports' 93 recommendations directly addresses the connection, and it is in the context of mandating addiction treatment in prison systems. Federal recognition of intersections of poverty, homelessness, and other disadvantages has been a promising initial step (Rice & Prince, 2013) but it remains quite partial.

### **3.5. Conclusion**

Suzanne Fraser and kylie valentine, who have examined MMT in the broadest terms to date, posit that MMT has numerous dimensions for clients:

Modern medicine obliges citizens to be well, to be reflexive, to make active choices, to be self governing, but methadone clients are outside this frame, so other things are imposed on them, notably restriction, infantilisation and punishment. Yet things are not so simple. For MMT is also an example of biomedicine, and exerts the same power and follows the same rules as other biomedical arenas. It invokes obligations, communicative exchanges, clinical encounters and therapeutic relationships. It is a technology of care and operationalises care of the self. Clients are subject to responsabilisation and feel obligations to be well, to make choices, to conform to prescribed norms . . . arguments about repression and responsabilisation are both pertinent but neither fully capture[s] the possibilities of treatment. (2008, p. 60–61)

My research contributes to knowledge about women's MMT participation in relation to experiences of deep exclusion in BC. Considering that MMT involvement can be both a personal solution to troubles and a social problem for women (Fraser & valentine, 2008), this study concentrates on the experience of MMT involvement but also examines the contexts of MMT participants' involvement with income assistance, additional formal programming, and informal supports, and explores how it might involve intense navigation and negotiation of identities. I theorize the study participants' experiences as being a process of supervised exclusion, whereby one's repeated encounters with often regulating policies and programs intersect with efforts to move out of long-term poverty and struggles to be heard and helped on one's own terms. This study interrogates the contradictory

regulatory and care aspects of MMT that Fraser and valentine refer to, beyond the clinic that organizes the lives of its clients and toward narrated concerns that emerge from lives lived. Of course, not all women in MMT in BC are in the precarious social position of living in poverty, but there is much at stake for those who not only experience redistributive neglect but also encounter a politics of care at this site of health treatment. There is a need for research about women MMT clients which politically and socially contextualizes their client experiences and their multiple and intense marginalizations, but which also allows their voices to be included in debates about identity and chronicity. The relative absence of women in addiction knowledge signifies a lack of theoretical attention to the different types of disadvantage that men and women can embody and to the different ideological, political, and material spaces they inhabit in drug and treatment worlds (Campbell & Ettore, 2010). The next chapter discusses various strands of drug use research, and the methodological literature that informs this study and its multi-method approach, and then explains the study's methods.

## **Chapter 4.**

### **Exploring Methodological Domains**

Most studies on drug use and treatments such as methadone maintenance treatment (MMT) have utilized quantitative approaches and fall within the positivist paradigm. However, study of drug use in the 20<sup>th</sup> century indicates diverging biomedical and cultural focuses, a broadening “biomedical–social constructionist continuum,” and increased uptake of qualitative approaches (Gootenberg, 2005, p. 481). There is an especially long tradition of narrative inquiry, ethnographic research in particular, in sociocultural study of drug use in society (Page & Singer, 2010). This study presents a contextualized, nuanced qualitative exploration of women and MMT and analyzes both lay and dominant knowledges in the process. I conducted life story interviews of women in BC who were MMT clients and qualitative interviews with MMT physicians and analyzed the content of several primary MMT texts. The multi-method approach reveals three distinct approaches to producing knowledge, and the three methods of life story, interviewing, and textual analysis address aspects of the stated research problem. Specifically, the study asks: what does women’s participation in methadone maintenance treatment reveal about the politics of care surrounding their marginality?

#### **4.1. Scholars on the Street**

Early ethnographies of criminalized opiate use in the U.S. located their research subjects on urban streets, in subcultures, and in ever changing legal and local contexts. This body of work traces back in the modern period to sociology scholars such as Bingham Dai (1937) from the Chicago School and Alfred Lindesmith (1947) who introduced a social theory of addiction (Acker, 2002; Page & Singer, 2010). Anthropological and sociological studies in the 1960s and 1970s continued to explore users’ perspectives on heroin and other drugs and observed the urban addict in drug use settings (often the poorest neighbourhoods) while exploring social learning dimensions of drug use and male addicts’ agency and entrepreneurialism (Agar, 2002; Becker, 1973; Page & Singer, 2010; Preble & Casey, 1969; see also Hunt & Barker, 2001). In his review of qualitative literature on

addiction, Agar (2002, p. 254) points out the unique approaches of early U.S. drug ethnographies: “Heroin addicts who obtained their drugs from urban street markets did, in fact, cluster in groups. The term ‘street ethnography’ was invented to reflect this focus.” Most early research on criminalized drug use failed to represent addicts as part of society in other ways—that they had complex lives, even if they tried to remain close to the drug markets they used. In the 1970s and 1980s, several studies sought to represent men and women who use heroin as immersed in society, with families, wide networks, and normative aspirations and goals (Page & Singer, 2010). Continuing the ethnographic trend of methodological innovation and researcher reflexivity and within this strand of research are studies by women about women’s drug use (Morningstar & Chitwood, 1987; Rosenbaum; 1981; Rosenbaum & Murphy, 1990). By the 1990s, reception to drug ethnographies was variable depending on the political climate, and notably, studies concerning the HIV/AIDS epidemic helped bring qualitative research into vogue (Agar, 2002).

#### **4.1.1. Ethnography and Methadone**

Among the early ethnographic studies specifically discussing methadone treatment is Hanson, Beschner, Walters, & Bovellevé’s (1985) Heroin Lifestyle Study (HLS),<sup>18</sup> which drew from interviews with 124 African American men living in the “ghettos” of four large U.S. cities. The scholars sought to understand “extreme cases” of drug use involving “hardcore” heroin use patterns and non-participation in treatment (Hanson, 1985, pp. 187–188). Most of the study participants comprehended methadone treatment as a problem on several fronts—they feared the addictiveness of the substance and its side effects and perceived methadone as a crutch and an ineffective means to achieve abstinence, and therefore ill-suited to help them address their root social problems, including poverty. More recently, drawing on more than a decade of ethnographic data, Bourgois and Schonberg (2009) produced an in-depth critical analysis, a “good-enough ethnography” of the everyday lives of 20 mid-adult men and women who experienced chronic addiction and homelessness in San Francisco, California. Drawing on Bourdieu, Marx, and Foucault, the authors expand on political-economy theories to show how the

<sup>18</sup> This research was not the first to employ indigenous interviewers within their inner-city communities but used these “insiders” to also recruit and screen interview subjects.

concept of “lumpen abuse” explains subjects’ chronic addiction and homelessness, abject poverty, and experiences of structural violence and social invisibility in neoliberal times. The 1990s and 2000s in the U.S. was an era of increased criminalization of addiction as the gap between the rich and poor grew wider. In this case, addiction-related subjectivities are not shaped by collective social consciousness but are based more on bio-sociality, such as identification with an HIV status or drug preferences.

As these examples show, drug ethnographies and other qualitative studies can emphasize links between addiction and citizens’ experiences of long-term poverty and other types of severe marginality, and can illustrate the relevance of power imbalances in these processes. On the one hand, the trend in qualitative research to access addiction research subjects in programs and therapeutic environments contributes to the categorical representation of drug users primarily as clients and program dependent, rather than as citizens foremost. Also, studies conducted in North American programs and places for the poor reveal the structural barriers that reconstitute personal troubles yet suggest that the pathologized woman “addict” can only be found in some type of setting of oppression, such as treatment and/or devalued inner city neighbourhoods (Rosenbaum, 1981). This can obscure understanding of the diverse settings and experiences of drug use among all social classes in society (Campbell, 2007). On the other hand, there is arguably a need for more knowledge of the social and political disempowerment that marginalized citizens’ drug use and treatment experiences imply, even if it might require seeking out study participants in the usual environments. MMT remains a specific site of governance and there is a lack of political urgency surrounding clients’ experiences of social suffering.

While critical and ethnographic research on urban drug use has revealed diversity among people who use drugs (i.e., ethnic identity, racialized identity, regional identity), many studies tend to discuss men rather than women. Few 21<sup>st</sup>-century studies on MMT include gender analysis and address MMT in depth, with the notable exception of Friedman and Alicea (2001) and Fraser and valentine (2008), whose work I draw on in particular. My study of women’s MMT client experiences and exclusions, while not an ethnography, addresses the paucity of sociocultural knowledge regarding women’s experiences of MMT in BC and explores their associated experiences of intense marginality. Attention to multiple contexts is largely absent in the critical Canadian literature.

## **4.2. Stories on the Margins**

Life stories, life histories, autobiographies, and oral histories emphasize individuals' experiences and meanings, in time and culture. Yet what more closely defines these stories and how they should or could be used in research are widely debated issues in the social sciences (Chase, 2005). Treatment of these narrative forms depends on epistemological stance; the broad continuum of approaches to stories reflects the extent to which social researchers distil narrative data according to research perspective and objectives (Atkinson, 2002). Also, scholars increasingly argue that stories are constructed through narrative interaction and texts, and some stories drift toward the definition of fiction or performance (Bruner, 1995; Polkinghorne, 1995). These perspectives challenge to various degrees the seemingly straightforward realist representations of subjective "truths" in storied research. Thus, research that draws on stories as data cannot ignore the crisis of representation that loosely characterizes the narrative turn. Health-related narratives especially traverse a methodological minefield, given that medical and therapeutic conventions typically rely on narratives in practice (Atkinson, 1997). Atkinson notes that with the general preference for studying illness narratives and the tendency to represent patients' illness experiences as authentic and recuperated through texts, much key literature in this subject area lacks methodological rigor. Still, realist interpretations of narrative necessarily inform phenomenological literature and humanist concerns, and privilege individual meanings of experience (Atkinson, 2002; Smith & Sparkes, 2008). In turn, Bruner (1995) notes that the naturalistic treatment of life stories is echoed in the growing use of narrative in media and therapy, which reinforces individualizing discourses. These arguments might advocate for or dismiss the notion of recuperating silenced groups, and especially display tensions, but in common lack adequate attention to gender and social class differences.

### **4.2.1. Locating the Multiple Truths of Addiction Stories**

Courtwright et al. (1981) draw on oral histories of elderly men and women in methadone treatment to examine their illicit drug careers and drug supply networks in the 20th century, as part of a larger project in the New York State Division of Substance Abuse Services. The authors argue that veracity and reliability of the participants' accounts are

central issues, given expectation that 1) career addicts might not share possibly incriminating accounts of heroin and opium use and associated activities, due to their “inbred distrust of all ‘straights’ (nonaddicts) and authority figures” (p. 47); and 2) participants’ memories may be possibly compromised by long-term drug use. To gauge the truthfulness of interviewees’ accounts, these authors drew on deviance literature in the field, arguing that participants’ narratives typically reveal “truths” and precise social context, as long as anonymity is ensured. They also reason that older treatment clients’ memories may be less reliable, primarily due to long-term poly-drug use, and further argue that many subjects of narrative research, regardless of their background, likely have unreliable memories due to wide use of alcohol and tobacco in society. This study reflects early interest in developing a history of drug use experience (Agar, 2002) and the extent to which considerations about veracity and reliability have limited the production of addiction narratives is unknown. Moreover, it is relevant that Agar (2002), commenting on the historical development of drug studies in the U.S., argues for far more attention to the voices of the researched. In exploring how women in methadone maintenance treatment (MMT) concurrently experience addiction treatment and social marginalization, I examine their situated truths and analyze the complex social circumstances from which their marginalized voices emerge. A crucial concern is not absolute verification of women’s stories but the need to explicitly and expertly illustrate the context and plausibility of their sense making.

Distinct from popular recovery literature<sup>19</sup>, a strand of sociological literature draws on treatment stories to explore individuals’ alternate meanings of recovery from drug use (Granfield & Cloud, 1996; McIntosh & McKeganey 2000; Vigilant, 2005; Zajdow, 1999). While typically exploring paths to abstinence, this literature represents people who experience addiction and who move in and out of recovery as actively reflecting on their sense of self and identities in relation to treatment organization and needs, revealing such aspects of the process as class positions, social capital, and social structures. While the

<sup>19</sup> Psychosocial or popular literature extols the pragmatic, structured use of stories to formally lead individuals toward recovery from addiction. Recovery in this sense refers to developing self-actualizing goals and abstinence narratives, as heavily promoted in AA and 12 step programs (Granfield and Cloud, 2015, Woodhouse, 1992). Zajdow (1999) argues that “12 step groups (with all their problems) give many disempowered individuals the possibility of meaningful community contact” (p. 76).

aim to recuperate “silenced” voices lacks adequate inspection in the literature (Atkinson, 1997), it is of significant concern that women’s lay knowledges remain silenced through addiction treatment processes, structures, and discourses (Fraser & valentine, 2008; Zajdow, 1999, 2005). This study facilitates the feminist aim of representing women as actors rather than passive subjects by highlighting their experiential knowledge and resistance to gendered inequalities in treatment.

### ***Stories of difference***

Life stories are at once socially constructed and constitutive (Dossa, 1994; Essers, 2009; Saris, 1995; Steffen, 1997). Production of life stories of difference also suggest that the issue of power is an inherent component of production and analysis of narrative, whether unconsciously enacted in the production of text, consciously acknowledged in the relationship between the researcher and the researched, or harnessed through narratives to effect change. Given the turn toward problematizing narrative, there is increased demand for life story researchers to become more conscious of their part and intent in the production of texts, and cognizant of their role in negotiations of truth and identity in this process (Blackman, 1991; Dossa, 1994; Essers, 2009; Hurd Clarke, 2003; Saris, 1995). The following discussion considers studies which address how social interaction, trust, power differentials and reflexivity are key considerations about the research relationship.

Hurd Clarke utilized the life stories of 22 Caucasian women aged 61 to 92 to elicit their perspectives on ageing and appearance, a gender-sensitive topic. She argues that social interaction is a major component and strength of life history interviewing. This text outlines the methodological challenges of life story research which include knowing how much researchers should share and self-disclose, recognizing features and the impact of impression management during access and interviews, and determining the limits of reciprocity. In this study, the author maintained a productive insider / outsider status due to her younger age. At the same time, the author considers how her role in this intergenerational researcher / participant relationship was often uncomfortable. Multiple interviews with each participant arguably helped to build participants’ trust in the researcher and research, and facilitated an in-depth exploration of issues surrounding ageing, body, and identity. Life histories allow for a non-objectifying means to explore the complexities of women’s embodied identities and Hurd Clarke found the method of life

history interviews illuminated the issues of context and the negotiation of meanings and identities over time. The author posits that self-disclosure of her own feelings on the topic facilitated an insider status due to the perceived commonalities of experiences. Women's perceptions and experiences surrounding ageing and appearance may differ, but the woman researcher and women participants in the study share a common exposure to cultural scripts of age and beauty that cross generations. On that basis, initial rapport was likely established. Hurd Clarke approached the study without a particular theory and conceptual frame at hand. At the same time, the gendered nature of the study required particular attention to feminist principles and knowledge, even if these were not explicitly identified in the research design. In all, this author makes a cogent argument that "other" differences (in this case, age and class) between women researchers and women participants in gender research pose methodological and analytic challenges that are not necessarily insurmountable.

Another concern is when researchers dominate the dialogue due to power differentials. Distinctions between impression management and reciprocity become blurred through efforts to maintain research relationships, and this appears to be a salient issue in life history research for it raises the issues of power and representation (Essers, 2009). Also, research that possibly generates an expectation of future contact and/or support may require researchers to sensitively disclose their feelings around reciprocity, rather than just reflect on this issue as an academic exercise (Bourgois & Schonberg, 2009). On the other hand, productive relationships can form through the dialogical nature of life history interviewing, which are based on mutual interests and respect. There appears to be no hard and fast rule delineating the boundaries of researcher / participant relationships and yet a framing theory helps to strategize access to and navigation of these relationships.

Discussing her research on immigrant entrepreneurship among women, Essers (2009) argues that there is a wealth of feminist literature that supports the use of life stories. Power differences and dialogical constructions shape data and in this case, the framing use of standpoint feminist theory helped Essers to empirically test how researchers might provide space for women's multiple voices. Nevertheless, the contingent nature of the relationship between researcher and the researched is ultimately controlled by study design and objectives, even as participants contribute to the process

of life story production. Literature proposing self-reflexive feminist standpoint theory accentuates researchers' accountability to respectfully acknowledge women's understandings at the time of research and gives us pause to consider how the intent to produce texts for purposes of empowerment may have unforeseen implications for women. Problems may arise when researchers and participants share few common defining experiences.

### ***Facilitating knowledge***

Life stories can facilitate textual production and distribution of cultural, regional, and local knowledge across both generations and societies; through collaborations between researchers, Indigenous people, and institutions, a "shared anthropology" facilitates multivocality and methodological reflexivity (Blackman, 1991, p. 58). Multiple interpretations serve to more practically provide a type of triangulated verification of portions of life history data. Yet life stories from the cultural anthropology field emphasize that narratives are "true" relative to cultures (Dossa, 1994), even as it remains difficult to gauge the "natural" and "artificial" boundaries of stories (Blackman, 1991). While not always addressing gender issues, Blackman's and Dossa's studies respectively identify the need for recuperating individual meanings, cultural identities, and collective concerns in order to make room for concerns about social inequalities and colonization.

Critical literature examining inequalities and diasporic oppressions perceive life stories as useful for identifying complexities and connections of situated identities, events, ideologies, and power (Dossa, 1994; Waterson & Rylko-Bauer. 2006). Drawing on critical feminist ethnographic methods, Dossa (1994) explores through life stories how fellow Ismailis individually and collectively experience societal and familial change. Self-reflection and dialogue emphasize the context as well as the content of stories. Thus, for Dossa, life stories are not just about individuals' perspectives, but concern empowering subjects, including herself, to develop a mutual understanding of marginalized experience that satisfies to some extent situated needs, in this case, a protracted longing for plural identity. Life stories exceed the traditional understanding of life history as being primarily a dialogue between research subject and anthropologist and can enable thick description, emotive content, and a richer collective record of experience than conventional life histories. Eliciting stories can be empowering for the researched if co-production avoids

hierarchical ordering of expression and context. Thus, as Dossa notes, a life story is more than a text produced to increase mainstream knowledge about worlds, but a means to build and re-build connections. The aforementioned themes and principles of narrative research on social difference—researcher reflexivity, multivocality, reciprocity, data reliability, and theorizing the implications of life stories for women inform my study.

### **4.3. Researching Women, Methadone, and the Politics of Supervised Exclusion**

*Women, Methadone, and the Politics of Supervised Exclusion* explores the lives of women who experience social struggles and constructs a response to how their troubles have come to be defined and addressed. Their life stories contribute to dialogue on the associated experiences of MMT and extreme marginality. Drawing on Zerubavel (2006, p. 66), I would term these associated experiences a significant “elephant in the room” issue. In other words, co-constitution of addiction and marginalization is not much remarked upon in mainstream literature, but is visible nonetheless. I conducted unstructured interviews with women enrolled in MMT to understand their experience of treatment in the context of their everyday lives. I conducted semi-structured interviews with MMT physicians to understand their perspectives on MMT and their women clients’ experiences. In this study, narratives comprised the bulk of data for analysis.

As this research concerns the confluence of drug use, treatment, and marginality, qualitative methods are valuable for locating knowledge of social problems from different standpoints and for exploring how cultural and political forces influence meanings and interpretations of social facts. Life stories and interviews furthermore directly contribute to dialogue on the associated experiences of MMT and extreme marginality. This study draws on critical feminist methodology with the goal of giving voice to women’s oppression and to help foster respect for women’s struggle for equality. The approach seeks to validate women’s everyday lives and their emotions (Ettorre, 2004) and while using the life story method to elicit women’s perspectives is not exclusively a feminist strategy, it helps to address the silences that surround women’s everyday troubles. Through life story methods, I explore participants’ voices and concerns in texts about their lives and represent them as active, rather than passive, participants in social constructions.

My analysis of narratives draws on Smith and Sparkes' (2008) theory of "storied resource perspectives" (p. 16). Their research approach helps participants develop personal stories that are idiosyncratic in their detail and unique to the circumstances of a particular life, but these cannot be extricated from the social. Such perspectives are an achievement by persons in relationships, employing resources held in common with other people. A person thus draws upon established and recognizable larger narrative resources to construct an identity and sense of self, but in ways that are unique to the circumstances of a particular life (Smith & Sparkes, 2008).

I also draw on Krumer-Nevo and Benjamin (2010) who discuss how a counter narrative, the voice/action narrative, can prioritize the voices and knowledges of people experiencing poverty. They explain that this approach challenges othering policies, practices, and discourses by eliciting lived perspectives and exploring participants' critical views on the structures and institutions they encounter. Their knowledge of the latter highlights the relational *and* political dimensions of living in poverty. Optimally, research participants' voices and knowledges are prioritized and a range of perspectives is presented. However, they state that there is a risk of exploiting people through this approach. Use of voices in social research must not be used superficially or simplistically, but should always be placed in social and political context and "anchored within specific discourses and within the discursive order" (Krumer-Nevo & Benjamin, 2010, p. 707). Otherwise, there is a risk that voices could be appropriated to serve individualizing and responsabilizing policies, practices, and discourses.

Of note, my research explores women's diverse experiences of MMT and other programs across time and places. The study was designed to exclude the perspectives of women who were living in Vancouver's Downtown Eastside (DTES) at the time of the study.<sup>20</sup> The approach to exclude women residents of the DTES was not meant to disregard those residents' identities or circumstances, but sought to avoid contributing to the over-research of marginalized groups in that urban neighbourhood. Furthermore, public health knowledge of women's MMT experience in BC is partial, often conflating devalued place and women's drug use and treatment experiences due to narrowing

<sup>20</sup> As discussed in Chapters 6 and 7, participants who had at times in their lives resided in the DTES were living elsewhere at the time of the interviews.

investigation to the activities in the DTES. This led to an overemphasis of place and expert knowledge at the expense of understanding women's complex overall experiences of marginality relating to health, poverty, and inequitable practices. My research to some extent resurrects and critically expands on some early concerns about social circumstances in that it explores women's lived experiences of navigating MMT and other services over time and the role of health texts and community physicians in this regard (VANDU Health Care Team, 2009). The study greatly respects the marginalized voices of women that emerge from the field and aims to build on women's situated knowledge of MMT and services in the province.

#### **4.3.1. Generating Life Stories**

This study received SFU Research Ethics Board approval in October 2010. I distributed recruitment letters to women's organizations in late 2010 and placed ads in free community newspapers in British Columbia in early 2011. Responding to the newspaper ads placed in January and February 2011, five women between the ages of 50 and 56 who were enrolled in MMT agreed to take part in the study. Beginning in February 2011, Camille, Debbie, Renee, Sarah, and Mariel (pseudonyms) began participating in multiple, sequential interviews, receiving \$50 for each individual interview.

The participants resided in three discrete geographical areas—Vancouver, Vancouver Island, and the BC Interior region. At the time of the interviews, Camille and Debbie received income assistance as persons with disabilities (PWD) and Sarah shared her husband's disability income through a family file. Renee was classified through the income assistance system as a person with persistent multiple barriers (PPMB), and Mariel was on regular income assistance and excused from job searches for medical reasons. One participant identified as Aboriginal and four as Caucasian. Camille, Debbie, and Mariel were single at the time of the interviews. Participants' reasons for participating in MMT were as diverse as their life experiences. Camille took part in 6 interviews, Debbie, Renee, and Sarah each participated in 5 interviews, and Mariel completed 3 interviews. The 24 audiotaped interviews took place in the participants' homes or at shelter locations and were between 30 minutes and 2 hours in length.

Overall, the design of this multiple sequential, collaborative study allowed for ongoing negotiation of narrative and iterative analysis (Gurstein, Pulkingham, & Vilches, 2011). The first meetings provided interviewees with detailed information about the interview plan and the optional elements of research participation. For instance, each woman was provided a journal to use if she wished and was encouraged to develop a personal project in parallel with the interviews. These first interview meetings utilized open-ended questions (see Appendix C) to broadly inquire about MMT involvement and everyday routines. Some participants spoke expansively about their lives during this first stage of the interview process while some did not share much information, preferring to question me about my life and the research. Arranged through monthly phone contact, subsequent interviews followed every 30 to 60 days in 2011 and built on previously discussed themes. The second to the sixth interviews began with my summary of our last discussion, after which participants corroborated or corrected their account, or added detail to their narrative. Thus, research activities included regular cycles of interviewing, transcribing, co-reviewing previous interview themes, and exploring additional topics raised through open-ended questions. Within a loose framework, interviews unfolded in myriad ways. At times, I set aside prepared questions to pursue or restore discussion topics, and participants sometimes asserted their right to close off questioning to alternately discuss what most concerned them at the time. Notably, each interview ended with a question I posed to participants which served as a thematic prompt for upcoming journaling or phone communication, and interviewing. For example, at the end of the first interview, I asked participants to think about their health concerns and health care experiences. At the end of the second interview, I asked them to consider how they get by financially, and following the third or fourth interview, I suggested that they might reflect again on how they sought help.

The method of life story construction is socially situated and understands memory to be a resource for meaning-making rather than fact-finding. The study participants drew on their memories in diverse ways to provide their perspectives over time, mainly through the process of responding to interview questions and participating in phone discussions. Debbie and Sarah additionally sent me emails and letters that captured their thoughts and memories about events or problems. Camille and Debbie journaled or completed artwork between interviews to augment their narratives. These supplements practically supported

participation in the interview process, providing new opportunities to re-visit earlier conversations, and helped to organize discussion themes. My fieldnotes helped me to record my observations, phone conversations, ideas generated in the field, and interview dialogue that occurred before and after audio recordings. This writing also increased opportunities to reflect as a researcher on my active role in the negotiation of meanings, and on my assumptions, expectations, and emotions. As the interviews progressed, I increasingly shared my reflections with the participants. For instance, during one interview, when Camille found it difficult to communicate, I read a fieldnote excerpt to her that contained my appreciation for her unique journal entries and this impromptu reading helped to build rapport between us.

Drawing from close readings of the interview transcripts and my fieldnotes, I developed five life story summaries. In 2012 and 2013, three of the five women reviewed their summary, two of whom provided minor edits. One participant declined to read my summary of her story, stating that she trusted my written interpretation. As I lost contact with Mariel during the interview stage, she did not have the opportunity to participate in the last review. Three participants remained in contact with me through email and phone until 2014.

### ***My project/Your project***

In our first interviews, I proposed to the five participants that they might create an individualized product of their own in addition to contributing to the dissertation, and Camille and Debbie elected to take part in that option. Camille journaled but also used the process to prepare a formal narrative for an upcoming residential school compensation hearing, which she found helpful for presenting the facts and the impact of her residential school experiences. She also hoped that it would be used as a basic script for a video she wanted to create for her children, but that second part of her project has not been pursued yet.

Debbie regularly created artwork throughout 2011, an activity which she described as cathartic, but not unusual as she sometimes identified as a long-time creator of “outsider art.” She had been actively journaling through this activity long before we met and at the time of the interviews, she purposefully created artwork that corresponded to

themes of her life story. At one point in the study, Debbie and I discussed the possibility of including a copy of one art piece in the dissertation, but it was ultimately left out because of my concern that it might identify her. In our first meeting, she discussed her reasons for wanting to complete a parallel project.

SP: It's something you can give some thought to. And you don't have to do it, but it's an option. And it's something I would help you with.

Debbie: I probably would like something as recording me. A record.

SP: Year by year?

Debbie: Of steps taken to become whole and healthy again.

SP: Okay.

Debbie: I'm still not quite finished yet. I mean, whatever.

SP: None of us are ever finished,

Debbie: But I would like to be able to, I think sometimes, be able to even join different things but my fear of running into anybody who's active and in an organization, [who] shouldn't be active in stuff, it angers me, you know, and then it takes me right back to why I don't trust it. So, but to have something for myself though, I enjoy reading some of my journals back then and I haven't kept one for years now. That may be something that could be put together there for everything I've said, and I forget, you might remember. I want something to show my progress. The leaps and bounds, everything, I think that would be cool to have a lasting record of that, to maybe give my kids when I'm eighty. . . . It's important for me to look back and see that, on days when I'm feeling like, "Ahh, this is just for nothing anymore, I'm just so down, why don't I go out and trouble will find me," I don't know, just down days, I can look back at the positive things.

Debbie hoped her participation in the study would serve as a useful record of her progress. These supplements seemed to be practical supports for Camille and Debbie during the interview process, helped us to organize discussion themes, and provided me with new opportunities to re-visit sensitive issues.

### **4.3.2. Recruiting Physicians, Sampling, and Interviewing**

Recruitment of physician interview subjects began in late 2010 with my written request to the College of Physicians and Surgeons of British Columbia (CPSBC) for names of physicians who prescribe methadone for addiction treatment purposes. The CPSBC provided me with a list of clinics employing or owned by physicians who had previously consented to have their names available for public view. Physicians listed on this publicly accessible document numbered less than 50, constituting a minority of the 226 methadone-prescribing physicians in BC with registered patients in 2010 (CPSBC, 2011). My letter-writing, phone calls and visits to clinics on the CPSBC list and not on the list continued throughout 2011 with the aim of recruiting half a dozen doctors for interviews. I would select physicians if their practice was in BC but located outside of the Downtown Eastside neighbourhood of Vancouver, and if they had at least one woman client between the ages of 50 and 60. In 2012, four physicians who met the criteria volunteered to be interviewed. I conducted an interview with Doctor 1 by phone and interviewed Doctor 2 in his private clinic. I conducted a joint interview with Doctors 3 and 4 in the community health clinic where they worked. Doctors 1, 2, and 3 are men and Doctor 4 is a woman. Each interview session lasted between 20 and 45 minutes during their working hours. Semi-structured interview questions covered the broad themes of MMT organization, clinical MMT practices, and knowledge of women clients' health and social circumstances.

Differing from life stories produced in this study, qualitative interviews with physicians reveal experts' perspectives on the thematic convergences of gender, opioid use, and marginalization. Physician interviews also provide insider knowledge of the MMT system and clinical practices. The approach emphasizes depth and complexity in explanations and perspectives, which can help expand understandings of the meanings and debates that circulate at the site of MMT provision. Interview questions about professional MMT knowledge, training, and regulatory guidance helped to fill in some gaps of knowledge about the role that physician autonomy plays in MMT regulation. As Reist (2010) notes, without CPSBC's official stance on why methadone prescribing is tightly controlled, we can only understand the issue through the statistics and the politics of the CPSBC/physician relationship. Questions in this study concern physicians' experiences of treating mid-adult women in MMT and their knowledge about women's challenges as

health subjects, elicited the lay language of the clinician and her or his reflections on practising MMT.

Analysis was an iterative and emergent process involving identifying and comparing themes at several stages of the study from the earliest interviewing and transcribing stage to close re-readings of all transcripts, through to development of initial coding maps and redevelopment of coding frameworks in 2014. I first developed descriptive codes, then increasingly created analytical codes. All interviews and fieldnotes were coded using NVIVO software. The study's interpretive approach draws on Zilber, Tuval-Mashiach, & Lieblich (2008) who argue for first "reading for context" to understand what each narrative reveals about intersubjective relations, the collective social field, and cultural meta-narratives (p. 1048). Attention to context raises the profile of local and experiential knowledge when developing addiction theories (Duff, 2007) and aids efforts to document the changing relationships between substances, citizens, and society over time (Campbell, 2007).

### **4.3.3. Content Analysis**

#### ***Sampling documentary texts***

Another component of the research was the examination of MMT documentary texts (hereafter referred to as MMT texts). The purpose of content analysis was to explore characteristics of expert knowledge that inform MMT practice in BC, especially treatment of women in the program. MMT texts in BC contain no specific mention of women in their mid or later adult years but rather mention women most often in the context of pregnancy and childbearing potential. The relative absence of reference to women past childbearing age shaped the sampling of texts because I ultimately broadened selection to get sufficient data, which led me to include texts that discuss MMT clients in general. I chose texts based on the following criteria: 1) the text's primary focus is MMT in the context of BC or Canada; 2) the text not only informs but also directs the practice of MMT in BC; and 3) the text discusses registered participants in BC in any way. Purposive sampling of expert MMT texts targeted only texts that authorize organization and practice of MMT in BC, whether in the context of medical practice guidance and oversight, professional best practices, or public health harm reduction reporting and economic analysis. This design is based on

the reasoning that MMT practices at the clinical level draw mainly on provincial guidelines. Content analysis of MMT texts is the most unobtrusive method of data collection in the study. In summary, the texts analyzed for this study are: College of Physicians and Surgeons of British Columbia (CPSBC), *Methadone Maintenance Program: Clinical Practice Guideline* (2014, 49 pages); CPSBC, *Methadone Maintenance Committee Reports* (Yearly, 2005 to 2014, 12 pages); CPSBC, 2014 Patient Assessment Form (7 pages); Health Canada, *Best Practices: Methadone Maintenance Treatment* (Ottawa: Office for Canada's Drug Strategy, Health Canada, 2002, 104 pages); Office of the Provincial Health Officer, *BC Opioid Substitution Treatment System. Performance Measures, 2012/2013* (Victoria: BC Ministry of Health, 2014, 12 pages); and 22 PowerPoint presentations by various authors for the CPSBC in 2013/2014 which were presented at the Methadone 101/Hospitalist Workshop and Methadone 201/Hospitalist Workshop (See Appendix A).

### ***Interpretive approach***

Content analysis is the non-interactive study of pre-existing texts and thus, data used in this study suggest a “built-in level of authenticity” (Reinharz, 1992 in Leavy, 2007, p. 7). The iterative study of multiple MMT-related texts explores the institutionalized norms that constitute expert knowledge and the woman MMT client. My close reading of the texts draws on an inductive, interpretive form of qualitative content analysis and a grounded theory approach, and I identified themes that drew on authors' language and perspectives (Julien, 2008; Leavy, 2007). I also draw on feminist qualitative approaches to explore how women are rendered visible or invisible through language use and to consider what textual visibility/invisibility suggests for women's experience of MMT in BC.

Content analysis of MMT texts is useful in this study for understanding the physician interview data and vice versa. The next chapter concerns MMT texts and practices and specifically examines the organization of MMT in BC and physicians' perspectives and practices in the field, in discussing the influences and discourses which construct the methadone client. Analysis was further guided by the expectation that “contemporary feminist scholars of cultural texts are likely to see meaning as mediated, and therefore to examine both the text and the processes of its production” (Reinharz, 1992, p. 145, in Leavy, 2007, p. 10).

## Chapter 5.

### Texts and Practices of MMT

This chapter thematically explores BC's MMT organization and practices, mainly drawing on texts produced by the College of Physicians and Surgeons of British Columbia (CPSBC) and the narratives of four methadone-prescribing physicians. To understand how MMT is organized and who participates in this treatment, I analyze CPSBC Methadone Maintenance Program (MMP) policy guidelines and committee reports and the College's curricula materials informing MMT physicians' clinical practices. I also explore the content of a Provincial Health Officer report and a Health Canada MMT text concerning best practices. Physicians' narratives provide further insight into MMT practices and professional perspectives on women's experiences in this program. All four physicians have "full authorization" to prescribe methadone.<sup>21</sup> As MMT insiders, the physicians also provide information on the system's organizational politics. Since publicly available information about MMT clients is quite sparse, I explore what texts and physician narratives reveal (and do not reveal) about client experiences and characteristics. The chapter examines the MMT system's knowledge of its subjects and how its guiding texts direct physicians' practices. It shows how MMT knowledges and practices orient to increased mainstream attention to risk (Fraser & valentine, 2008; Quirion, 2003) which obscures knowledge about women's interrelated challenges of drug use and marginality.

#### 5.1. Locating the Elusive Facts and Subjects of Methadone Maintenance Treatment

The CPSBC Methadone Maintenance Committee (MMC)<sup>22</sup> meets quarterly and its mandate is stated in its 2015 report, specifically aiming "to assist physicians in prescribing methadone safely and effectively by developing guidelines, providing education and reviewing cases." Each year the MMC provides one or two pages

<sup>21</sup> The guideline briefly explains levels of provincial authorization involved with methadone prescribing, such as full, temporary, or hospitalist authorization.

<sup>22</sup> As of June 2009, the Advisory Committee on Opioid Dependency (ACOD) changed its name to the Methadone Maintenance Committee (MMC).

summarizing committee activities and program statistics, such as the numbers of registered clients; new physicians in the opioid substitution program; relevant coroner cases; and in some years, the number of physicians attending workshops. 16,668 persons were registered in the MMP in 2013/14, which represents a rise of 61% in client numbers since 2008/2009 (Office of the Provincial Health Officer, 2015).<sup>23</sup>

The four physicians interviewed for this study had varied forms of practice located in the City of Vancouver. Doctor 1 prescribed methadone through private family practice, Doctor 2 operated a private MMT clinic, and Doctors 3 and 4 worked for salaried remuneration in a public multidisciplinary clinic. The physicians reported that it takes one to three weeks for MMP client applicants to begin treatment. Doctor 2, who oversees a private clinic, noted that some of his clients have acquired opioid addiction or entered MMT in correctional facilities but leave without a prescription, which complicates re/enrolment after release. While some clients have had prison involvement and experienced the differences between prison MMT and clinical MMT, the physician interview findings concern clinical MMT practice exclusively. Clients' clinic visits typically last between 10 and 30 minutes, with intake/first visits typically being the longest consultations, and private fee for service physicians spending less time with clients. Many of the interviewed physicians' clients have disability status and many report poly-substance use before and while in treatment. Clients enrol in one of four sites of MMT service delivery in BC: family practice; public, multidisciplinary clinic; private fee for service clinic; and federal or provincial prison (Luce and Strike, 2011). Among the multidisciplinary clinics are ones that provide service to a particular group of patients. For instance, Sheway and Fir Square in Vancouver address the MMT needs of pregnant and parenting women.

<sup>23</sup> Authorities' basic counts of MMT clients differ depending on why they examine MMT involvement. The MMC reports appear to provide "snapshots" indicating how many patients are registered in the Methadone Maintenance Program (MMP) at given times, such as at the end of a calendar year. Thus, the College under-reports the extent of MMT involvement, listing 16,527 persons as being registered as clients of MMT by February 2016 (College of Physicians and Surgeons of British Columbia, 2016). In contrast, public health figures include a count of *all* registered methadone clients within a fiscal year, in part to study client retention, expenditures, and other governance strategies. The BC Ministry of Health gathers these statistics to account for movement in and out of MMT and often indicate higher numbers of patients in a given annual period compared to the College's reporting.

Despite CSPBC's early vision of expanding access through family practice, most clients are still most likely to access MMT through private or public MMT clinics, with remote areas underserved (Reist, 2010). Furthermore,

access is about more than system capacity measured in terms of the number of prescribing physicians and dispensing pharmacies. Some providers attempt to keep their methadone prescribing "under the radar," partly for fear of community backlash but also "afraid of an avalanche" of new and complex clients. While such tactics may be necessary for the provider, they make it difficult for people in need of MMT to find and access services. (Reist, 2010, p. 8)

This suggests active management of client numbers or patient "quality." At the time of the study, CPSBC was mandated to keep a roster of patients and physicians in the program, and many doctors preferred not to have their names published in its publicly available physician directory.

## **5.2. Authority and Experts: Limited Resources for Marginalized Clients**

Yearly MMC reports list the number of physicians currently with and without registered patients and show that while the number of clients has grown in the past decade, the overall number of MMT physicians with patients has not changed much from between 2004 and 2011. 2011 figures show that out of 422 MMP physicians, only 225 treated patients, a trend that existed from 2004–2010.<sup>24</sup> The number of physicians with authorization to practise MMT far exceeds the number of physicians who provide the treatment to patients. Based on these latest available CPSBC figures listing total numbers of clients and active methadone prescribing physicians, I calculate that the average client/physician ratio grew from 40:1 in 2004 to 58:1 by 2011, which may help to explain the relatively brief client visits that the study participants report. Furthermore, physicians do not receive basic socio-demographic information about all clients in MMT in BC, such as age and gender distribution, neither through committee reports nor through the

<sup>24</sup> For the year 2009 and since 2012, the College has not provided information about how many MMP doctors had patients.

College's *Clinical Practice Guideline* or Ministry of Health text. It is important to note that local clinical knowledge about clients' lives is mainly produced through client consultations. The number of MMT clients that each interviewed physician treated ranged from 6 to 130. Among these clients, the number of mid-adult women (aged 50–60) they treated ranged from 2 to 17, and two treated one or two women over the age of 60.

The physicians volunteered to be interviewed for this study to facilitate research on MMT and to increase public and professional understanding of addiction in general, “because there’s so much ignorance about it, particularly with our federal government” (Doctor 2, private clinic). Their individual clinical practices are not located in the DTES, and to varying degrees, through their professional and political interests, they stayed informed of the city’s and DTES drug use situation, the provincial organization of MMT, and national and international addiction health developments. I posed several questions to the physicians concerning trends in the MMT field, the training of MMT physicians, and CPSBC oversight of MMT practice in the province. The data reveal physicians’ knowledge and experience of regulatory and professional aspects of their work.

The four interviewed physicians found some recent trends in the field promising and some trends problematic. Promising developments include easier access to MMT than in the previous decades, growing public recognition that addiction is a health issue, regulators’ official recognition that clients require addiction counselling, and the introduction of the drug buprenorphine/naloxone (Suboxone®) as a potential alternative to methadone. At the time of the physician interviews in 2012, BC health policy was still limiting client access to this pharmaceutical based on its higher cost to the health care system. One physician commented,

I think it’s a great option, Suboxone®. . . . Unfortunately, PharmaCare has limited access to [it], so they have limited access criteria. So, people either have to have previously failed on methadone maintenance or else have an intolerance to methadone, or not be able to take methadone because of medical complications. So, it’s a little bit limited unfortunately. But hopefully that’s going to change with time, with better access to Suboxone®. I think it would be good, I mean, [it’s] safer. It’s also less regulated so the ability to go to carries is quicker, we can go [with] methadone’s daily ingestion for a long time for stable changes, with Suboxone®

we'd be more comfortable giving people carries sooner. And then of course translated to convenience for them . . . and stigma. Less stigma as well. There's a lot of stigma attached to methadone. (Physician 2, private clinic)

This quote reveals that at the time of the interviews, physicians were advocating for buprenorphine/naloxone for client convenience and to address the stigmatization that accompanies daily directly observed dosing. Since 2015, access has increased and Suboxone® is the preferred option for new clients because the substance reduces the risk of overdosing (Providence Health Care and Vancouver Coastal Health, 2015).

Doctor 3 (community health clinic) also identified other problems with regulation that included inadequate monitoring of MMT services which results in some unethical pharmacy practices and the presence of some “methadone factory”-like private clinics in the array of BC's MMT services. Doctors 1, 2 and 3 further noted that the continued federal criminalization of addiction was at odds with more health-centred provincial addiction policy, which stifled broader development of MMT and best practices in the province and across Canada. They expressed frustration that addiction medicine occupies a silo within the medical field, found the medical community generally disinterested in knowing more about addiction and MMT, and called for improved education on addiction for all physicians. Doctors 1 and 2 who work in family practice and a private methadone clinic respectively especially spoke of clients' experiences of being stigmatized in emergency rooms and in other institutional settings as evidence that professional addiction/treatment knowledge is lacking and that medical practices can discriminate:

St. Paul's got a better reputation than the other hospitals who are often emergency physicians who are incredibly prejudiced. If they think someone's a substance abuser or even if they're on methadone, trying to get off substances, they get third class treatment. (Doctor 1, private family practice clinic)

Doctor 1 suggested that this situation can result in poor health outcomes for clients whose physical concerns are never limited to addiction experience. One physician found other health professionals' lack of interest in learning more about addiction problematic:

It would be worthwhile looking on the list if there's a list of doctors who are members of the American Society of Addiction Medicine and the Canadian Society of Addiction Medicine, and the International Society of Addiction Medicine. I'd probably be shocked how few there were and how few are doing methadone. The Canadian Society of Addiction Medicine has had its annual meeting in Vancouver. It's in Toronto now, in November. And I tried to persuade every psychiatrist I knew to come. . . . Because one of the biggest problems I think with addiction is most psychiatrists have little interest and little training in it. (Doctor 2, private clinic)

This physician identified a lack of interest among psychiatrists and even MMT doctors in sharing clinical addiction knowledge and associated professional development. Overall, the participants did not foresee significant changes in the Program's organization or practices but hoped that general recognition of addiction as a health issue would spread among professionals and the public. Physicians mentioned or discussed at length recent political issues surrounding MMT at the policy and professional levels, such as the heroin-assisted treatment research trials and the Conservative federal government's criminal justice preoccupations. In addition, the interviewed physicians noted the need for improved coordination between MMT, health care providers, mental health services, and prison administration.

### **5.3. Guidelines and Interpretations**

The College of Physicians and Surgeons of British Columbia (CPSBC) directs physicians who apply to or currently practice in MMT to its latest publication, the *Methadone Maintenance Program: Clinical Practice Guideline* (hereafter *Guideline*). Physicians seeking to work in the program must complete a one-day workshop and an interview, a half-day preceptorship, agree to participate in at least 12 hours of continuing medical education each year, and undergo a peer practice assessment (PPA) (CPSBC, 2014). A physician's successful completion of these requirements results in Health Canada granting her or him the exemption to prescribe methadone under section 56 of the Controlled Drugs and Substances Act. The *Guideline* text recommends that the newest MMT physicians encounter special provincial and federal oversight for a relatively short time, such as review of their prescription practices for up to one year after

application, at which time she or he will undergo peer assessment. This publication generally represents CPSBC as an important institution and the authority of the Methadone Maintenance Program. Typical of MMT texts, this publication is fairly silent about the history and outcomes of MMT policies and practices.<sup>25</sup> Nonetheless, the *Guideline* communicates that physicians are encouraged and practically guided to make discretionary decisions. Represented as an “evidence-based” resource to “assist” physicians in MMT practice, it indicates that physician’s clinical judgments in MMT practice involve interpretive processes, that clinical judgments are loosely expected to align with the “expert opinion” of the Methadone Maintenance Committee and moreover, “physicians should carefully exercise clinical judgment when considering whether it is appropriate to deviate from these guidelines. Any deviations should be documented in patients’ medical records, together with the rationale for those decisions” (CPSBC, 2014, p. 1). Although there are obvious practical elements to what the *Guideline* communicates to physicians, the administrative language conveys authority. The fact that deviations from College guidelines are discussed on the guide’s first page is noteworthy even as this acknowledgment is conveyed as a soft warning. The *Guideline* points to some tensions surrounding authorization of clinical practices in the MMT field.

Physician narratives provide some information of how MMT works for practitioners and clients, what kinds of experiences doctors have with MMT practice, and the MMT system’s documented knowledge of women’s MMT treatment, health care, and some of their social circumstances. Physicians seeking to practise methadone treatment must attend a one-day course, Methadone 101, plus a half-day preceptorship, and then participate in a peer practice assessment (PPA) in the first year of their practice. Another one-day workshop follows. Participants spend about 30 minutes with a new client during the initial intake visit, conduct blood and urine tests, and gather additional information about the client’s addiction histories, patterns of current drug use, and social circumstances (i.e., housing situation and employment status). In these and subsequent visits, the physicians often use forms suggested and provided by the BC Methadone Program, but not exclusively. The program does not demand that MMT doctors document

<sup>25</sup> An evaluation of the program, which included numerous recommendations (see Reist, 2010), has not resulted in significant changes to the program. This particular evaluation drew in part on interviews with MMT clients in BC.

their practices in a particular way, but a minimum amount of recording is required by regulation.

And I think every so often we kind of have to review and see where we are standing with the patient. How far we have got? Have they managed to come off drugs? Are they still using? Are we looking at tapering them off? Are we looking at maintenance? Are they engaging in counselling? How much their quality of life has improved, in terms of housing. Are they looking to find a job or college? Various things, from time to time, they might have started off at one point. And I think the College expects us every so often, like every three months or six months, just to make a brief summary in the notes, as well, just to see. It was told in the Methadone 101, we start off and we keep just documenting, but then they said, if you put in like a brief note, like a small summary, to see how far we have got. And that helps the clinician as well as the patient. Just to keep on the right track. (Doctor 4, public clinic)

Consultation can involve asking a range of questions, some pertaining to addiction health and some to social circumstances and goals. Specifically, doctors must document health and social benefits of MMT for each client during treatment planning. Forms provided by the program contain a section to record progress in a formulaic way, such as reporting different aspects of a client's psychosocial characteristics. Doctor 4, who worked in a public clinic, alternately drew on psychosocial discourse during the interview, referring to clients' "readiness to change" and their "determination" to end drug use. Thus, physicians more often self-monitor their clinical reporting than encounter regular formal auditing of the process. Although extensive documenting in MMT practice is encouraged, the governing body certainly does not demand it. Its minimal expectation is that MMT doctors are recording clients' treatment progress in client files and summarizing the treatment plan every few months. The style and extent of documentation are left up to the MMT physician. Doctor 3 in the public health clinic who conducted peer practice assessments found the loose regulation on documentation problematic because it does not encourage accountability, especially for the "bits and pieces" that MMT doctors are responsible for, such as MMT counselling. Doctor 1, the family practice physician, stated that the College's minimum programmatic measures did not reflect knowledge about the diverse range of client outcomes. Overall, the four physicians practised MMT in fairly autonomous ways.

### 5.3.1. Plural Counselling Practices

My broad questions posed to the four participants about counselling suggest that the meanings of counselling are multiple and participants counsel their clients in various ways. Three participants worked to engage their clients in counselling by referring them to the in-house counsellor or in-house recovery meetings.<sup>26</sup> And while they saw value in using a psychosocial framework in MMT counselling, some considered counselling in MMT practice to be limited. The four physicians referred some clients, including women, to mental health services. Practical elements to MMT practices that might programmatically fall under the umbrella of counselling included helping clients apply for disability-related income benefits and handing them pamphlets on addiction or lists of resources. The examined MMT texts in this study dictate the formal expectation that doctors should be counselling clients, and the fee covers this practice. When doctors are too busy to counsel and/or develop their knowledge in this area, they hire staff for that purpose, although CPSBC does not monitor or regulate the counselling staff that physicians or clinics employ (Reist, 2010, p. 10). Physician narratives also suggest that client resistance to counselling can be an issue:

Doctor 3: We don't do group counselling here, we do offer recovery meetings once a week. But we do encourage counselling.

SP: Okay, you encourage it but it's not mandatory.

Doctor 3: It's hard to make things mandatory, I mean people,

Doctor 4: Yeah, engaging and we have to keep engaging and kind of push them for counselling, and some people are keen. Again, personalities are different. For counselling I think some people can and some people can't. So, we actually tread slowly with them when we push them for counselling. You can't force people to go.

<sup>26</sup> One of the private clinic physicians has hired staff to conduct in-house counselling and recovery meetings.

Steering some clients toward counselling can be initially subtle out of necessity. Of note, the practice of engaging clients in counselling can take several forms and the meanings of counselling at the site of MMT are as diverse as its practices.

Physicians' concerns about counselling sometimes related to client retention. One private clinic physician (Doctor 2) developed his own literature to give to clients who wished to leave MMT with the aim to show clients how leaving MMT disadvantages them. His perspective was that MMT clients require more than two years of this treatment and that some may require it for many years. The community health clinic physicians (Doctors 3 and 4) found some other MMT physicians were too coercive in their approach to MMT clients in general. One stated that two years in MMT is an optimum stay because "it gives them time to stabilize other areas of their lives and get some distance from the using and when the time comes to taper, there's less risk of relapse" (Doctor 3, public clinic).

To summarize thus far, texts and narratives reveal policy gaps and professional concern about some underdevelopment in the program. MMT involves a number of clinical practices, such as prescribing methadone and monitoring for drug use, and still, clinic practices are interpretive to a notable extent. Clients generally face long waitlists for access to family practice physicians and mental health services. The interviewed MMT physicians sometimes provide health treatment and in-house recovery counselling, and referred clients to primary care and mental health services.

### **5.3.2. The Notions of Stability and Risk**

In the case of MMT, the meanings of risk and harm are highly fluid and contested. As Roe (2005, 2010) argues, in Vancouver, tensions persist between health professionals' and neighbourhood activists' conceptualizations of risk and harm. The first group frames risk and harm as observable, takes a realist or pragmatist position, and follows a health promotion agenda. In particular, health experts regard social aspects of addiction as risk-related phenomena involving individual behaviour. Activists, whose voices are marginalized in harm reduction research, policies, and practices, view harm reduction as a means to politically confront the larger harms of social, economic, and political inequalities. My research explores how MMT texts communicate particular and narrow conceptions of risk and harm, which frame physician interpretations and their official

recording of clients' related social circumstances. By prioritizing stability and risk issues at the expense of acknowledging clients' lived circumstances, this perpetuates decontextualizing women's concerns related to addiction and can silence women's concerns about MMT policies and practices.

The CPSBC *Guideline* directs physicians to work with clients and assess through "positive brief interventions," biopsychosocial history, stability, and clients' "readiness to change" (CPSBC, 2014, 25–26). A fair amount of this text authorizes and melds medical and biopsychosocial knowledge in both subtle and overt fashion and communicates that information with scant reference to literature. Determinations and documentation in MMT practice rely not only on signifiers that medical tests provide, but also on the symptoms of addiction (as understood in biopsychosocial terms), such as knowing a client's housing status, employment status, relationship status, how she or he procures illicit drugs, their networks, family situation, and crime involvement. The expectation is that MMT physicians will use this frame to interpret and keep record of clients' physical state, social situations, goals, choices, and most of all, behaviour. The Patient Assessment Form provides space on three of its seven pages for recording numerous aspects of "biopsychosocial history" and another page for listing mutually defined client goals. The boxes "high risk behaviour" and "child at risk" are to be checked if the physician deems that these terms apply to the client's case.

The MMT medical community assessments make several groups highly visible. The *Guideline* classifies eight groups as "special populations": "adolescent patients; women of child-bearing potential; pregnant women; non-injecting opioid-dependent patients; patients with comorbid conditions; hospitalized patients; provincial and federal corrections patients; patients who wish to travel" (CPSBC, 2014, p. 34). The text supports discussion of two of these eight specific groups with extensive citations and discusses women only on the basis of child-bearing potential. Of the text's 31 literature citations, 19 refer to pregnant women (17 citations) and patients with comorbid conditions, such as HIV/AIDS patients (2 citations). Furthermore, among the 19 references, the majority concerns American, European, or Australian research subjects. Thus, knowledge is produced using mainly "distant" evidence rather than local evidence. The *Guideline* aligns with the Health Canada *Best Practices* document, constructing pregnant drug-using women as especially placing their children at risk and requiring institutional intervention,

such as MMT and MCF involvement (see Boyd, 1999). Notably, texts use gender-neutral language until mentioning women, whereby risk is discussed in the context of pregnancy or in the contexts of relationships, violence, and sex trade work. Thus, the notion of risk is strongest when framing discussion of specific types of clients.

The notions of stability, change, and risk are often found close together in MMT texts and these are fluid terms in this context. For example, texts can refer to risk and/or stability in matters of health, pharmacological processes, patterns of drug use, and in regard to social circumstance, living conditions, and even in compliance with the MMT regime. It is not that the terms of stability, change, and risk are overused to the point of becoming meaningless, but that the frequent use of them shows that they are quite embedded in MMT discourse and display narrow understandings when broader meanings would better represent women's lived circumstances as they move through treatment. This displays the need to raise the status of women who use health systems to better their lives, and the need to move attention away from reproductive issues (Inhorn & Whittle, 2001).

Expert knowledge is negotiated through MMP administration and clinical practice. CPSBC strongly supports biopsychosocial theory in MMT and expects physicians to use it in practice. As a result, doctors who regard social aspects of addiction as important as health aspects may consider them as individualized, risk-related phenomena. While they are overseen by a regulatory body and under some surveillance themselves, similar to other forms of medical practice, physicians are granted considerable authority to interpret many facets of MMT clients' lives and are authorized to produce texts about those lives.

### **5.3.3. Methadone 101 and Methadone 201 Curriculum**

All physicians applying for an exemption to prescribe methadone must attend a one-day Methadone 101/Hospitalist workshop. Physicians working in MMT practice must attend a subsequent Methadone 201 workshop after their first year of practice. To my knowledge, these training activities are not video or audio recorded. In 2013/14, mandatory Methadone 101 and Methadone 201 curricula included respectively twelve and ten PowerPoint slide presentations. According to the CPSBC, the Methadone 101

presentations constituted that workshop's morning instruction and MMT doctor-patient roleplaying continued in the afternoon.

Various physicians and health professionals created and delivered Methadone 101, which covers the following twelve topics: MMP and Health Canada regulation; overview of addiction in relation to brain physiology; the use of language in health policy and medical practice; triage and assessment; pharmacology of methadone; urine drug testing; pregnancy; rural practice; hospitalist practice; Suboxone®; deaths from non-illicit, non-methadone opioids; and how to be effective in seven areas of MMT physician practice. Methadone 201 covered the following nine topics: overview of the College's role in MMP and opioid prescription regulation; methadone as an analgesic; alcohol and benzodiazepine use and recovery; chronic pain; coroner cases; hepatitis C virus and human immunodeficiency virus; pregnancy; Suboxone®; and urine drug testing.

The curriculum material falls within CME activities and specialized knowledge production in the MMT field. Various slides instruct on how to determine clients' stability and assess risks in different aspects of local MMT practice. Furthermore, some presentation slides address recent local addiction trends, include citations of local studies, or discuss local cases or public health statistics. These exist in contrast to the guiding documents produced by Health Canada, the BC Ministry of Health, and the CPSBC, in which far fewer BC studies are mentioned. As workshop presentations contain more practical and detailed information than is provided in the College's guideline text, they more closely link risk discourse to physician practice. Workshop instruction reveals a more fluid use of risk discourse than in the MMT guidelines, especially regarding who the College determines to be "special populations."

### ***Women's visibility as risky health subjects***

As I am interested in how the curriculum represents women in MMT, I examined and compared the slides from the two workshops that concern pregnant women. One physician delivered two different presentations on this subject to 101 and 201 workshops. As in the *Guideline*, the Health Canada report, and the provincial *Best Practices* text, the Methadone 101 presentation on pregnancy draws on the notions of risk and stability. The following shows that the onus is on the mother to comply with MMT in the interest of her

child, and deviations from policy can result in apprehension of the infant. One bulleted statement advises physicians to:

- Explain that with tapering, risk of relapse is high—and with it, child apprehension. (Rieb, 2014, Slide 13)

Another slide states,

- Drug and lifestyle stability along with early voluntary MCF referral make apprehension less likely. (Rieb, 2014, Slide 18)

Another presentation in the 201 workshop includes these two sets of instruction almost word for word and likewise discusses precise aspects of the medical care, contraindications and so forth. The second presentation frames MMT during and after pregnancy as a complicated scenario with risks and benefits for both mother and child. The introduction begins with a humanistic message:

#### A Time of Change

- How do people change?
- Desperation or inspiration
- Pregnancy is a phenomenal opportunity for change in a woman's life
- Most want a better life for their child
- Nurture the mother and she'll be more likely to nurture the baby
- Think of the mother-baby pair. (Rieb, 2013, Slide 2, See Appendix)

Unlike the 101 presentation, the 201 presentation encourages client-centred treatment of mothers in this context, while still utilizing notions of risk and stability, and draws on readiness to change theory without appearing too punitive or indifferent. This presentation implores physicians to be open to change and more nurturing as health practitioners. Among the various messages communicated through numerous presentations, this one stands out as unusual instruction.

As Fraser and valentine (2008) argue, risk calculation sorts out who is left to self-manage and who must be managed, and accordingly portioned resources. Furthermore, MMT clients are constructed as lacking rationality and agency, thus deemed to require management, “rather than people who are at risk [who] have the capacity to share in the

management of that risk” (Fraser & valentine, 2008, p. 72). Readiness to change language illustrates the continued paternalistic tone in BC’s MMT guidelines used to describe some women’s need for supports.

#### **5.3.4. Coordinating MMT and Health Care**

The MMT guideline text recommends that “MMT be part of a spectrum of treatment focused on improving health and social outcomes” (CPSBC, 2014, 8), stating that other health services are necessary tandem or alternate supports, such as detoxification, day and residential treatment, and mental health services. This text does not communicate that such services can have long client waitlists. Given inadequate funding of ancillary addiction and mental health services in BC (Smye, Browne, Varcoe, & Josewski, 2011) and the relative absence of multidisciplinary approaches, “the majority of MMT work is done by prescribing physicians and dispensing pharmacists” (Parkes & Reist, 2010). Furthermore, the guideline does not discuss primary health care for clients.

Clinician interviewees in this study raised this issue of providing general health care to clients. The practice of addiction medicine / primary medicine in clinics can be complex. In the public MMT clinic, Doctors 3 and 4 worked within regulatory constraints to sometimes serve in their capacity as General Practitioners (GPs) for their clients in order to monitor health problems, whether or not clients’ health issues were related to addiction histories. As Doctor 4 stated, “it’s not easy to clearly define where addiction ends and general practice begins sometimes. I mean there are many medical conditions that overlap with addiction. We have to deal with those, if they’re not being dealt with elsewhere.” They conducted Hepatitis C treatment (such as interferon injections), oversaw HIV medication, helped clients manage other systemic disorders, treated abscesses and one physician treated a client’s chronic pain, and both sometimes dealt with their clients’ general health issues that arose. Questions posed to these two doctors about their mid-adult women clients elicited various perspectives on how clinical practices addressed their needs. One physician expands on the complex intersection of women’s addiction health and general wellbeing:

Even though we’re not a primary care clinic here, we do try to track that the important surveillance stuff is done, that women’s health checks are done. So, we

will remind people or even try to set up appointments for them to do a woman's health check, you know, if there's a history of dysplasia or previous abnormalities, abnormal pap smears or such. So, we will kind of track those things and try to make sure, and *addiction being the disease that it is, a lot of times people don't take care of all those kinds of details and we do try to keep on top of those things. That should be taken care of.* Not just provide methadone maintenance. You know, not just a methadone prescription, dealing with problems in general. . . . We try to deal with those kinds of issues if they come up, preferably by making referrals to primary care and handing those issues down to them. Not always easy because there's, you know, there's not a lot of GPs taking new patients at some of the community health centres, so that is a challenge, definitely, just connecting people with primary care at all. It would be nice to work alongside primary care in the same building, so if you have good communication and a referral process, that would be nice. (Doctor 3, public clinic, emphasis added)

In remarking that persons who use drugs “don't take care of those kinds of details,” this physician's view constructs difference between such clients and other citizens, describing the former as incapable of following up with health concerns without physicians' oversight, reminders, and actions. The interviewed physicians sometimes reiterated paternalistic medical views, even as they sought to help clients by referring them to family practice clinics to ensure that their disorders and need for testing were better monitored over the long term. However, with the shortage of family practice doctors in BC, physicians sometimes made do with resources at hand in the interest of clients' overall health concerns.

Practitioners can incorporate discursive elements into practice which help to maintain the status quo, that is, the devalued status of women in society. Data suggest that clients, both men and women, are rendered visible in MMT only where experts deem them to be special problems. One way that practices and texts especially mesh is through the case management record. Textual invisibility/visibility of women in MMT broadly suggest gaps in services for them because of the way in which their myriad challenges come under medical scrutiny, some of which might not relate to addiction health. For instance, physicians' knowledge of clients' social circumstances, such as employment,

welfare involvement, and relationship status, become tools for psychosocial judgments that obscure women's need for crucial health and social supports.

Physicians' practices can re-invoke notions of risk, stability, individual choice, and responsabilization, but can occasionally challenge them. The physician interview data is useful in part for showing how MMT for women experiencing social marginalization is more complex than texts suggest. While authorities inaccurately deem that some women require monitoring and risk management (Boyd, 1999), such as pregnant women and women sex trade workers, physician interviews provide some evidence of what constitutes treatment of women in MMT, especially women in their mid-adult years. Doctors in MMT report on what this might look like in a practical, "in the field" sense and how it can involve medical testing, physicians' pleas for auxiliary health and social supports and looser regulations around Suboxone®, oversight of women's general health, and more in-depth counselling expectations than some MMT physicians are prepared and qualified to give.

### ***Identifying women's health and marginality issues***

When asked about the differences between the treatment of men and women in their practices, Doctor 2 suggested that women MMT clients often require health monitoring and more than MMT counselling due to extensive experiences of trauma. Doctor 3 framed women clients' health and social problems in terms of risk and stated, "Depending on their social circumstances, I think generally they're more vulnerable, they're more at risk in terms of housing, unstable housing, relationship abuse issues, sex trade, risks associated with that. There's differences that way." The physicians indicated that women between 50 and 60 years of age who were now in their care are more likely to be long-term MMT clients, but held various perspectives about what women in that age group needed and how clinical practices addressed those needs. There was consensus that they needed more social supports in general. While perspectives differed about how long clients should remain in MMT, two physicians stated that women's long-term participation in MMT is not ideal due to associated health issues:

The goal would be to get somebody off methadone as they get older, there are some risks with being on methadone, a few issues. Sometimes they're really happy on methadone, they don't want to come off their methadone. . . . I think that will be

one of the challenges, to get them off their methadone. (Doctor 4, public health clinic)

In terms of immune system problems, I mean chronic opiate therapy is associated with decreased immunity, so I can't give you good examples of how it has affected women's immunity in that age group but we know that there are increased risks of all kinds of infections because of low immunity, chronic opiate therapy. So, something to be aware of. (Doctor 3, public clinic)

The latter quote might be pointing to a debate among researchers about the possibility that opioids reduce immune function. Research comparing untreated subjects and substitution clients to determine the causes of immune modulation conclude that methadone or buprenorphine can help to restore immune function (Sacerdote et al., 2008). What is noteworthy here is that these two interviewed physicians in this study viewed aging on methadone as a health problem, but did not elaborate on the range of issues involved in specific terms.

Physicians also regarded buprenorphine prescription as a viable alternative to methadone in MMT because it reduced the stigma that clients experience, and at the time of the interviews, they hoped the province would loosen regulation so that they could prescribe it for more clients. The physicians' perspectives varied about whether age is or is not a factor in health challenges among mid-adult women in MMT. One physician did not find that women's "older" age necessarily suggested health challenges. In contrast, the other physicians found women in MMT often experience health problems and social marginalization by mid-adult age due to the cumulative effects of stress in their lives, such as through injection drug use practices, unstable housing, and abuse trauma. My research question specifically explored MMT doctors' experiences of treating mid-adult women in MMT and their knowledge of the women's challenges as health subjects. Doctors might regard social aspects of addiction as important as health aspects, but the narrow lens of medical interpretations observes these social troubles as individualized, risk-related phenomena. Physicians, of course, regard older women clients first and foremost through a medical lens, yet like texts, their perspectives display how women's health and social marginality issues are elided. Risk-centred constructions of the woman MMT client obscure the full extent of harms that MMT experience alludes to.

## 5.4. Discussion

Clients are produced through the practice of regulation whereby interpretations can involve “law, suggestion and surveillance” considerations when policy is silent on an issue, and responses equate clients’ agency and resistance to lack of compliance (Fraser & valentine, 2008: 81). It is noteworthy that best practices or guiding MMT texts do not contain much information about MMT practices in the field. It is a paradox that the program in BC is both underdeveloped and heavily promoted by health authorities and physicians, and while client retention has become the measure of the program’s effectiveness, retention rates are falling (Reist, 2010). The interview data provide some information on the links between expert knowledge and practices of MMT. To the extent that the interviewed physicians are insiders and they actively explore new MMT knowledge, their perspectives provide insight into practices and organizational politics of MMT. These participants practised MMT in diverse ways and with a fair bit of autonomy, particularly in terms of primary health care and counselling. Professional narratives also reveal that MMT policies and practices have been resistant to change. The interviewed physicians narrated the need for the development of MMT and called for greater accountability for other clinics. However, they did not foresee significant changes in how the BC Methadone Program is administered.

The main intent of MMT guiding texts is to impart medical knowledge and guide physician behaviour, but they also briefly mention, often in passing, the larger issues of homelessness, trauma, violence, poverty, and other social struggles. MMT texts narrowly interpret social aspects of addiction through a biopsychosocial and risk lens and communicate the expectation that MMT physicians will do the same. Texts instruct doctors to document knowledge of clients using conventional medical and more recently introduced biopsychosocial understandings of addiction. In this respect, texts reconstitute narrow mainstream understandings of the lives of women in MMT.

In discussing interpretations of guidelines, Fraser and valentine (2008) argue that interpretive power in MMT rests with providers rather than clients. Of course, MMT clients, like other medical patients, have agency, but “their activity and agency is constituted as illegitimate” (Fraser & valentine, 2008, p. 73). At the same time, it was clearly advantageous for clients that community health MMT physicians identified and acted to

manage their general health treatment. The research on the whole, however, shows experts' recognition of structural barriers the women faced over the long term, specifically, the cumulative effects of mid-adult women's experiences of social trauma, homelessness, and abuse. Physician interviewees drew on risk discourse to frame these clients' social marginalization, using the terms "management" and "monitoring," and sometimes "surveillance" to describe their health problems, but they also used these terms to refer to addiction treatment. As well, MMT physicians worked within a number of constraints. Two participants had large caseloads and saw the need for more methadone prescribers in the field. Three found it difficult to refer their clients to primary care practices because of the shortage of family doctors in BC. Their MMT clients also faced long wait lists for mental health services.

Lastly, physicians seemed especially attuned and sympathetic to their clients' experiences of stigma in medical treatment, which they linked to a lack of addiction medicine knowledge among the medical professions. The physicians did not discuss the whole range of their practices with MMT clients. I did not ask about their clients' frequency of visits, about mandatory "surprise" urine testing for drugs or clients' non-compliance with MMT rules. Nor did doctors offer information on these aspects of treatment when responding to broad questions or specific discussions about women in MMT. Furthermore, none of the physicians reported specific conflict with patients, which contrasts with how the five women participants in this study refer to their intense client-physician relationships. Physicians generally described the clinical practice of "working with clients" as a collaborative activity. How physicians framed the MMT doctor-client interaction downplayed the fact that they hold considerable power in this clinical relationship. The private clinic physician who sought to educate the medical community and public took pride in the literature he created for his clients when they sought to leave MMT, although his methods were arguably coercive and can be viewed as partially self-interested as he runs a fee for service practice. This instance of convincing clients to stay in MMT echoes Järvinen's (2008) findings in Copenhagen where MMT professionals often resist clients' wishes to leave MMT and attempt abstinence.

My study explores the problems and potential of the relational, "personal," and value-added side of the doctor-client encounter. One physician regarded long-term MMT participation as somewhat problematic for health reasons, and he and his clinic colleague

made a case for leaving MMT sooner rather than later in life. Similar to Fraser and valentine (2008), this thesis argues that MMT consultation in BC is an interpretive practice that involves texts, referrals, and numerous institutionalized expectations for clients. The term “authority” can refer to state policies or programs, or it may refer to biomedical knowledge, or different articulations of texts and practices, but certainly biomedicine dominates discussion on health inequalities (Moss & Teghtsoonian, 2008). When policies and practices reduce women’s issues of poverty and trauma, family circumstances and housing to health risk factors, they render women’s complex experiences of marginality invisible.

This chapter examines MMT organization in BC, including MMT texts and practices that constitute the woman methadone client. The physician interview data helps to explain some local MMT practices and I use this data to complement text analysis because it reveals some features of MMT unremarked on in texts. Overall, policy frameworks, institutionalized rules, and professional practices are in place to manage crucial health risks related to the controlled substance of methadone. As Olofsson et al. (2014) argue,

in order to understand the new complexities of the (re)production of social inequalities in modern societies, we have to reconstruct how they combine in the description and management of social problems as risks, and as a result, identify certain social problems while producing and legitimising ways of dealing with others. (p. 420)

MMT texts frame women’s converging social problems in terms of risk management, favour the status quo, and reconstruct women’s invisibility in policy. Physicians’ perspectives were more likely to acknowledge the intersection of medical supervision and women’s marginality, but they drew on individualizing notions of risk to do so. MMT treatment is not as uniformly applied as texts suggest; physician interviews reveal it is a site of complex and sometimes competing practices and meanings. While guiding texts render some women visible in MMT and regard some women’s challenges in relation to their social circumstances, they more often discuss women in risk-conscious terms. As Reith (2004) notes, the dual emphases of modern addiction discourse—the medical gaze involving physiology and the psychological gaze—involves investigation of subjective experience. Drug use-related identities are fluid as individuals come to see and act in

accordance with their identity, and to engage in new interpretations or re-establish old understandings of who they are within society at a given time (Järvinen, 2014).

Both texts and physicians were silent about how MMT is intense medical supervision of addiction treatment compliance that can affect other areas of clients' lives. In this way, MMT is concerned with participants only as health clients and not as citizens. Texts and local practices reveal some competing understandings of the body and care but overall link health and social circumstances to clients' individual behaviours and risks. When structural constraints were mentioned, physicians were most critical of laws concerning access, or they called for further education for physicians in order to improve practices and reduce clients' experiences of discrimination in health care settings. Like other MMT clients, mid-adult women in this treatment are often stigmatized in health care settings, recovery homes and public places such as pharmacies, and Chapter 7 explores this in more detail.

The physicians narrated some professional and societal constraints at play in the issue of clients' experiences of discrimination. Furthermore, there appears to be no meaningful mechanism in BC MMT policy for women in treatment to challenge the stigma that is "built into" the program. Health treatment in the context of addiction involves not only personal monitoring of clients by physicians but a range of panopticon-like approaches related to directly observed therapies (DOT) (Elliott, 2007). MMT is an example of how "management of risky populations sets up exceptionalist interpretations of agency and choice: models of contemporary patienthood based on negotiation and activity exclude particular kinds of patients, and treat particular kinds of activity only as non-compliance and risk" (Fraser & valentine, 2008, p. 87).

*Women, Methadone, and the Politics of Supervised Exclusion* explores how women can experience intense medical supervision of addiction treatment compliance and coinciding prolonged, sometimes severe, social and economic marginalization. The process of "supervised exclusion" is one that overall: 1) reflects a constellation of control and neglect approaches to social problems; 2) characterizes participants as clients and not as citizens; 3) privileges professional knowledge of risk over clients' experiential knowledge about harms; 4) renders the complex contexts of women's drug-related struggles invisible.

The next two chapters draw on life stories of five women in MMT to explore their experiences of supervised exclusion. The next chapter examines, in turn, each participant's distinct social history, substance-related trajectory, social circumstances, household composition, and, most notably, their experience of and insights about MMT. Women's narratives richly illustrate the links between MMT participation, social processes, and structural constraints.

## Chapter 6.

### **Trajectories and Tensions: Complex Intersections of Women's Drug Use, MMT, and Program Experiences**

Raikhel and Garriott (2013) take up the term addiction trajectories to argue that addiction knowledge and categories, therapeutic practices, and treatment experiences are highly interconnected and have implications for clients' everyday lives and subjectivities. I further use the term to refer to longitudinal aspects of lived experiences of addiction and treatment (Prins, 2008; Garcia, 2008). This chapter explores five women's MMT-related experiences, and from the vantage point of mid-adult age, Camille, Debbie, Renee, Sarah, and Mariel elaborated on aspects of their addiction trajectories. I fashion and present the women's stories according to my research objectives (Atkinson, 2002), which is to empirically explore women's MMT participation relative to their ongoing experiences of social, economic, and political marginality. The analysis also stresses the importance of personal narrative. Life stories expand time frames for exploring experiences before, during, and beyond treatment, including problems that developed over time, although their MMT participation is a centrally narrated feature. These experiences were part of addiction trajectories that were shared and organized by the process of MMT within the context of shifting BC policies. The life stories describe connections between drug use and service involvement while foregrounding the study participants' situated knowledges of clientization and marginalization processes.

Gubrium and Järvinen (2014) broadly define clientization as the process of turning troubles into problems; in this sense, client-making begins when professional knowledge renders personal life troubles visible and transfigures them into social problems through rational, bureaucratic management. As a form of professional knowledge, MMT likewise renders personal addiction-related troubles visible and converts them into problems through rationalization and bureaucratization. Gubrium and Järvinen (2014) further point out that the client-making process is inherently methodical and political, and sometimes interrupted or incomplete. Drug treatment was not the only human service program the participants of this study accessed. To various degrees, Camille, Debbie, Renee, Sarah, and Mariel also navigated multiple basic services during their adult lives, and thus

experienced multiple forms of clientization in the context of marginality over time. This chapter begins to explore these women's experiences of medically supervised addiction treatment, in concert with their experiences of primary health care, income assistance, and services and programs targeting low-income groups. The life stories reveal that the study participants were not passive clients but citizens who actively navigated MMT and negotiated for other social supports where available as part of their efforts to improve the quality of their lives. As Kerkvliet (2009, p. 232) states, "everyday politics involves people embracing, complying with, adjusting, and contesting norms and rules regarding authority over, production of, or allocation of resources and doing so in quiet, mundane, and subtle expressions and acts that are rarely organised or direct." Struggles for autonomy and improved life chances can hinge on complex or intertwined late modern understandings and politics of the body and care, can involve policy and human service interventions, and can include clients' contestations of expert knowledge (Fine, 2005, 2007). Overall, this study shows how the politics of service provision, especially the politics of MMT can shape, even dominate women's everyday lives, especially when their long-term needs exceed what any one service is designed to provide.

As stories presented in this chapter show, there is no predictable path to or through MMT, or to and through marginality. The narratives reveal varied life circumstances and service experiences among women who sought out this treatment to improve their life chances, and MMT entry was one significant moment among others in their lives. It offers a study of intense clientization and the different ways that "troubles" can become "social problems" once subjected to professional gaze (Gubrium & Järvinen, 2014). For example, Camille had turned to MMT treatment in her late 20s, and Debbie first encountered it in her 30s. At the time, they were experiencing physicians' and/or front-line workers' alternately tough and sympathetic interventions, and they were struggling with physical crises, such as severe illness, trauma from gendered violence, or homelessness. In comparison, Renee, Sarah, and Mariel entered treatment while in their mid to late 40s, shortly after they began using illicit opioids on a daily basis, and in Mariel's case, after an opioid prescription could not be renewed. Like Camille and Debbie, the three women found life troubles accumulating and would similarly experience the conversion of some of their troubles into social problems. These complexities of women's drug use remain invisible to

the addiction treatment field (Ettorre, 2004), as do the exigencies and complications of their client experiences.

The life stories in this chapter begin to describe features of supervised exclusion; specifically, they show how women in MMT experience the constellation of service control and neglect, encounter notions of risk, become clients, and in the process, have their complex needs rendered invisible in the MMT field. The stories are organized according to the length of time the five women have been in addiction treatment—from nearly 20 years to several months. This does not imply a hierarchical approach to their experiences but chronologically summarizes each participant’s addiction trajectory in the context of specific policy trends. The women’s life experiences reveal that some issues, such as residential schooling or employment history, are unique to a single participant, and several themes—trauma, categorization, and surveillance, among others—can be discerned across the narratives. Each summary specifies ways in which addiction trajectories can include: cumulative harms; “at risk” client labels and categorization; surveillance and care; diminishing quality of life and personal agency; and multiple problems with pain. The chapter concludes with a discussion of cumulative social suffering and its invisibility in addiction health policies and practices (Bourgois & Schonberg, 2009).

## **6.1. Life Story Overviews and Addiction Trajectories**

### **6.1.1. Camille**

Camille is Cree and throughout her life has struggled to cope with the effects of gendered and racialized violence she experienced in residential school in the 1960s. Her specific recall of being taken as a young child from her home to an institution constitutes one of her earliest memories:

Let’s start off from the beginning. Okay, as far as I remember, I was five years old and my Mom fixed us all up for a trip somewhere. I think there was some guy that came. No, he met us at the train station and hopped the train with us. . . . My Dad left at the train station. So, our big brother was sitting between [my sister] Tara and I. We fell asleep and it was a very long ride. And then when we got to some town

or whatever, it was dark and cold and then another long car ride. And then we stopped in front of this great big brick building. I'd never seen a building like that in my life. We went into the building, and then they said, "Okay, take the boy, take the girls, junior girls and a senior boy." They were splitting us up. And I went crazy. I went wild, I held on to my brother's leg and wouldn't let go, and so did Tara. We were crying, "I don't want to go!" "Oh no!," crying. They were very cold, the woman supervisor or whatever. It was nighttime. It was just a job to her. She just snatched us up, she was rough, told us to be quiet, said, "Enough of that noise!" Yeah, they ended up carrying me into the building. When they were pulling us apart we were kicking and screaming. They took us up lot of stairs to the top door, then a shower, changed. We had to make our own bed. I was crying all along and then I wanted to sleep with my sister. She was on the other side of the room. [pause] That night, I cried myself to sleep. The supervisor was saying, "Shut up!" Then I just cried myself to sleep. For many, many nights I cried myself to sleep. In the morning, my eyes were swollen, my throat was sore. Headache. I wet my bed. I got heck for that. This was St. Ambrose Residential School. I was starting Grade One. I never spoke about this.

Camille conveys the longstanding trauma resulting from this episode of colonial violence; she had "never spoke[n] about this" incident and subsequent physical and sexual abuse at residential school but linked her drug use issues to these early life experiences. Many of her relatives, including a grandmother, her parents, and most of her siblings, had similarly been removed from their homes when they were children and sent to live in institutions.

At age 12, Camille left school and in her mid-teens moved from her reserve to a large Canadian city. By the age of 30 she had worked in sales and service industries and was married and raising children. Alcohol and substance use coincided with her early work life to the extent that it was incorporated into a weekly work routine. Camille, her husband, and children moved to British Columbia in the 1980s. The marriage floundered a few times and then permanently dissolved when her husband began using heroin. A tug of war for the children ensued, and after her husband gained custody of them, Camille herself turned to heroin in despondency.

Camille first entered MMT as a client of an inner city public health clinic in Vancouver's Downtown Eastside neighbourhood in the late 1980s. Sometime after, she was banished from this clinic during a compliance-related argument with her methadone doctor:

He made me believe that the only way that I could be on methadone was through him. . . . Then I was off methadone for two years and because of him I didn't think that I could go to another doctor. And for two years I struggled on the streets, selling this, that, anything but myself . . . it's hard for a woman especially, you know.

Losing access to methadone left Camille vulnerable and confused while she struggled with intense heroin and cocaine addiction. Following this first experience of homelessness, Camille found housing again but soon after suffered a life-threatening assault by a male stranger which hospitalized her and set her back physically and emotionally for months to the point that she found it difficult to leave her home. After learning through a friend how to access another doctor, she entered MMT again, yet still felt vulnerable while she adjusted to methadone once more. She explained,

When I first got [back] on it, I was afraid that it would stop somehow. It was like, you had to get used to it being there every day and you're scared that maybe you will spill it. . . .it was a big load off your shoulders and your mind, and you had to get your mind used to having it.

Camille feared losing access again because methadone provided a practical means to significantly reduce illicit drug use and offered respite from significant worries and the various dangers of open drug use environments. Although she found that the strict clinical routine was at odds with the physical benefits that methadone provided her, she was determined to remain in MMT. Camille described methadone as "100% helpful," especially supporting "good" periods, such as when she provided live-in care for an elderly relative, re-connected with her children in their teen years, and worked in a college. Life in her 40s became less settled again when her drug use increased and with relationship problems. She became further impoverished, experienced periods of homelessness, and began contact with shelters and drop-in centres. Camille eventually received common residential

school compensation, which she shared with her children, and it inspired her to apply for individual compensation, a lengthier and more difficult process. The application required that she speak to her memories of childhood sexual abuse, which she found difficult, as she had never shared this information before, not even with parents or siblings, many of whom were dealing with their own institutional traumas.

I met Camille in 2011 when she was 50 years old. She was receiving disability benefits based on physical injuries, some of which were from assaults, and had just moved from a temporary stay at a homeless shelter to an inner suburb of Vancouver where she was renting a room in a heritage house partitioned into single room occupancy (SRO) units. Her name remained on a waiting list for supportive social housing. She hoped to obtain an apartment far from the Downtown Eastside (DTES) area where she sought out cocaine during occasional visits to friends and where a family member lived. Over the years, Camille vetted various methadone-prescribing physicians and had recently found one sympathetic about her periodic relapses. Now her visits with doctors and pharmacists constituted a minimal routine service experience. She especially resisted any form of counselling, explaining, “What could they say to help me? Is there a magic word they can tell me and then everything will be okay or what, you know? . . . So I’ll just deal with it myself, I guess.” She spent most days on her own and deliberating over her application for residential school compensation, an activity that required her to continuously reflect on her traumatic experiences but which provided hope that her economic situation would soon improve.

### ***Dealing with cumulative harms***

Camille’s experiences of residential schooling, sexual and physical abuse, addiction, and poverty speak to multiple harms accrued over many years. Camille searched for help for associated drug use and poverty-related problems, and two continual routes she took to access basic resources were MMT and income assistance. However, her combined long-term involvement with these two programs and eventual categorization as a person with disabilities had not prevented episodes of drug use relapse and homelessness while she continued to contend with the consequences of abuse traumas. Furthermore, multiple harms helped to construct Camille’s longstanding distrust of structured programs. Thus, her participation in the MMT program for almost two decades

is significant given that no other treatment supports such as mental health programs, victim counselling, addiction counselling, or residential addiction treatment appealed to her.

Camille returned to and remained in MMT because she found methadone to be a substance useful enough for her life that she committed to navigating changes in local MMT organization and practices. Camille's early negative encounters with clinic rules and her physician's heavy-handed response to her challenge to his authority resulted in her leaving the program by 1990, but she returned nonetheless when she was able. Camille's subsequent fear that treatment "would stop somehow" was highly relevant. At the time, MMT practices in BC followed federally administered rules aligning with strict Canada Drug Strategy policies, and enforcement efforts reflected the broad punitive response to chronic addiction-related activities until the mid-1990s (Fischer, 1999). Camille rode out the addiction policy shift from criminalizing and moralizing chronic addiction to medicalizing it and was still in MMT when public health authorities and addiction medicine professionals began working with the established system of drug prohibition to insert new knowledges and logics in the face of growing drug use (Roe, 2005). While MMT in BC has always been a medical initiative, when the College of Physicians and Surgeons (CPSBC) gained the authority to administer this treatment in 1996, it soon situated the program within a newly constructed public health-informed, harm reduction focus (Fischer, 1999). Programs seeking to mitigate addiction-related harms were never designed to address the myriad oppressions and problems surrounding drug use (Boyd, 2007). Still to this day, there is little political impetus to "move beyond a narrow concern with the harms directly related to drugs and drug use practices to address the harms associated with the determinants of drug use, such as homelessness, and the harms of drug and health policy" (Smye et al., 2011, p.10). Camille's bouts of homelessness likely trace back to her experiences of early childhood trauma (Fitzpatrick et al., 2013) and her story further draws attention to the multiple harms she had experienced since, and her ongoing efforts to live through and with their effects.

Camille linked her drug use struggles to institutional abuses and did so long before these connections entered public discourse and were officially recognized. Indeed, the state was slow to formally acknowledge two basic, connected facts: 1) that Canada's residential school system was a key mechanism among the laws and policies that denied

equal human rights to generations of Aboriginal families; and 2) residential school survivors' continued life problems can include addiction (Truth and Reconciliation Commission of Canada, 2012; Stanton, 2011; Marshall, 2015). Camille regarded her compensation application as an opportunity to narrate her experience of these intersecting issues and to meaningfully confront injustices. However, the process's narrow frame provided little scope for Indigenous women to speak to the affective, gendered, and multi-generational dimensions of their residential school experiences (Million, 2009). Long silenced, Camille found the application process to be re-troubling, as it concerned *all* her life troubles and related complex traumas from childhood onward.

### **6.1.2. Debbie**

Debbie grew up in an upper middle-class household with siblings and successful, doting parents. She described herself as an adopted child who became increasingly “unmanageable” as her childhood progressed. By her early teenage years, she began to use alcohol, experienced the juvenile criminal justice system, and left high school. She married in her late teens and several years later, moved to BC with her husband and young children. After her parents presented her with information about her birth mother, Debbie made further inquiries and learned that her biological parents had regularly used heroin before her birth and while she was an infant in their care, leading Debbie to believe that her drug use issues were genetically determined. She and her husband used alcohol and drugs recreationally and at one point, Debbie completed alcohol detox treatment. Following a divorce, the children remained in her care for several years, and when one of them sustained a severe injury, she began to use cocaine more often to deal with stress at home. She eventually sent the children to live with their father and her drug use increased further to include heroin use when she moved in with a new partner who introduced her to the DTES and drug injection practices.

By the late 1990s, Debbie had experienced various substance-related medical emergencies, such as overdoses, pneumonia, and abscesses, and had accessed detox programs and street level harm reduction services. This was an extended period of daily heroin and cocaine use when she was evading arrest and frequently experiencing homelessness and street violence. Once she enrolled in MMT, her participation was

initially discontinuous and she resisted her physician's expectations of her commitment and compliance.

He wanted me at one point to "give a clean sample or you get kicked off." So I would get kicked off and go back . . . I was really sick and ended up in the hospital . . . and didn't wake up for 10 days...and woke to be told that I am on the methadone and [my methadone doctor] had been there and that was a good start with him. The urge of the cocaine was pretty much gone, and just starting to try and feel normal with this methadone, I mean, and I did. So it was on and off for probably two years, off and on, off and on.

Debbie's MMT physician convinced her at her hospital bedside to give methadone a serious try as her drug cravings had faded during her stay there. Her severe health crises led to more frequent compliance with the treatment rules, but she still struggled to be a conforming methadone client, continuing to see this physician at his DTES location. She was drawn to his clinic because of his high status in the harm reduction field, even while she feared his judgments. She stated,

I was more afraid of [my first and favourite methadone doctor] because he could make or break your day. Or he could say, "That's it, you're off." . . . [He] had a lot of power, I felt intimidated for sure. And it was always, and it still is, hard to ask for help. But I think having [my outreach counsellor] there a lot was, you know, he would come in with me, to help me tell him what I needed, what he thought.

Debbie felt intimidated and was hesitant to directly ask this doctor for help, but her reliance on and emotional connection with his clinic's outreach counsellor eventually led her to commit to staying in MMT as a condition of court sentencing. This clinical relationship also prompted her extended stays in recovery homes and second stage housing. While ensconced in the latter and facing a serious addiction-related health problem, she ended use of illicit substances.

When I met her in 2011, Debbie was 50 years old and living near her children and grandchildren in a city far from Vancouver. After participating in MMT for 12 years, she had taken her last dose of methadone five days earlier and credited the substance for

helping her leave behind a severe addiction to heroin and cocaine. She related that the process of exiting MMT was lengthy and difficult:

I'm over! I've been over since the 17<sup>th</sup>, just struggling to feel good through it. No, I'll never go back to that. There's, [pause] I don't know. Just proud of myself, it's so horrendous to get out of it. I would never put myself back in it again because I wouldn't live through it. No. I mean if you go into methadone and you're around those kinds of people, that's what you have in common and away it goes again. You could easily stumble and fall right down the hole. I'm looking forward.

Debbie also resolved to continue distancing herself from “those kinds of people,” namely, others who also faced substance use issues. This was an approach she learned through participation in addiction treatment programs and 12 step meetings on her “long road” to recovery. Now, “looking forward” required moving forward by mustering her energies and locating supportive services. She was living on disability benefits, experiencing long-term health problems, some of which were addiction-related. She also struggled to make ends meet and searched for part-time work to supplement her disability benefits even though she had a thin employment history and only a few service contacts for help with job applications. By 2011 Debbie had long distanced herself from drug use environments, had been a long-term client of a publicly funded MMT clinic, and had recently secured a social housing apartment. Together these circumstances helped her feel confident enough to go through the steps of leaving MMT. At our first meeting, Debbie described herself as fiercely independent as a teen and young adult, and her narrative shows that she was again drawing on this quality to navigate primary health care and to search for ways to increase her inadequate income. A number of challenges remained, including her need to shed the addiction-related identities that interfered with her search for comprehensive health care, and her efforts to tackle persistent poverty and growing isolation. She officially remained an MMT client because of medical monitoring and in following months she found her MMT identity was lingering much longer than she expected or preferred.

### ***Navigating the “at risk” label***

Debbie's intersecting experiences of MMT and other services began when she was living in the DTES neighbourhood. Several things were happening simultaneously in

the area. Vancouver's implementation of the Four Pillars Plan in 2001 sought to reduce public disorder, revealed DTES politics was a "struggle about space," and involved ongoing mainstream anxieties about the visibility of disordered bodies, leading to health and policing regulation (Boyd, 2008, p. 21). BC's harm reduction initiatives had by then "matured" into professionally controlled addiction health programming, especially following the 1997 HIV/AIDS emergency that signalled new policy and service intent to address "at risk" groups (Roe, 2005, 2010). To professionals, Debbie's DTES-associated activities, such as injection drug use, periodic homelessness, and addiction-related health problems especially marked her as an "at risk" client. Furthermore, when the province's medical authority gained administrative control of MMT in 1996, it softened some MMT rules and regulations for both clients and physicians (Fischer, 1999). These developments together facilitated Debbie's early, frequent returns to this treatment in the late 1990s and access to harm reduction supports in the 2000s. Her early access to MMT seems less hindered than Camille's, and yet she too was "intimidated" by her physician's significant power to influence her everyday life (The VANDU Women CARE Team, 2009). This raises questions about how clients labelled as "at risk" can struggle to communicate their needs. Although front-line workers, such as outreach workers, can mediate during service interactions and can translate a client's requests to align with professional meanings, there is no guarantee of such help in the absence of public funding of such supports for MMT practices. In general, MMT experts and policies fail to comprehend and formally acknowledge client narratives, and favour influential professional knowledge rather than lay knowledge of this treatment (Järvinen, 2014; Järvinen & Miller, 2010; Ning, 2005; Reist, 2010). Debbie's encounters with silencing practices continued throughout and after her MMT involvement.

Debbie had found methadone meaningful for literally improving her life chances in a harsh drug-using environment, and while her trajectory through MMT and other harm reduction programs began in the DTES, it did not end there. Her most severe drug-related medical problems closely preceded MMT entry, and some of them continued for years after. By the age of 50, she was also dealing with additional illnesses unrelated to addiction. Debbie remained in MMT for eight years after ending use of illicit drugs, and had sought out additional types of short-term and long-term treatments and programs in various areas of the province. Just as Debbie entered MMT with the general intent to

improve her physical and social situation, she left this treatment in 2011 for these same broad reasons, and MMT entry and exit were both difficult transitions. Her struggle for over a decade to be heard and trusted in various service settings had more recently implicated an MMT client identity that especially mired her efforts to obtain further help for health problems. Distancing herself from an “at risk, drug user” identity was not just a personal recovery strategy (Zajdow, 1999), but required formal recognition that she was no longer associated with illicit substances or treatment and was deserving of suitable medical treatment. Ning (2005) argues that clients draw on alternate meanings and practices of recovery to navigate the MMT system, and “what constitutes a “successful” treatment is subject to various interpretations” (p 373). Debbie’s story concerns reconstitution of the woman methadone client, and her experiences leaving the system highlight how women wishing to shed their MMT identity can come up against powerful texts and practices, as well as institutionalized notions of progress.

### **6.1.3. Renee**

Renee spent her early years of childhood with siblings in a working-class, lone mother household. Her mother had struggled to support her family and had sometimes turned to income assistance. The man her mother later married provided the family a reprieve from poverty but he secretly preyed on Renee and another child relative, sexually abusing them over years. Renee left school in her early teens and began working in the food service industry for minimum wage, then married. Following the birth of her daughter, she divorced her husband because of his emotional abuse and severe alcoholism. As a lone mother and without the father’s financial support, she turned to income assistance, then eventually returned to low-wage employment. Moving between service employment and income assistance several times, Renee struggled to support her child and herself on low income. At times, she accessed employment or poverty-related services, but she had not pursued formal mental health counselling for her experiences of gendered abuse.

Renee recreationally used drugs during periods of her adult life. She described how in her 40s, she was caught unaware one evening when she smoked heroin for the first time with her daughter, her cousin, and her cousin’s children at a family party. Her physical dependence on the substance developed over a few weeks, and after she and

her daughter moved in together, their heroin use accelerated over several months, and Renee returned to income assistance. Through casual drug use, Renee developed a daily heroin dependency over a short time. Two years later, her poor health prompted some family members to intervene:

I would say I was pretty close to my, to my death. I was just very, very depressed . . . , I mean, I was skin and bones . . . , actually Christmas Eve, my mom and older sister came and picked me up and when they picked me up that day, I never went back.

Never going back meant she did not return to her housing situation nor did she return to such a debilitating state of addiction. In further reflecting on these events, she noted, "I think I was pretty good. That's why it's sort of, you know, like what the hell happened here? Even [the young adults in the family], they're like, "What happened to us? Why did we get into this stuff?" Her enrolment in MMT a few years later was also a shared, intergenerational event:

I started at, I think it was 16 ml. I don't really think I should have. It seemed like it was a fad or something, like everybody was sort of going on it, and . . . I just sort of went on it, I should've never went on it . . . because I don't really think I was that bad into doing the heroin. Like, [my cousin] and a few people got into it. . . . So I thought oh, okay. Well, I might as well do it too.

Renee followed family members into MMT because it seemed at the time to be a popular and viable alternative to problematic drug use. She then moved in with a new partner who used cocaine recreationally, and although she strived to keep drugs and drug paraphernalia out of her sight, to follow MMT rules, and to display stability, she continued to smoke heroin and rock cocaine occasionally.

When I met Renee in 2011, she was 55, had been in MMT for eight years, and was on income assistance, categorized as a Person with Persistent Multiple Barriers (PPMB), and she was still sharing the apartment with her partner. It was a typical morning, and she was keeping close to home after her walk to a neighbourhood pharmacy for her daily methadone dose. Her fear of the local drug scene "out there" literally and figuratively

kept her close to home, although she was in daily contact with her adult daughter, who herself periodically ventured back into drug use. Renee reflected on why she felt comfortable revealing that she used illicit drugs with members of her immediate and extended family:

I've always been open about what went on and whatever. I don't really hide it, . . . I'm really glad that I had, not glad, those maybe aren't the words, but I'm glad that I experienced it. . . . I can understand why girls will sell themselves and, you know, things that people do. It's like wow, I mean you've really, really got to be in other people's shoes, you know, before you open up your mouth. . . . I know people, a lot of people are very secretive about their life and if they do, they can't admit. Like me saying my [daughter Alexa, pseudonym] has prostituted. A lot of people would never let anybody know that. I'm just really, hey, I think the truth is good. . . . Yeah, when you break down, it hurts, it hurts a lot. . . . Maybe that's how I survived, by maybe not holding it all in.

By candidly speaking truths about family drug use from her experience, Renee hoped to counter some moral judgments and silences that surround drug use subjectivity. Renee's outspokenness was not meant to "out" family members but was about conveying knowledge and regrets about life developments in the context of caring for herself and loved ones. Through sharing drug-related experiences, she had insider understanding of women's local drug-related problems and directly witnessed her daughter's vulnerabilities associated with sex work. Renee did not identify as a person who chronically used drugs, but as a mother and grandmother, and her mothering practices included emotional and practical support of her closest family members when possible. However, she had few material resources to share with them as she was struggling to make ends meet each month.

Renee felt emotionally and physically unable to pursue employment, job training, or addiction-related services other than MMT. She was experiencing surveillance as a client of both the MMT and income assistance systems, and while the programs supported her in minimal ways to get through each day, she had not found them particularly caring or helpful over the long term. Her MMT physician, who was also her primary health care provider, had been generally supportive but over time became increasingly patronizing

and critical of her behaviour. She no longer agreed with him that she needed pharmaceutical help for depression, and over the course of the interviews, she stopped taking the anti-depressant. She still relied on her doctor's supporting documentation for maintaining PPMB status which authorized her need for time to privately deal with traumas, as well as complex and at times, re-troubling family dynamics.

### ***Care and surveillance***

Renee and her relatives entered supervised treatment when enrolment in MMT in BC was rising at a considerable rate. Since 1996, treatment became increasingly available with an increase of authorized physicians in BC, from 147 to 398 in the period 1996–1999 (Fischer, 2000). Correspondingly, between 1996 and 2006, the number of MMT clients had more than tripled, from 2,827 to 9,601 (Reist, 2010). Renee's narrative suggests she was swept up by family and local movement into MMT, which on the one hand, resonates with Agar's (2002) observations of group effects surrounding drug use. On the other hand, her experience of MMT is particular to her social circumstances and identities, and also illustrates her agency (Järvinen, 2014; Ning 2005).

Renee, like others before her, became discouraged by the extent of surveillance she encountered there (Bourgois, 2000; Friedman & Alicea, 2001; Järvinen, 2010; Reith, 2004) and MMT is a notable example of the addiction field's use of "technologies of suspicion" that range from lab testing for evidence of drug use to policies and practices which institutionalize distrust (Campbell, 2004, 78). However, the meanings Renee gives these experiences are particular to her biography and social circumstances. While methadone reduced Renee's desire for heroin, it did not eliminate her cocaine dependency, and she remained a "stable user" and over time became a "dissatisfied customer." Her MMT experience illustrates how "broad cultural narratives, social expectations and clinical judgments effect changes to clients and professionals, and so too do the activities of clients" (valentine, 2007, p. 511). Clients experience MMT in relation to what is deemed possible in culture and normative practices. However, they also carry other identities (some more fluid than others) with them into treatment, which can bear on outcomes.

Renee's identities as a mother and a client of both MMT and social assistance intersect. For example, as a mother, she sought to model stability for her daughter by decreasing drug use, even if she reluctantly continued with MMT to do so. Renee also remained on income assistance because she was unable to work but found the system's rules constituted another form of surveillance in her life and were difficult to circumvent. As an MMT client, she was unwilling to change MMT physicians for fear of losing the support of PPMB status, which afforded her some time to deal with past trauma and associated depression, and with familial stresses. While her problems were circular and sometimes disempowering, her reluctance to be medicated for depression and her desire to leave methadone treatment suggest active resistance to medicalizing of her troubles.

Health experts view client resistance to medication as a problem (Bourgois & Schonberg, 2009), as non-compliance and normatively associated with the poorest neighbourhoods and surveillance (Elliott, 2007). The most "service-resistant" can actively reject not only the medication but also the categorization, the identity, and the service path it implies (Luhmann, 2010). I suggest there are multiple reasons why marginalized women reject or take up licit pharmaceuticals. From the perspective of women who struggle to survive in harsh social conditions,<sup>27</sup> psychiatric medication can signify weakness and reveal where the social safety net fails (Luhmann, 2010). Renee's narrative suggests she was both "label-resistant" and pragmatic; she worried about how others viewed her and she found that anti-depressants and other medications made her feel "unhealthy" and mentally and physically diminished. Her efforts to reduce or eliminate medical doses illustrate the politics of care at the specific site of medical treatment, as her doctor typically disagreed with her decisions. The way she drew on support from family and provided it in return also involve a politics of care. Renee's additional identities, as a grandmother, partner, and MMT client converged as stark surveillance and care issues, which contributed to her desire to move out of a state of limbo and to her ambivalence about leaving MMT.

<sup>27</sup> In many respects, Luhmann's (2010) description of Uptown as a "service ghetto" for de-institutionalized patients with mental illness echoes popular descriptions of the DTES area, albeit a location less characterized than the Vancouver neighbourhood as an open drug use locale. Unlike Camille, Debbie, or Sarah who had frequently visited or lived in the area at some point in their adult lives, Renee was never herself involved in the DTES. While she preferred to spend time with extended family at or near home, she often referred to the dangers of the neighbourhood due to her daughter's drug use experiences there.

#### 6.1.4. Sarah

Sarah was proud of her immigrant, working-class background, that she pursued job training at age 16 and eagerly entered the labour market soon after. She began using illicit substances as a teen in social settings and to cope with memories of childhood trauma. There was also a strong relational component to her drug use history:

Sarah: My life?

SP: Well, let's say, other types of drugs, can you remember back?

Sarah: It was mostly pot and then acid and then MDA, and then the coke. And then [inaudible] how did that work? Yeah, it was pot, and then the hard drugs, and then I ended up being with somebody who sold coke. And I was 19 or 20. And I was with him for 13 years. And then I was on my own again and met Ian [pseudonym].

For Sarah, being in a spousal relationship held strong meaning for her. After leaving a long-term, emotionally abusive relationship, she met Ian and when they moved to the BC Interior region in the early 1990s, they sought to distance themselves from most acquaintances and the drug scene in Vancouver. In their new locale, Sarah worked alongside her partner at the same manufacturing business earning union wages for close to a decade, but they lost their jobs when their employer relocated to another province. The couple's search for work or training programs soon became frustrating and further complicated when Ian developed a serious health problem that made it difficult for him to do physical work. By 2006, after exhausting employment insurance income, temporary formal and informal employment opportunities, and depleted their savings, they became regular income assistance clients.

Sarah and Ian have long employment histories, and throughout their work years, they concurrently used and sold illicit drugs in a functional way. Sarah explained what led her to MMT:

Well, because of our drug problem. But we're getting better, like we're hoping soon to be able to get some help. It's not the heroin, it's the coke. . . . But we're just about got that under control, so. . . . I only started doing heroin about three years

ago. And it was like once a year, one thing a year, type thing. And a few times previously, but nothing before. It was in my older age I did it. Which is, seems strange to a lot of people.

She later clarified that while she had long preferred to use cocaine, she began to use heroin occasionally when she was in her 40s and the practice grew into an unaffordable daily problem by 2008. The couple had been managing a growing physical dependence to heroin while selling the substance to help them pay for it. At the same time, they were encountering increased pressure from the income assistance system to find work, and along with drug use activities, this situation pointed to their fears of increased institutional surveillance. These converging troubles prompted them to seek out MMT. Unable to locate a methadone physician in their area, they began treatment in another city, travelling there three or four times during the month.

We finally said, we've got to go in and see the [local] doctor. And we didn't want our family doctor to know and when we did tell him, he said, "Why didn't you let me know earlier?" Because it was hard to get a doctor, a methadone doctor at that time because there weren't that many. You either had to go to [another city in the BC Interior region]. . . . Like you can't afford that either and if you have to go once a week, that's even worse . . . , so we finally told our doctor and then it worked out good because he knew that methadone doctor. He said [to him], "I've got a couple patients of mine that need you and they're good patients."

Travelling to clinical appointments became financially untenable, and they eventually appealed to their family doctor who immediately referred them to a local methadone-prescribing physician and advocated for them. Once initiated, MMT provided Sarah some respite from worries about the economic and social costs of their drug use. The program also helped her to feel well enough to work alongside her husband in his low-paid, "under the table" contract work before his health further deteriorated and he gained formal disability status.

I met Sarah in 2011 when she was still living in the BC Interior region. She was 52 years old and shared a modest home with Ian who was now chronically ill. They had been quietly living in their semi-rural surroundings for about 20 years, occasionally visiting

friends or family members when they could afford to. Few people in their small social circle knew that they had dealt substances in the past, used illicit drugs, or began MMT a few years earlier. Given that she and her husband worked in the same industries for years, that their drug use co-escalated following job loss and they entered maintenance treatment in tandem, it is not surprising that she often chose to use the word “we” to narrate her story. Sarah primarily identified as a spouse and loyal employee whose substance use was “off and on” and now mostly under control. Over five interviews, while her husband was in and out of earshot, Sarah related what it meant to live on family disability benefits and how she struggled to find work and training. Ian was sometimes lying ill in the bedroom, watching TV, or milling around the home doing chores. Now that Ian was bedridden some days, Sarah assumed the essential caregiving activities associated with his illness. She was also travelling often to the local employment services office to scroll through job listings there. The family received about \$1300 a month in disability benefits and Sarah was searching for a formal way to increase their income, with the target of an allowable \$500 employment income for the family.

At one point, Sarah made plans to apply for bi-weekly periods of work at a Northern BC work camp where she expected to make decent wages before retirement age, a plan compromised by her lack of compliance with MMT rules. Her physician would not give her permission to carry methadone doses home for more than the occasional day or two, let alone for “travel for work” periods. Sarah was left to apply for jobs in their immediate vicinity where unemployment is moderate to high, depending on the season. While navigating clinical surveillance, Sarah sometimes argued back when her doctor reproached her after mandatory random clinical testing revealed traces of cocaine in her body. Unlike her doctor, Sarah found it unrealistic to maintain absolute sobriety given their histories, financial difficulties, and the additional stress of searching for scarce work and training. Her physician did not force her to leave MMT following her occasional substance use, but her reasons for cocaine use were not collaboratively explored during treatment discussions.

The family could not keep pace with expected or unexpected expenses, and it financially “made sense” that Sarah and her husband travelled to the same doctor for methadone prescriptions, shared drugs, and some medications. The combination of MMT surveillance, difficulties making ends meet each month, frustrated job searches, and

caregiving activities contributed to Sarah feeling tired, sometimes down and out for days, and she resented that others were “making it” while they struggled. She worried about what would happen to them both if she became sick or if she obtained a job, what extra energy that would require from her. At the same time, she reflected that taking on a steady part-time or low-paid full-time job would likely require that they move to a more populated area which could set them back at least temporarily as they had no money to pay for relocating expenses. Overall, her expectation that MMT would help her recover their standard of living had not materialized.

### ***Diminishing quality of life and agency***

Research shows that MMT clients’ hopes for normative participation in society are not often realized when additional problems, some related to this treatment, surface or resurface to perpetuate their social, economic, and political marginalization (Bourgois & Schonberg, 2009; Friedman & Alicea, 2001). In Sarah’s case, her experience of increasing heroin use and economic and political marginalization in mid-life partly reflect structural changes in the province at the time. One could suggest that geographic moves and MMT involvement checked an imminently downward spiral, but these are shown to have had limited benefits for Sarah’s security. Following the loss of their unionized jobs in 2000, the couple turned to low paid short-term formal and informal work, which, along with continued drug use, kept them economically vulnerable. Work was becoming harder to find due to converging national and provincial restructuring policies that led to sharp rises in poverty in BC since 1999, affecting the most vulnerable citizens:

The decline in social welfare was a result of decisive government policy (both federal and provincial) that affected not only public support for the general population and those in poverty, but also lessened the ability of a substantial portion of the population to stay out of poverty through paid work. (Cohen & Klein, 2011, p. 61)

Their economic situation spurred the couple to enrol in MMT. Their move into a local MMT program seemed opportune considering the continued undersupply of methadone-prescribing physicians in locations outside of the largest cities in BC, which limits access

for citizens living in rural or remote areas<sup>28</sup> (Reist, 2010). Sarah's MMT entry reveals that fears about loss of privacy and being stigmatized can contribute to hesitation to seek out local addiction health resources, such as MMT. Overall, her experience shows she made extra efforts to find treatment and stay in the program. Once secured, MMT involvement helped the couple quickly curb illicit drug use and temporarily supported the informal work activities that the family relied on for additional income. Sarah regained some economic security through MMT, but only temporarily.

MMT is rife with contradiction (Fraser & valentine, 2008); it is a health-oriented treatment yet has been heavily promoted as a prescription for addressing social troubles, such as those arising from unemployment (Dole & Nyswander, 1967). According to Fischer et al., "there is neither a pragmatic rationale nor good reason to expect that biochemical treatment for opioid dependence, as provided by MMT, will produce 'social betterment' for individuals or populations as socially marginalized or disadvantaged as most illicit opioid users" (2005, p. 7). Sarah's narrative presents a nuanced picture of the link between economic disadvantage, drug-related troubles, and MMT involvement. The couple's work routine could not be sustained, especially as her husband developed health problems, and when Sarah's renewed search for formal employment or training encountered dead ends, she could not envision an improved financial situation given the severely limiting social supports they received. Like the four other MMT participants interviewed for this study, Sarah found the treatment useful for curtailing drug use and additionally found her prolonged poverty debilitating.

Sarah's narrative is a critique of the structures and institutions that contributed to her poverty and related social problems in fundamental ways (Krumer-Nevo & Benjamin, 2010). Her discussions about drug use continually returned to matters of employment, security, and loss of control. First of all, older workers and/or those who have experienced critical life events are not well served by policymakers who define exclusion against labour market participation; these citizens would benefit more from policy attention to quality of

<sup>28</sup> Recent figures show that the highest increase in client numbers is in the BC Interior Health Region (Office of the Provincial Health Officer, 2015). A recent MMC document states: "The lack of prescribers in rural British Columbia concerns the committee and the Ministry of Health. New prescribers from rural areas are therefore particularly encouraged to apply for an exemption" (College of Physicians and Surgeons, 2015).

life (Levitas et al., 2007). Sarah's case fits this scenario. Secondly, more specific to MMT, Fischer et al. (2005) suggest researchers and policymakers must re-think the basic premise that this treatment leads directly to social inclusion; these authors call for standardized quality of life measures in their support of creating different therapies for different groups. While Sarah's diminished quality of life is measurable in some ways (e.g., loss of income), it is immeasurable in other ways (e.g., loss of agency). Unable to locate resources amid diminishing public supports, she became discouraged. Sarah's narrative helps to illustrate the tensions between the benefits MMT can quickly provide to women who lack immediate options and the ways in which MMT might exacerbate deep exclusion by reducing women's agency.

#### **6.1.5. Mariel**

Mariel grew up in a middle-class household in BC. She described herself as "rowdy" during her teen years when she was with friends and explained, "I smoked pot. Drank. We were cowgirls. We were rednecks, . . . skipped out of school, went horseback riding. We didn't do school. We were getting married and having babies. . . . Yeah, it was our generation." While in her 20s, she married a man whose child she helped raise along with the two children who were born after the marriage. The husband physically abused Mariel and two of the three children in the blended family, and she eventually divorced him. After a prolonged battle for child custody, her drug use increased and her lifestyle changed. As she states,

I've always been around drugs, and I did them. And when my kids went to go live with their dad, I'd binge. I got addicted to heroin and coke, cocaine's more psychological. And so, I learned a lot about the drug world and people. . . Like I had a big habit, so and that's when I stopped doing it from day to day type thing and just chipped once in a while. Didn't get rid of the friends, right? Every once in a while, go on a binge, and I was just lucky when I didn't die.

One particular overdose experience led her to reflect deeply on her life, and she concluded that her relationship with drugs and with others who use drugs was fateful and sometimes near-fatal.

In 2009, an unexpected financial windfall led again to months of frequent drug use with a new partner in a different part of the province and the relationship ended after he brutally assaulted her. Mariel moved between a transition home and city shelters, and then, experiencing physical and financial problems, she returned alone to her “more passive” hometown and to regular income assistance. Mariel sought out the methadone maintenance program in 2010 when she was experiencing weakness and pain from illness, still recovering emotionally from the assault, and withdrawing from a year-long period of steady illicit and licit substance use. She was searching for some way to be physically and mentally comfortable on her own terms:

I started taking the methadone myself because when I was in [a different city], I wasn't on Dilaudid anymore because the doctor here couldn't write triplicates. He was getting in trouble with the Surgeons.<sup>29</sup> So, he couldn't put me on because he had no notion of me being on, no [suspected illness] showing up in my CT scan. There was no reason to put me on Dilaudid, even though I had been on it. And so I got through Christmas. I'm not going to detox myself off of Dilaudid, after ten years, through Christmas with all these people in and out? No. So, I took methadone myself. And then I just told the doctor I have to take methadone.

Unable to renew a prescription of Dilaudid (hydromorphone), she first secured two bottles of methadone from a friend then sought out an MMT physician. She was aware of the growing medical use of methadone for pain management and approached a physician asking for methadone for her pain.

[In January], I said I wanted to go on meth for the pain. And he said, “Yeah, you can do meth.” And I said, “Okay, put me on it” . . . and I said, “As long as I don't have the pain, I don't care,” right. And he said, “Okay, we'll see how this works.”

Mariel began the program on a daily dose of 40 ml and reflected on the dosing regimen that required her to take her dose at a pharmacy every day:

<sup>29</sup> She is referring to the College of Physicians and Surgeons of BC.

Yeah, they treat you pretty good at the drugstore, you go off on the side. I guess some people are embarrassed about taking it . . . they kick you around the corner. . . .and I said, “No way . . . I don’t give a shit, just give it to me.” Like I’m there for a reason. All different reasons, right. You can tell people that are rode hard and put away wet, there’s still junkies that are in there. I can understand that you want to hide them around the corner.

The pharmacist can treat clients fairly well, but they can also “kick” them around the corner. In comparison to some of her other experiences surrounding drug use, Mariel found that lining up for a methadone dose in full view of all pharmacy customers was a relatively tame experience and a small price to pay for physical relief.

I met Mariel in 2011, a few months after her enrolment in MMT. She was living in her friend’s home in the outer suburbs where she rented a room, was visited by her two biological children who were now young adults, and her poor physical state and her poverty often kept her close to home. She was on a waiting list again for social housing and was planning to apply for disability benefits. She also planned to travel again once she could pay her auto mechanic to repair her car. Access to a vehicle would have allowed her to remove herself more quickly from stressful or unsafe places and social situations. Overall, her living situation and negotiated travel arrangements kept her dependent on a few friends for her many medical specialist appointments and daily trips to the pharmacy. A few months later, she moved to an unknown location in another city and I lost contact with her.

### ***Navigating multiple problems in pain***

Mariel’s story addresses material opportunities and restraints, embodied struggles, and physical and emotional extremes of using substances over time. Her narrative also reveals her ambivalence about MMT involvement. She pragmatically approached the treatment aware of the growing clinical prescription of methadone for pain management and requested methadone for that purpose. While she sought methadone for opioid withdrawal as well, she did not articulate that intent during treatment entry. This was possible because the differences between methadone as a prescription for drug dependence and methadone as an analgesic have become increasingly blurred. Mariel’s

experience raises questions about what has become possible in MMT. As Helen Keane (2013) argues,

liberalized opiate prescription has made the distinctions between the different uses and users of methadone more difficult to maintain. The rise of prescription painkiller abuse as a high profile public health problem has promoted a new vigilance about opiate use even among those identified as genuine pain patients. Categories such as “opioid misuse,” “problematic opioid use” and “aberrant drug related behaviours” are now discussed alongside the more extreme pathology of addiction. Such categories of problematic use blur the medical/illicit divide and suggest a continuum of uses and misuses which can occur among all users. The recognition that chronic pain, including severe pain, is prevalent among MMT patients also undermines any understanding of pain and addiction as mutually exclusive. Perhaps most importantly, the experiences of suffering reported by these patients are not easily divisible into separate categories of disorder. (p. e23)

This development suggests increased medical surveillance of a medically constructed problem, but also reveals MMT’s fluid practices and meanings (Fraser & valentine, 2008). Moreover, Mariel drew productively on the “analgesic” meanings of methadone to obtain relief and distance herself from a “drug user” identity. While she did not strive to “recover” a life lost through substance use, such as Debbie sought, or wished for employment as in Sarah’s situation, Mariel navigated her MMT entry partially on her own terms and gained some relief from trauma and pain.

Her narrative suggests she found MMT provided her with physical benefits, and at the same time she experienced continued health problems and struggled to gain back some independence by seeking out a few basic formal and informal supports, such as income assistance, housing, and transportation. These activities required her to actively manage her identities (Goffman, 1963) and she narrated multiple instances in which she ignored or challenged drug use discourses in the process. Reith (2004) notes the continued presence of “addict” identities amid prudentialism, specifically arguing that “multifarious identities” arise through self-definition or serve as discursive “markers” for the “public” to avoid in risk society (p. 295). A convergence of discourses related to drug use increases individuals’ self-vigilance and instigates the need “to keep watch on

subjective states—to continually monitor one’s freedom” (Reith, 2004, p. 296). Mariel was certainly “watchful” about opportunities and drug use environments. Furthermore, she expressed resistance to categorization in particular, and how this affected her access as an MMT client to health and social supports over the long term is unknown. Lastly, it cannot be taken for granted that Mariel remained in MMT after I lost contact with her.

## **6.2. Cumulative Social Suffering**

Camille, Debbie, Renee, Sarah, and Mariel turned to MMT when they could no longer afford their opioid use and were experiencing physical distress from withdrawal. Their full participation in early phases of treatment was not constant but “off and on” and involved the state of starting to “feel normal” (Debbie; Sarah). Rather than strictly adhering to the MMT regime in those early months or years, they turned to illicit substances at times of increased stress. For instance, drug relapses sometimes occurred while participants navigated justice system and income assistance demands, when they were experiencing serious health or family problems, or when struggling to find formal or informal work because of money shortages. The unaffordability of substance use also precipitated turning to MMT in the expectation that service cost for methadone prescriptions is covered by the state.<sup>30</sup> While MMT involvement can follow problematic opioid use, its link to various physical, financial, and social vulnerabilities requires in-depth exploration of the social environments, forces, and policies that perpetuate sheer misery (Bourgois & Schonberg, 2009).

While poverty was a major struggle for the participants in this study, their accounts also show they experienced sickness and violence. MMT entrance also coincided with times they encountered multiple triggers to use and were experiencing converging social and personal struggles, as Camille, Debbie, Renee and Mariel’s situations especially show. Triggers included pressures from partners or family members, risky street locations, and being assaulted, all of which illustrate severe social and physical vulnerability. Camille’s experience of multiple harms especially points to how traumas can accumulate

<sup>30</sup> Until July 2016, persons in MMT in BC and on income assistance or disability assistance had a portion (\$18.34) of a \$60 methadone fee removed from their cheque each month.

in life, which factor into client experiences. As the vignettes presented earlier in this chapter show, experiences of intersecting and accumulating social problems constitute further hardship and involve multiple social forces. Injection drug use, homelessness, and indigent poverty especially signify severe social suffering and likewise implicate numerous broader influences that perpetuate “race,” class, and gender inequalities (Bourgois & Schonberg, 2009). Participants’ narratives show that their move into MMT was closely connected to their experience of structural constraints.

As this chapter demonstrates, the five women interviewed for this study have diverse social histories and also distinct substance-related trajectories, social circumstances, household compositions and, most notably, diverse experiences of and insights about MMT. Overall, their complex experiences show that harms accumulating in their lives over time include, and were not limited to, illnesses, abuse and injuries (related and unrelated to drug use), and longstanding poverty. Thus, social troubles intersected in many ways and partially, but strongly implicated restructuring policies and processes. In Canada, women and other politically marginalized groups have disproportionately experienced problems arising from welfare state restructuring and income polarization (Rice & Prince, 2013; Morrow, Wasik, Cohen, & Perry, 2009). Indeed, the participants’ experiences of job loss, dead-end job searches, and meagre income assistance or disability benefits were significant generators of lengthy poverty-related experiences. This study raises questions about the construction of the gendered methadone client in the context of MMT-related addiction trajectories and the everyday politics of supervised exclusion and finds their lives were constrained in several ways. At the same time, Camille, Debbie, Renee, Sarah, and Mariel also displayed agency; for instance, in pragmatically turning to MMT (Keane, 2003), they reduced their daily distress arising from increased opioid use. While not initially constant, early efforts to participate in MMT helped to ward off sickness and to gain physical benefits. MMT clients navigate, withdraw, negotiate, and speak out, sometimes in subtle ways (Järvinen 2014; Ning, 2005). In the next chapter, I explore the ways that women’s MMT participation and overall clientization involve complex embodied experiences of a politics of care.

## Chapter 7.

### **Women's Experiences of Clientization and the Politics of Care in MMT and Beyond**

One of this study's objectives is to broaden empirical knowledge of 1) MMT organization and practices in BC; and 2) women's various client experiences as they move to and through MMT. Another objective is to build theory to explain how addiction-related marginalization can persist. Chapter 5 examined MMT texts and practices that display multiple interpretations of clients' needs and rest on risk management strategies. Chapter 6 presented five women's life stories and explored their drug use trajectories and MMT involvement amid shifting policies and structural constraints. Personal narratives show how women participants at different stages of MMT involvement were daily and yearly dealing with social troubles, such as poverty and trauma from violence or other abuse. This chapter continues to answer the following questions: In what specific ways do the participants experience MMT and overall clientization? How do these experiences reflect the process of supervised exclusion? This chapter compares and contrasts Camille, Debbie, Renee, Sarah, and Mariel's narratives according to analytic themes. I first explore their experiences of methadone as a substance and then MMT as a system, both of which are focal points for analyzing the meanings, practices, and identities constituting women MMT clients. I next examine the five women's experiences of formal social and health supports, such as primary health care, and income assistance and other services and programs targeting low-income groups. These sites further reveal aspects of the clientization process. For example, participants narrated how they balanced obligations with their need to act in their best interests. Lastly, I examine informal supports as "give and take" resources that sometimes added to overall obligations.

The clientization process can involve competing interpretations of troubles. According to Järvinen (2014),

institutions define and clients conform. However, things aren't this simple in practice. Some clients' perceptions of their troubles match those of the human service organisations. Others work to adapt their narratives to the institutionalised

stories of their experience provided by organisations. Still others refuse to adopt a specific institutional narrative about themselves and their troubles, insisting on their own interpretation, sometimes with the consequence that the human service organization in question cannot help them. (pp. 50–51)

Thus, clients' interpretations can echo institutional narratives or diverge from them. Here I explore how participants understood their troubles in light of the complexities and contingencies affecting their treatment outcomes, and examine the tensions within each participant's interpretations. My study adds another dimension as it explores participants' ambivalence, which is a distinct response to supervised exclusion. First of all, during interviews the study participants often spoke of the substance of methadone and the system of MMT as separable phenomena and the next sections explore participants' perspectives of each.

## **7.1. Experiencing the Methadone Substance**

Methadone is positioned on a continuum of marketable drugs that can be prescribed, traded, shared, stolen, and coveted (Bourgois & Schonberg, 2009) and clients ascribe to methadone a low status among meanings of licit or illicit substances and accordingly contest aspects of its prescription (Bourgois, 2000). This section explores what this substance means for participants in the context of their lived experiences (Ettorre, 2004). Campbell (2007) notes that "meanings attributed to drugs differ among social contexts, which partly shape the experience of drug effects and the interpretation of seemingly physiological sensation" (p. 10). The five women especially shared their knowledge of what being on methadone through treatment "felt like." Methadone gave Mariel, Debbie, and Camille some near-immediate relief from sickness, pain, and exposure to violent environments.

I used methadone as the way to stop the other things, to stop, as they say, to stop the insanity and just concentrate on not being sick today. And working on how that feels . . . and I totally believe if you work it, it works, because it does. (Debbie)

It helps me to be good. I'm not running around looking for money for heroin through this methadone. Thank God for the methadone, in more ways than one! Not only for my heroin sickness, but for all the aches and pains I would have in my body if it wasn't for the methadone. If I was to get off the methadone, I would be more on painkillers and stuff like that. (Camille)

Like Debbie, Camille valued the substance over the long term. Both women perceived methadone to be beneficial in several ways, especially noting the physical benefits of methadone and the relief from having to regularly search for money for heroin. They also noted that the substance could "mask the pain" of health problems. For Renee, Sarah, and Mariel, methadone left them fatigued and unmotivated. Mariel noted, "All I do is just sleep on it. How long! I'm tired. It's just terrible." Sarah noted,

You have no ambition to get up. Like I just sit here. You know, like for me to get up and go talk to [my doctor], like I can't be bothered. It's weird. It's very strange to understand how a drug could do that, so physical. It's scary almost.

Renee further specified that methadone had "caught her" like other powerful substances and that it numbed her emotions. MMT clients have questioned the physical effects of methadone over time (Bourgois, 2000; Fraser & valentine, 2008; Friedman & Alicea, 2001; Järvinen, 2014; Reist, 2010).

You know, I think like if a person really isn't fooling around with drugs anymore, like why don't they try to get us off this stuff? Like there's got to be a better way, instead of being on this for the rest of your life. Because I think once you do it too long, you know, I think it just gets right in your bones and everything, and then you can't really get off of it. (Renee)

Renee feared lifelong dependence on the substance and Sarah found the substance continually felt foreign; of the participants of this study, they were the most critical of methadone. The five participants regarded methadone as a unique substance but also as a medicine situated along a continuum of pharmaceuticals that are powerful and potentially life changing in their effects.

Whether dispensed through a pharmacy or diverted to the street, methadone has value as a substitute for opioid use and as a pain reliever, and it is prescribed to treat addiction health clients or general population patients. These two formal streams of clinical use have unstable boundaries (Keane, 2013). As the newest MMT client among the study participants, Mariel approached a physician who was licensed to prescribe methadone for pain as well as for opioid use and she chose to emphasize her need for pain management. Likely the attending physician would have helped her regardless of her disclosures or lack of them because medical testing and clinical diagnosis remains the conclusive official means of determining evidence for MMT participation. However, Mariel found methadone's increasingly blurred uses generated an opportunity to primarily self-identify as a medical patient rather than a person who used illicit drugs, even as her involvement in MMT involved controls and introduced professional scrutiny of her drug use. Methadone's emerging meanings amid the recent extensive prescribing of opioids in Western society could animate moralizing, discriminatory medical responses to MMT clients' pain issues (Keane, 2013). As Mariel noted, "It's got a lot of stigma, you know, because if you're on methadone, they're just starting to use it as pain medication, so the stigma, it's like you're an addict. It's like anything."

Another consideration is that MMT client status has "bio-value" for inner city research (Elliott, 2007). For example, being "stable" on methadone (which means a dose does not change much and the client follows MMT rules) helped Camille and Debbie occasionally barter their participation in pilot research projects for access to specialized health care, or for small honorariums or nutritional supplements. In this regard, they found methadone client status and treatment compliance had situational utility. The position that methadone occupies in hierarchical meanings of substances likely shifts in relation to local and cultural perceptions and experiences of a substance's usefulness.

Developments such as rising drug use and shifting cultural understandings about opioids have blurred some distinctions between methadone and other narcotics, or prescribed and non-prescription drugs, or licit and illicit substances. Renee and Mariel deemed methadone to be a relatively temporary replacement for drug use. Camille and Sarah suggested it might remain a permanent part of their lives. Whether perceived as a temporary or permanent support, the women valued the substance to various degrees. They especially appreciated access to it in the early months after entering the program

and when their health and financial states, and/or sense of safety were quite compromised. At the same time, methadone had mixed positive and negative meanings for these study participants, suggesting some ambivalence in their experience of the substance. The next section explores how and why the women could be ambivalent about their experience of MMT due to contradictory practices and meanings they found there.

## **7.2. Experiencing the MMT System**

As Moss and Teghtsoonian (2008) argue in the context of illness, embodied knowledge receives far less recognition than conventional and authoritative knowledge. It is a form of individual and collective expertise that sometimes effectively contests the status quo. Participants experienced the MMT system in intense ways, specifically, physician practices, doses, and testing, and their narratives illuminate the relational and surveillance aspects of this treatment. Clients must fulfil obligations in order that they can remain in treatment (Fraser & valentine, 2008; Friedman & Alicea, 2001; Järvinen, 2014). I explore in this section how the five participants navigated institutional demands, specifically how they encountered expectations for program compliance, made sense of the process, and sometimes challenged it. Participants' MMT experiences illuminate the complexities of clientization, not only because MMT is a demanding client experience, but also because of their need for additional supports for living.

### **7.2.1. Physicians, Dosing, Testing: Experiencing Difference**

As an addiction health treatment, BC's MMT program contrasts to many other types of medical care for the general public as it accentuates "difference" (Reist, 2010), not only in the type of service it provides but also because of some different environments in which this health service can be delivered. This section examines practices and technologies that help construct the woman methadone client and explores how MMT reflects the constellation of control and neglect approaches to social problems. The participants' obligations generally involved keeping regular bi-monthly MMT physician appointments; demonstrating through blood tests or urine tests conducted at the clinic that they have not used controlled and unsanctioned substances, especially opioids, while further complying with unscheduled drug testing at any time between appointments; and

ingesting daily doses in front of a pharmacist or other approved medical worker. Also, obligations are sometimes less concrete, more subjective, and internalized. The women's understandings of obligations display some tensions between client dependence and independence. MMT client obligations could last years as in the cases of Camille and Debbie, or be newly encountered, as in Mariel's experience. Debbie found that she had to follow rules and maintain connections with MMT physicians and workers, and also noted, "You have to work it" and strive for "stability." For Sarah, MMT was about "getting it under control" and for Debbie, Camille, Mariel, and Renee, treatment involvement instilled in them a need to distance themselves from places and objects that triggered them to use drugs and from persons who are associated with a style of living they left behind. It required, in Camille's words, a constant awareness of her requirement to "be good". Notably, the five participants had almost exclusively accessed male physicians throughout their MMT involvement.

The process of clientization in MMT becomes still more complex when women jointly attend doctor visits with family members, a practice constituting client units. Renee welcomed the opportunity to share appointments with her daughter and it was important to her that her physician recognized her intersecting roles as mother and client, that she emotionally supported family members in MMT and vice versa. Sarah and her husband shared the same physician who prescribed to them the same methadone dose, consulted with them jointly, and called them in together for random drug testing. Sarah's frequent use of the terms, "treated us" and "our doctor" during interviews directly reflected this clinical arrangement and she remained ambivalent about being treated as a co-client. She used her husband for moral support during medical appointments but resented that their physician's attention to her husband's unique health problems or relapses left little time for discussing her own concerns, such as her Hepatitis C Virus (HCV) diagnosis and the continued effects of stress. Doctors assume that clients who use together can be treated effectively together regardless of gendered concerns, but as Sarah asserts, "Like, that should be a separate case. I'm me, he's him. I have my own problem, right?". The five participants characterized their physicians as being alternately adversaries and allies, and mostly related episodes when doctors were dismissive or situationally supportive.

The study participants considered their client relationship with their MMT physician in broad terms, in that they could hold physicians' personalities, appearances, and

practices up to high standards. Moreover, they expected a methadone physician to be an approachable health professional who did not make them feel like less than a typical medical patient. Debbie stated that her last methadone physician/family doctor had a “terrible bedside manner. Very smart, I think, but he doesn’t listen. If he had listened to me, I wouldn’t probably be this far along with [health problems]. He’s just so arrogant.” The participants found medical decisions to be sometimes helpful and at other times unfounded or arbitrary. Interactions with methadone doctors could be emotionally stifling and frustratingly counterproductive for women’s health (Camille; Debbie; Sarah) or very motivating at times (Renee; Mariel). As Renee alternately commented:

He always sort of [compliments] me and [my daughter, Alexa]. He’s like, “You know, Renee, you and [Alexa], you’re such nice, good-looking people” . . . So, it didn’t make you feel like, a street person or junkie or whatever type thing. Gave you incentive and whatever.

For some time, Renee felt supported by her physician’s compliments about her appearance but over time she came to place greater value on her maintenance of (PPMB) income assistance status. Overall, the women were more likely to retain their MMT physicians when another one was not readily accessible or because a physician displayed a caring demeanour at times and/or was useful to the woman in some way. Debbie later remained with her “hateful” doctor because he worked out of a public clinic that provided free over the counter medications. Participants resented their doctors or admired their particular qualities yet ultimately expected their emotional and practical support, whether or not it was forthcoming. At times physicians respectfully responded to unique circumstances. For instance, Renee and Mariel’s physicians helped them manage the demands of income assistance policies by authorizing their need to be excused from mandatory job searches due to emotional or physical challenges. Debbie’s doctor worked with her to reduce and eliminate her physical need for methadone to help her prepare for leaving MMT. Overall, these treatment participants’ perceptions and strategies display some of the purposeful ways in which women navigated their relationship with MMT physicians.

Bull (2008) argues that MMT clients do not really have as much choice about their everyday routine as other medical clients because daily dosing is the requisite and still

there are benefits when MMT stabilizes a chaotic daily life routine that can occur through illicit opioid use. Fraser and valentine (2008) alternately state,

It is possible to argue that the demands of the clinic and its queuing reproduce rather than depart from the model of waiting and dependence widely seen as characteristic of lifestyles associated with regular heroin use. Not only is waiting and a sense of uncertainty around when and whether access to the drug will be achieved characteristic of heroin use, for many it is also a central experience of MMT. From this point of view, it is perhaps only a small stretch to argue that rather than gaining access to a new and liberating lifestyle, treatment can, under certain conditions, merely shift the waiting, the service, the attentiveness, from the illicit drug market to the licit drug market. (p. 111)

Levels of prescribed methadone doses also remained a concern throughout the participants' MMT involvement. Even the smallest dosage reduction could make one feel ill but Renee felt that if clients show interest and commitment, they should be encouraged to try to reduce doses, even if they "slip." Sarah feared losing access to methadone as it helped her rein in opioid use. Episodic periods of heightened stress could also lead to MMT physicians advising methadone dose increases as in the cases of Mariel and Sarah. Narratives suggest high doses could be problematic because they can increase fatigue and compromise plans to progressively reduce a dose. Debbie's "working down" of her methadone dose took a period of three years and involved negotiating the terms of MMT exit with her MMT physician. She only began to feel better two months after her last dose, which also illustrates the physiological power of the substance and reasons for her ongoing MMT appointments. As stated previously, MMT could be an expense for clients, when they had to pay at least a portion of a dispensing or counselling fee. Travelling to receive daily doses could be an additional expense and one must use transit, a bicycle, or a vehicle to go to pharmacies beyond walking distance. Sarah stated, "You've got to really watch, you have to think I need at least \$40 dollars extra a month for gas to get it. It's been tiresome, right down to the day before, we haven't had a penny." The dosing regimen was tiresome (Mariel; Sarah) and consistently took physical and mental effort (Renee; Debbie; Mariel).

As discussed in Chapter 5, MMT physicians' practices centre on managing the health risks associated with ingesting such a powerful controlled substance. Test results supply MMT physicians with physical proof that a client is not using other opioids or other controlled drugs. Surveillance implies physicians' constant suspicion that drug-using clients are not truthful (Bourgois & Schonberg, 2009; Friedman & Alicea, 2001). Clients must still "prove it and prove it" after passing tests (Debbie), reorganize daily schedules, and give up on plans for working out of town if one infrequently uses cocaine or marijuana (Sarah). Debbie continually sought help for health problems and encountered moralizing and discriminating practices in the process:

And I always felt he was always looking for a bit of the downfall in me, you know. . . . Or the same treatment I would feel from just random doctors, at a hospital if they knew you were an addict, you know, the "different" treatment. And that's what I felt from him. Just, he was doubting me and not taking my aches and pains seriously and, you know, "What does she really want [that for]?"

She feared being judged and censured, losing access to medication and, like Sarah, resented having to tell her story again and again because it distracted doctors from her health problem(s) at hand. Sarah found that missing a random testing appointment could animate the physician's arbitrary expressions of distrust:

We've said to him, "We're not doing heroin." And finally, after about the fourth time [my husband] said it, and we repeated it ourselves, finally [the doctor] said, "Yeah, you have a point there." . . . They don't want to give in to you, they have to be strong. It's understandable. . . . We're like, "We don't lie to you." He says, "Yeah, I know." But he still has to throw in, "Well, I assume that you're doing it and you don't want to see me." He just says that to get under your skin.

Sarah both understood and resented being labelled a problematic client, especially as she preferred to disclose to her doctor that she used drugs rather than conceal the fact. MMT participants experience an intense institutionalized type of professional surveillance that generates the perception that these clients lack agency (Fraser & valentine, 2008). Furthermore, continued policing of people who use drugs to alter consciousness is additionally problematic for MMT clients (Boyd, 1999). Western preoccupation with

controlling or governing deviant women forecloses development of innovative and truly compassionate substance use treatments (Boyd, 1999; Campbell & Ettore, 2010; Ettore, 2004; Garcia, 2008). The sum toll of medicalization and criminalization of addiction on MMT clients is under-recognized. The next section explores the study participants' social outcomes while broadening inquiry to include their understandings of developments in their lives.

### **7.2.2. Determining Progress in Treatment**

For Camille, Debbie, and Mariel, periods of intense, prolonged drug use had been especially bound up in various stark combinations of loss—loss of safety, homes, family relationships, and good health. At the time of the interviews, all five women were in different social and/or health circumstances than they were on the day they entered MMT. The range of threats associated with daily heroin use includes the spectre of contracting HIV or HCV through shared needles (Spittal et al., 2003), injury and death from gendered violence, exposure to impure opioids, and arrest (Bourgois & Schonberg, 2009). Those who had experienced grievous life conditions while using, such as sleeping in alleys, experiencing drug overdoses, and losing extended contact with loved ones, remarked during interviews on how their lives had improved. Debbie emphasized, “you don’t have to die out there, and you can have a home, and you can have a life again.” The five women’s perspectives on their progress varied, not least because defining success for oneself is a subjective exercise. Normative ideas of progress or “life course imaginaries” do not determine lives, but are often taken for granted influences that shape the sense of self (Gullette, 2003, p. 102). Amid the diverse meanings and measurements of progress, narratives refer to MMT as crucial help for navigating daily life in general (Camille), a strategy to keep pain at bay (Camille; Mariel; Renee), a partial means to “solve” problems (Sarah), or as a “road to recovery” (Debbie).

I think there’s all steps you have to do. Not necessarily NA steps, just your own stuff. And, you know, the thing is, I don’t hope to get anybody on it but there’s a certain way to do it, there’s a process. You can’t just, “Okay, now I’m on methadone, okay, I can do some Trazadol.” (Debbie)

Debbie linked treatment progress to her patience and personal commitment, and to her social and health goals. Camille concluded, “Well, I don’t think I should come off it completely because of the aches and pains. It’s there to help me manage my life and to keep my aches and pains in check. So, it’s a good thing.” Methadone also helped Camille, Debbie, and Mariel distance themselves from street environments and Camille stated, “I could relax at home and almost live a normal life, you know? Yeah. Definitely for the better.” However, when MMT participation conflicted with the desire to avoid medication in general, or when it “catches you” or exists as a “back-up” while one still used other drugs (Renee), these situations meant barriers to progress. For the participants, progress was more often measured in relation to stable housing, financial security, and supportive family relationships than treatment compliance. Progress could mean having enough money to live on to be independent or “being clean” and healthy enough to perform valued work (Debbie; Sarah; Renee). Narratives show the five participants drew on MMT because their goals involved some combination of physical, material, and emotional security, and their treatment progress had to be meaningful for their daily lives. Thus, their diverse goals illustrate why it should not be left to physicians to have the final word on how MMT helps or does not help women.

### **7.3. The Multiple Dimensions of Stigma**

Moralizing about substance use (Bourgois, 2000; Bourgois & Schonberg, 2009; Room, 2005) and the “othering” of addicted women (Boyd, 1999; Campbell & Ettore, 2010; Ettore, 2004) persist in Western countries across a range of sites and through various mechanisms. Stigma is a significant issue for opioid substitution participants despite the recent conceptualizing of addiction as biological illness (Harris & McElrath, 2012; Netherland, 2011; Smye et al., 2011). Goffman’s (1963) phenomenological study of spoiled identities illustrates the ways in which a stigmatized Self evolves out of social relations and society-wide perceptions, and how one’s stigmatized identity can be mediated to an extent by an individual’s identity work. Goffman’s seminal research importantly stresses the relational aspects of social differences that favour some and disfavour others, but it does not explain broader institutional constructions of difference such as race, class, and gender that limit the effects of strategies. While extensively studied in the social sciences and social policy field, stigma remains underdeveloped as

a concept and variably defined due to disciplinary lenses (Link & Phelan, 2001; Manzo, 2004). Conceptual limitations include over-emphasis on individual perception and under-recognition of sources of stigma (Link & Phelan, 2001; Sayce, 1998). Link and Phelan (2001) argue that narrowing study to individuals' perceptions of stigma misrecognizes that stigma has multidimensional features and structuring effects. They propose that the word "label" describes more accurately than "attribute" or "mark" how social and cultural processes can lead to identification of difference and status loss. They explain that,

stigma exists when the following interrelated components converge. In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from "them." In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Finally, stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination. Thus, we apply the term stigma when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold. (Link and Phelan, 2001, p. 367)

Labelling and judgments about undesirable characteristics and stereotyping are mutually reinforcing processes that construct the stigmatized methadone client in MMT in BC (Smye et al., 2011). Furthermore, Link and Phelan (2001) note that status loss and discrimination are closely entwined and have broad consequences (i.e., housing, income, health, education). That stigmatized individuals come to expect poor treatment and adjust their behaviour to avoid it of course factors into the process. However, exercise of power in this process is especially taken for granted. Link and Phelan (2001) specifically link stigma to structural discrimination and call for locating its distinct sources. Sayce (1998), in referring to disability, similarly argues that normative individualizing understandings of stigma "[do] not address at all the more systemic shifts that are needed, including through new law, new employment policy, new influences on the media" (p. 339). Suffice to say,

locating the precise locations of stigma in the addiction field in order to actively dismantle them poses a daunting task as stigma harks back to broad legal and social policies and processes, such as criminalization of drug use, gender inequities and racialization, violent colonial policies, and neoliberal economic policies.<sup>31</sup>

My research adds to evidence of how MMT's restrictive policies and social control mechanisms institutionalize stigmatization of clients (Bourgois & Schonberg, 2009; Friedman & Alicea, 2001; Fraser & valentine, 2008; Harris & McElrath, 2012; Parkes & Reist, 2010; Smye et al., 2011). Debbie, Sarah, and Mariel reflected on episodes of discrimination before and after MMT entry, such as in hospitals, health clinics, pharmacies, or public spaces. Mariel generally "found it pretty good in the hospitals." She remembered only one encounter with discrimination in that health care setting and reflected, "They just treated me badly because I had hepatitis and they treated me like a junkie. And I wasn't one at the time, so I was kind of upset about that." MMT involvement connotes the potential for clients to be stigmatized in society because of the discursive link between methadone and criminalization of drug use (Bourgois, 2000; Boyd, 1999; Smye et al., 2011). Experiences of stigma also involve being associated with specific places. Debbie reflected,

The discrimination I've had in the past really, it still kind of stifles me. . . . I don't want to be treated poorly because I've been treated poorly because I was an addict. . . . All the time, different things, all the time . . . right down to the core of being downtown Vancouver. People's comments when they would go by, "Look, she looks so dirty" . . . , "You're nothing."

Fear of being stigmatized can be longstanding and "stifling," and Debbie recalled an experience of discrimination in an Alberta hospital following an overdose:

And then I was walking around, just waiting and waiting to get released, right. So, I decided to wander down the hall to the nurse's station. And I can hear two of the nurses talking about me, "Well, she's from BC, she's just going to go back and do the same thing again, and so, let's get rid of her."

<sup>31</sup> I thank Susan C. Boyd for directing me to this issue.

Despite their different backgrounds, Debbie and Renee both expressed a longstanding fear of being stigmatized through association with the DTES area of Vancouver.

Participants' narratives further show that the experience of stigma involves identity work and navigation of service environments and practices. Sarah went so far as to travel hundreds of miles to an MMT clinic with her husband for fear of alerting their family doctor that they were using heroin. Some "marked" individuals strategize to avoid or subvert stigma (Goffman, 1963) and MMT clients sometimes challenge stigmatizing treatment practices (Ning, 2005). Mariel and Sarah's experiences suggest they followed these approaches, but Debbie's strategies were subtler. For instance, while Debbie quietly resented the rules, line-ups, and side doors of pharmacies because they signified her as needing methadone, she eventually sought out pharmacists who treated her respectfully, maximized privacy during dosing, and/or provided perks that rewarded her as a customer, such as by giving her small gifts at Christmas and consumer loyalty reward points to trade for merchandise, both of which provided Debbie a small measure of material compensation and short-lived relief from feeling stigmatized. Notably, the dosing regimen in pharmacies can also encourage an ethos of surveillance among those involved in MMT; this is somewhat reiterated in Debbie, Renee, and Mariel's efforts to watch for and avoid others who visibly use illicit substances, and in their occasional moralizing comments about "junkies" they encountered at dosing sites or in the streets around their home. Often these actions involved pragmatic and strategic considerations about how to reduce exposure to triggers. For instance, Debbie, Renee, and Camille sometimes circumvented entire neighbourhoods where they might witness others injecting, panhandling, or binning. Being conscious of the stigma that generally surrounds chronic addiction in society, the women entered this treatment with the expectation that MMT had utility for decreasing the threat of discrimination. Overall, Debbie, Sarah, and Mariel understood stigma as discrimination, remarked on its persistent presence, and strategized to avoid it.

Contrastive analysis of narratives in this study thus far considers the participants' embodied experiences of methadone as a substance and MMT as a system, and the study endeavours to shed light on some of the meanings and practices that constitute woman methadone clients. Numerous factors shape the everyday politics of MMT participation, including physician practices in concert with supervising technologies (e.g., dosing, urine and blood tests, and healthcare databases), and clients' social backgrounds and their

expectations for their lives. At times, it could be difficult for women to convince MMT physicians and other health workers to listen to requests or explanations, especially as institutional practices, such as labelling, categorization, surveillance, and sidelining client concerns provide little scope for continuous clinical dialogue between clients and professionals. Lastly, the potential to be stigmatized as a methadone client was ever present. The diagnosis of addiction and the label of “at risk” suggest the need for increased self-management of identity, and this situation raises the issue of harm reduction as concept and practice. Participants sought to additionally improve their health and social circumstances through other services and these efforts are discussed next.

#### **7.4. Seeking Help for Health Issues**

Participants' efforts to improve their life chances sometimes involved seeking help for various health issues, and their narratives show that health problems sometimes arose directly from or were exacerbated by illicit substance use. Heart problems, Hepatitis C Virus (HCV), abscesses, pneumonia, depression, and tooth loss were some major conditions that the women sought treatment for in hospitals and clinics over the years. Health treatments addressed participants' chronic conditions and short-term emergencies, such as when Debbie and Mariel were hospitalized following drug overdose incidents. Debbie concurrently used street health vans for primary medical care while living in the DTES in Vancouver. Camille, Debbie, Sarah, and Mariel had contracted HCV through the practice of sharing needles. Camille and Debbie sought out or were referred to Vancouver-based research studies of people who inject illicit drugs, and their participation in these “fast-tracked” health treatments led to consistent medical monitoring of their illness. In contrast, Sarah waited a couple of years to receive basic instructional supports from her MMT physician following her HCV diagnosis. In terms of mental health, Debbie had been taking a particular mental health medication for several years, and yet she experienced unsettling side effects and struggled to reduce the exceptionally high prescribed dose. Renee, Sarah, and Camille resisted taking medication for mental health issues and resisted participating in group or individual mental health counselling. According to Camille, who was experiencing depression and some lingering health problems arising from violent abuse, she and her physician had not much discussed the effects of trauma on her health.

Health conditions seemingly unrelated to substance addiction included diabetes, asthma, hearing loss, digestive illnesses, osteoarthritis, early osteoporosis, and chronic migraines. These illnesses were followed up with medical testing and sometimes treatment that varied in depth or effectiveness. Health problems were sometimes discussed in the context of aging and included complaints about joint pain and fatigue. Those with the fewest or most minor medical issues described themselves as quite healthy. Camille, Debbie, Renee, Sarah, and Mariel's narratives show that in anticipation of their later years, safety and security, nutritious food, and affordable housing and medication were deemed crucial supports for health. Overall, participants' health issues varied, and some used methadone physicians for family practice care and some kept their MMT and general health care separated. Either way, the participants' experiences as health clients meant their drug use histories were exposed to professional scrutiny.

Interviewees reflected that some of their habits and associations had at times compromised their health, such as injecting drugs and sharing needles, smoking tobacco, not exercising, or accessing impure street drugs (Renee; Debbie). Friends and associates sometimes had a direct contributing role in accidental overdoses or injury and/or need for emergency health treatment (Camille; Debbie; Mariel). Conversely, the fluid meanings of substances and medicines, licit and illicit, make it difficult to definitively mark some of the participants' drug use habits or networks as non-productive for physical and mental health states. Cannabis or illicit methadone use or sharing prescriptions could relate to recreation but had also at times helped alleviate pain or discomfort from health problems (Sarah; Mariel). Overall, participants preferred that their health and poverty, rather than substance use, were the main focuses of medical and state scrutiny. They especially sought open and honest, non-judgmental communication with their health care providers. Still, participants in my study most trusted their own knowledge of their bodies and felt ostracized when medical practitioners dismissed their physical symptoms. They were often left to speculate about their health problems in isolation, and not knowing the status of their health distressed them. Also, as other research has found (Pulkingham & Fuller, 2012; Pulkingham, Fuller, & Kershaw, 2010), participants' health and financial circumstances had to deteriorate significantly before they would seek income assistance disability status because of the fear of what that identity also signifies. When Debbie's

financial troubles during health treatment worsened, she began applying for disability status:

That's when we started filing disability papers. Because it suited to say I couldn't walk three blocks without having to stop. So, it was perfect timing for that. I should have done it years ago before that, but I didn't want to make myself look so bad on paper. It was all [in] vain. But once I got that sick, and \$140 a month to eat on and smoke on, and I was in bed, finally I let [second stage housing staff] know. "I'm not eating right," "I can't get out to shop," "I don't have any money for it." So, they all kind of, they came around.

Present or past MMT participation can sometimes compromise health care in that participants both experienced and feared the stigma of being labelled as an ex-substance user or a suspected substance user.

Debbie's experience illustrates how one's addiction history and need for health care can be arbitrarily judged. She found it difficult to continue seeing a methadone physician for family practice care after leaving MMT, and at the time of the first interview she was still fielding his suspicions that she was vulnerable to relapse. By our third interview, her active search for a new family doctor in that clinic who would be attentive to her health concerns and who would reduce some of her medication doses raised specific hesitations. Debbie's account reveals her frustration:

I want to move forward. But what I don't know about finding a doctor is, telling them everything. And then they get that little part in their head, "Oh, she used to be," "Will she still be?," "Will she always be?" That, I don't know what to do about yet.

She began to doubt that medical practitioners would view her clinical identity as a methadone client favourably regardless of her successful recovery. She frequently asked physicians during appointments to remove reference to methadone from her medical file. It took several months before a new physician assented. Debbie reflected on what that meant for her everyday life:

I don't have to tell anybody. It's going to be more of my past again. So, I don't need to tell anybody, I don't need to have to worry about having it. I don't have to worry about going down to get it. Miserable every morning. Crappy every morning. What a long journey.

Not having to "tell anybody" was very important for Debbie and she reflected further on her lingering clinical identity as she discussed her continued struggle to find a new family doctor:

I don't know. I'm scared to tell a new doctor. But, yet I think the doctor needs to know everything about me, if they're going to take care of me. I don't know. I'm thinking there might still be some repercussions of poor health because of so long of it just being masked, I don't know. I'm stuck, I don't know. . . . Maybe I'm not quite, I'm not proud of the past so I don't want to carry it with me wherever I go. But, of course I carry it with me wherever I go [brief laugh]. However, I don't know if a new doctor needs to do that, we could just start at zero. I don't know.

These two quotations illustrate some of the politics of health care surrounding biomedical subjectivity (Rose, 2007). It took considerable effort and time for Debbie to successfully navigate her exit from MMT, and removal of methadone client status from her medical file had broad implications. By striving to dismantle an MMT identity she sought respectful treatment in health care settings. However, there was no guarantee that her general health would improve, and as Debbie notes, a family physician may need to know of her past substance use so that she or he can monitor for "repercussions." This quandary not only compromises her sense of progress but displays reconstituted fear of being stigmatized and of the inability to access necessary medical care.

Participants' narratives show that women's health issues and health care were sometimes related and often unrelated to substance use. Overall, women's navigation of status or stigma in health care settings took effort and identity work, constituting a politics of care that rested on professionals' pathological understandings of the body and on clients' ability to move past barriers to access everyday health supports. The study participants' accounts display a keen awareness of growing competition for supports and benefits (Lister, 2004). Interview discussions about health care and addiction treatment

animated participants' negative statements about "deserving clients." Sarah stated that one is more likely to qualify for disability benefits if you "say [that you're] mental or something, that's about the only thing." However, HCV diagnosis or mental health issues had not guaranteed eligibility for disability status. Furthermore, diagnoses of disability or mental illness had not guaranteed better access to health or social supports, although connection to some types of services and research studies helped. For instance, specialized services for women could help temporarily bridge health care service gaps or helped women apply for temporary supportive housing.

## 7.5. Navigating Income and Disability Assistance

Lister (2004) discusses four types of agency/resistance related to poverty: *getting by* through juggling being resilient and resourceful; *getting out* which is a personal striving to reach goals; *getting back*, such as working under the table or outside of rules, and other creative ways to subvert society-wide expectations or welfare demands; and *getting organized*, which is a collective effort to act against poverty. The following section covers all of these issues through a discussion of the participants' economic disadvantages. As the study explored women's social marginalization over time, references to poverty were considered with respect to women's receipt of provincial income support. Renee had lived for many years in poverty before her drug use experiences and had encountered the system of income assistance as a child:

SP: How have you managed to get by all these years on such low benefits?

Renee: Probably because I was brought up on welfare too. My mom, as we were young, and Mom worked when we were old enough, I guess, I was 11 or 12 when Mom was working. Um, yeah, so just learnt. My Mom was very good at looking after money. Because my Mom is not a drinker, or drugs, yeah, so yeah, just learnt to look after your pennies . . . and I was always very appreciative [of the income assistance system]. . . . I never really ask for much, like, I don't bother them.

For Renee, close accounting of money was necessary for each month of living. Camille frequently spoke during interviews of her monthly struggle to pay bills:

I was praying that God can help me pay my phone and TV cable and that, I had phoned them up last, this past Tuesday, and asked them, it said I had until the 19th and they give you fifteen days chance to pay, so it's supposed to be paid by the 19th. But I said "I can only pay it on the 25<sup>th</sup> . . . when I get my money, give me the bills. We've got to get in sync here you know." And he says "Ok, I understand, well I'll put it down here but I can't guarantee." So, the next day, Wednesday, I was watching TV here and everything went out on the TV and I checked the phone and it was still working and I phoned them up right away.

While Camille eventually negotiated a service re-connection that month, this illustrates her constant struggle to pay bills. Mariel stated,

It's stressful and not knowing when my, not knowing if I was losing my car or not. Me being broke is the worst thing that could ever happen to me. I'll crawl up and die being broke, I'm just not used to having no money. Yeah, it's really bad.

Whether they first encountered income assistance as children or as adults, the participants did not usually discuss the extent of their ongoing poverty with friends or extended family. Also, as expected, they did not disclose to social assistance authorities that they received material help from others or when they had temporary access to small program benefits, out of fear that their assistance benefits would be reduced. Borrowing or working under the table for cash and drugs increased fear of not only social assistance surveillance, but sometimes also justice system and MMT surveillance (Sarah). Whether they were homeless or had homes, actively using or abstinent, compliant or non-compliant in MMT, or independently making their way or living in supportive housing, Camille, Debbie, Renee, Sarah, and Mariel each had consistently found income assistance benefits inadequate to cover basic daily living expenses. For years, the five study participants had infrequently accepted help from family members or friends to obtain food, shelter, or transportation, and usually as a last resort. In turn, they provided resources in kind to loved ones, such as sisters, mothers, children, and/or grandchildren. Larger amounts of money or financial windfalls, through inheritances or lawsuits, residential school compensation, victim compensation, bulk child support payments, or gifts had not improved participants' financial security, partly but not exclusively because of ongoing substance use issues. Notably, by the time of the interviews, Camille, Debbie, Renee, Sarah, and Mariel were

continuing to experience severe financial struggles while on any type of income assistance because income benefits, including benefits to disability clients, did not cover their monthly expenses. Participants' incomes were too low to meet personal and nutritional needs, and in addition to going without food, they relied on drop-ins, food banks, and small gifts of food from others. For several years, their struggles to make up monthly financial shortfalls included the activities of borrowing, pawning personal items, running tabs at local corner stores, walking instead of using transit, and myriad other approaches.

As this study shows, participants' income issues often intersected with practical health issues. As MMT clients, the study participants who sought higher guaranteed income relied on methadone physicians' support when seeking to qualify for disability assistance or PPMB (Camille; Debbie; Renee). Although disability status was valued because it did not require participants to answer to some income assistance system demands such as the requirement to search for work, the \$500 earnings exemption<sup>32</sup> offered little hope for improving security when health problems, mental illness, homelessness, or lack of local opportunities made it difficult to participate in the labour market (Camille; Debbie; Sarah). Still, Debbie and Sarah actively sought out work and relayed that a worker identity had meaning because it signified the ability to make ends meet. Participants' experiences of disability status illuminate the different ways that it can impede a sense of progress, even as participants appreciate the extra monies that come into the household. For example, Sarah's co-client disability status, like her MMT co-client care, constructs her as a dependent on her husband's status and clinical interpretations of his health issues rather than guarantees attention to her health problems.

Due to their low income, women shopped around for the least expensive access to MMT and medication. This could involve frequenting pharmacies that were located closest to their homes or shelter stay (Camille; Renee; Sarah), and returning to pharmacies that allowed for consumer perks, such as loyalty shopping points to trade for merchandise (Debbie). Furthermore, participants borrowed to buy or obtained over-the-counter medications and prescribed substances. As mentioned earlier, Debbie directly experienced cuts in recent years to disability-based prescription allowances, which forced

<sup>32</sup> At the time of the interviews, disability assistance clients were allowed to earn \$500 income each month without having it deducted from their benefits.

her continued reliance on a public health clinic that she was eager to leave. At the same time, when referring to medication and dental costs, participants designated as disability clients considered themselves more fortunate than regular income assistance clients, although they were also expected to pay back received crisis grants. Those on disability assistance also found diet allowances, which typically hovered around \$40 a month, grossly insufficient as health supports.

Notably, whether receiving income assistance or disability assistance, participants who sought no or low cost resources for living were competing with others on low income for various limited social resources, including tangible resources such as food, clothing, and furniture, and coveted housing such as shelter spaces and subsidized mid-term and long-term apartments. Debbie and Sarah's continued active searches for resources sometimes but not always located used clothing or furniture at food banks and other non-profit organizations. Camille and Mariel were even less successful in locating free or low-cost supports for living, and even when homeless, there was no guarantee that they could access a shelter at any given time. The isolation the participants were experiencing through poverty along with the competition between low-income citizens for dwindling resources suggest that organizing around poverty would require extra effort and the help of advocates and front-line workers.

## **7.6. Traversing Services and Programs**

One question posed to the interviewees sought to understand how they asked for help and to whom they turned for help. The concept of "help" held diverse meanings for them and their accounts show that they could be ambivalent about various services and programs for low-income clients. While the study participants both navigated and resisted programs, it would be difficult to narrowly describe their lives as an immersion in "institutional circuits" (Luhmann, 2010). My study shows a broad range of program use among the participants, from Debbie who accessed many programs and supports over many years to Sarah and Renee who remained quite solitary, fairly service-resistant, and family-dependent. The participants drew on various programs or formal supports when their substance use was heaviest, but again, the five women who participated in my study experienced various levels of service access. Notably, programs targeted to women

exclusively have been especially useful for them. In the context of harm reduction and social marginalization, the narratives suggest the five participants' various needs and social circumstances sometimes matched the mandates of the particular programs they accessed. For example, Debbie, Camille, and Mariel accessed drop in and shelter supports for women to escape gendered violence. Services may be profit-based or non-profit, voluntary or mandated, and like physicians and other clinical workers, service workers sometimes helped to mediate participants' access to government resources. In terms of health, Camille and Debbie's early use of harm reduction services such as needle exchange and inner-city MMT clinics helped to keep them alive and kept them safer and healthier than they would have been if they had not used those services. Services addressing various street-related problems (i.e., hunger, need for wound care) are quite accessible in the largest cities in BC and Debbie found that she "just joined the line." In contrast, narratives show that participants had varied success with accessing some addiction health programs, such as with detox services, and mental health counselling. Like hospital services, services for women provided more comprehensive, and the safest and most valuable temporary respite for participants with the poorest health, who at times were homeless or living in unaffordable or unsafe housing and/or fleeing violence.

The interviews show participants' experiences of abuse by men did not usually result in access to mid-term or long-term supports. Violent crimes committed against Camille more than a decade earlier were punished in the justice system, but she remains quite traumatized by them, had not participated in counselling, and had not remained connected to victim services for very long after the events. Her financial compensation for one victim experience was small, reflecting neither the gravity of the crime nor its physical and psychological effects for Camille's life. Her story especially illustrates the persistent connection between addiction treatment, despair, and accumulating experiences of trauma arising from colonialism and abuse of different types (Garcia, 2008). When Camille lived in and near the Vancouver DTES neighbourhood, she made tentative and very temporary connections with programs targeting First Nations residents and after leaving the area she did not access them at all.

Participants expressed appreciation for some of the practical types of service help they received and found some of the workers they encountered inspired them to make extra efforts to improve their own lives.

Workers. The guys who walked around exchanging needles, “Yeah you shouldn’t be here” and “You don’t belong down here,” and “Don’t die down here.” “Oh, I won’t die down here.” “Well you will if you don’t get out soon.” A lot of people. If you want to hear it, you can have it. So once the boyfriend was gone and things became rougher then, I got tired. I mean, I just got so sick and tired of day in, day out, hour by hour, you know. 10 minutes by 10 minutes. (Debbie)

Importantly, at times of the heaviest drug use, harm reduction workers or practices reached Camille, Debbie, and Mariel where they were located, providing immediate or short-term supports.

Short-term resources for women in MMT were not limited to harm reduction programs but were more prevalent in the decade prior to the interviews and could range in type from job bank programs to art therapy. While workers could provide them with advocacy services and encourage labour market reintegration, low-income clients could no longer rely on gaining access to the most valuable long-term women-centred programs once dismantling of social welfare began in the 2000s. The creation of the Canada Health and Social Transfer (CHST) and the 1999 Social Union Framework Agreement, involving significant corporate tax cuts, and changes to labour legislation, social assistance, and housing policies had the combined effects of increasing poverty and starkly reducing funding for social programs and supports (Cohen & Klein, 2011). Sarah and Debbie’s monthly reliance on food banks and difficulty accessing a regular supply of food illustrates the effects of structural changes on the poor.

Debbie often referenced the period before the provincial funding cuts when describing her program participation programs in the early to mid-2000s to explain how she had become reliant on small program benefits in the form of minor honorariums, meals and bus tickets that rewarded sustained program participation. Furthermore, participants accessed fewer services once housing became more stable, not because they did not need assistance, but because accessing services required that they know how or were willing to ask for assistance in institutionalized ways. This involves filling out forms, “telling their story” to a stranger, getting along with other clients, and performing for program workers and their expectations (Camille; Debbie; Sarah). Similarly, Dara Culhane (2011) raises crucial ethical questions about the stark social class differences between

marginalized subjects and privileged researchers and the roles each group plays in the research encounter. Thus, there is an increasing need for more equitable forms of interaction involving program access or research on low-income citizens. My research suggests that inequitable or intrusive program expectations sometimes reduced the participants' service use.

Furthermore, as the participants identify, the benefits of accessing services in the inner city must be weighed against the risks and triggers to use substances that proliferate within specific locales. For this reason, the participants, whether they lived near open drug use areas, or had experience with them sought to distance themselves physically from these places at times, and eventually regarded some neighbourhoods or some residents of them as dangerous to their bodies, mental states, or progress. Interviewees sometimes expressed distrust of other clients in locations where addiction health and MMT clients congregate, such as pharmacy lines, detox facilities, and recovery houses. Debbie stated,

Yeah, some people come and go. Or they'd sit there and they'd get their meth and they'd go sit on the couch like that. [nodding] That is not recovery! You're trying to absorb everything out of that. That's the wrong thought. And I would see people around me getting kicked out. By then I'd say, "Why are you here?" and "Get away from me," "I think you're using, I'm going to say something." And I would. I still do that if I'm at [the women's program].

Participants' narratives show that judgments and fears about other clients and a few workers are expressed in the context of discussing programs that brokered highly valued resources, such as methadone doses, honorariums, shelter accommodation, or social housing.

Also, some programs did not serve participants well. For instance, services and programs for persons struggling with poverty and addiction are unevenly distributed and in major cities tend to be concentrated in the poorest neighbourhoods (Bourgois & Schonberg, 2009; Culhane, 2003b; Roe, 2005, 2010) and in areas that women deem to be less safe for them. Accounts show that some programs may not have appealed to the interviewees because of where they are situated, or because of the clients they serve (e.g., men, harm reduction clients), or because the programs offered few long-term

benefits. While operating on the principle of inclusivity, women-centred programs in the province struggle to maintain enough funding and enough autonomy to address the multiple problems that women with addiction issues face.

### **7.6.1. Women's Recovery and the Self**

Accessing supplementary supports such as recovery or MMT support houses, 12 step programs, or similarly structured services held interest only for Debbie who remarked that such programs use a “lingo of recovery” and “different catch phrases.” She also reflected, “it was just what I needed at the time” and that she found some residential programs for women were especially “good about helping women kind of feel that they were useful, you know what I mean, that they had value, and that work had value.” In her experience, program expectations or house rules were helpful to some degree in fostering program participation. Yet her participation in recovery and residential programs only began because a street counsellor intervened, imploring her to access them, and because he and other program workers, as well as administrators, supported her continued participation. While unusual, Debbie's experience suggests access to an extensive and sustained amount of professional intervention. While her MMT involvement lasted over a decade, throughout much of that time, she drew on formal and informal mentors, and she received supplementary emotional support from family members when she wanted it.

In contrast, Renee and Sarah's narratives reveal they had not accessed recovery-type programs or women's programs, had far smaller networks to turn to, and occasionally relied on their mothers or sisters for crucial practical or emotional aid. They did not oppose in theory available counselling programs for women, and yet those formal supports, especially those with therapeutic or 12 step programming, held little meaning for them in their daily lives. Renee and Sarah hoped that continued MMT involvement would be sufficient to improve their life situation. Overall, Camille, Renee, Sarah, and Mariel's reluctance to access mental health and drug and alcohol counselling or recovery programs may also relate to individualizing discourses.

As Netherland (2011) notes, individualizing explanations for addiction are most prominent, whether originating in the field of science or among treatment participants.

Marisol framed the issue of recovery as a matter of individual choices and capacities, stating,

Life is what you make it, right. If you're going to do well on abuse . . . you're not going to get any better. It's like being an addict, except you're an addict and you stay away from it. Yeah, that's all you can do . . . a lot of people need help and they need detox and that. I just figured I got into it easy, I can get out.

Through a few brief psychiatry sessions, Marisol learned that her own "clinical personality" helped "stress roll off," and thus preferred to work on her substance use issues in private. Renee resisted any form of non-MMT counselling, stating that her doctor "thinks I need a lot of time myself to whatever." Sarah followed her husband's advice to keep their life circumstances private, and she discontinued alcohol and drug counselling after a few sessions. She believed that she, and not a counsellor nor her physician, was the best judge of her treatment progress. Years earlier, Camille had infrequently used a DTES drop-in program for women but had never accessed a program or service designed for sustained participation. In addition to her experience of sexual abuse as a young child at school, her experiences of institutionalized violence reveal early, multiple sources of trauma from the age of five. When asked if she wanted to connect with a First Nations counsellor attached to the Residential School Hearing process, she was hesitant, expecting it might involve referrals to live-in types of addiction treatment programs. Camille remarked, "Well, there's not much else they can do for a person if they don't want to go to those places like uh, recovery houses and that. Like, I never wanted to do that. I wanted to do it myself, I guess." Camille further stated that she was extremely uncomfortable with the thought of sharing information about her life in group counselling sessions where others had "no shame or pride," and she held little hope that "some magic word" would help her deal with her complex traumatic experience of colonialism (see Garcia, 2008; Culhane, 2003a).

Luhrmann (2010) explores how homeless women in Uptown, Chicago regard and experience psychiatric medication, primarily for psychosis, as they circuit through and between homelessness and institutions, such as shelters, hospitals, and jail. These women, who tend to cycle between the street and primary care, typically fear being diagnosed or perceived by others as being psychotic. Luhrmann found that some

participants resisted supports that signified the state of being “crazy,” “weak,” and “vulnerable to violence.” While they had not always refused psychiatric services, as accessing those required a particular strength, they were reacting to the “last resort” connotations that mental health medication and services imply in their world—that women experiencing extreme poverty cannot survive, physically and mentally, without medication and counselling. Being regarded as mentally and physically strong helps women in vulnerable life circumstances negotiate across different settings. As Luhrmann further argues, this was not just a political stance so much as a survival skill for individual women amid grim social conditions and myriad emotional and physical demands. Similarly, my research found participants sometimes resisted services and labels. Furthermore, for participants in my study, being service- or label-resistant can also be about avoiding drug use triggers, protecting privacy, and restoring dignity. While Järvinen (2014) found that some clients refused to accept the last-resort connotations of MMT in Denmark, participants in my study were variably resistant to this treatment and narrated experiences they had over the years with additional programming. Notably, by the time of the interviews in 2011, all five participants were drawing on few if any programs and all had developed distrust that program participation would help them gain more permanent supports.

As shown thus far, the participants had diverse client experiences as they navigated their life troubles, and while their problems are constructed through participation in MMT and other formal programs, the participants also displayed agency in striving to improve the quality of their lives.

## **7.7. Informal Supports and Crises**

Over the years, the study participants occasionally, but not regularly, turned to informal help for everyday resources such as short-term shelter, food or clothing items, or help with transportation. Camille, Debbie, Renee, Sarah, and Mariel valued support from close and extended family members and readily accepted help from them, whether it was provided unconditionally or freighted with expectations. In the spirit of give and take and with a deep concern for loved ones’ security and health, they in turn sometimes provided labour (e.g., caregiving, cleaning) and gifts of food and clothing, and especially shared their meagre resources with their children and grandchildren. Camille gave a significant

portion of her residential school compensation to her children and hoped for more compensation so that she could “put away something for [them], that’s what I want most of all.” She also cared for her aged mother for an extended period. Participants’ receipt of informal help and their aid to others could be driven by altruism and interdependencies, or be imposed. These experiences suggest complex responses to issues of reciprocity, including refusal to give or accept informal support at times (Offer, 2012). Participants’ experiences of informal supports over time reveal varied give and take scenarios. By the time of the interviews, Camille and Mariel were more likely to accept help from friends than from family and had little to give in return, as they preferred to share their few resources with their children or grandchildren. Friends, fellow clients, and strangers also provided informal supports at times but helped the women less often and in less structural ways, offering mostly emotional help and the most inexpensive material resources. Fellow clients or friends and some family members were often experiencing poverty as well and could little afford to help with housing, loans or material gifts.

Sarah, Debbie, and Renee drew on family more often than friends and readily helped their family members when and how they could. Still, participants’ informal support to family members could be a burden. When Renee’s daughter could not access shelter accommodation, she and Renee’s grandchild “sort of moved in” on Renee and her partner, living in the small one-bedroom apartment for some months. Renee advised her daughter not to disclose to front-line workers that she was getting help from her mother and other family members:

She’s been phoning [shelters and transition homes] every morning, and she’s got the little one. Like I just say [to her], “Don’t say you’re staying with your mom . . . or that you’ve been sleeping on people’s couches.” Because as soon as they think that mom will look after them, I mean, there’s no room. I would like to get a place with her, because I’ve been sort of thinking of sort of packing up and going. I’d like to get a place with her and get a nice little place together, but we’re not good for each other right now. Because I’ve been fooling around a bit and she’s fooling around a little bit more than I am. Yeah, so it’s not, not the scene.

With the lack of local shelter resources, tensions between Renee, her partner, and her daughter increased. Renee’s narrative illustrates efforts to maintain her caring mother and

grandmother identity, to keep substances out of her home, and to keep her closest family members physically safe.

Like harm reduction programs, informal help of any type aided the women somewhat in times of severe crisis. Mariel drew on a friend for emotional support for several months after leaving a transition home and moving to her home where she rented a room. When Renee was heavily using drugs, her mother and sister provided crucial support. While Debbie increasingly helped her children in recent years, she had drawn on help from her parents, siblings, and her children during crucial periods of her recovery.

Several harm reduction programs and women's services were instrumental in helping Debbie obtain housing and other supports over the years. While the combination of help from family and services helped her in significant ways, she described the improvements gained through some services as “things falling into place.”<sup>33</sup> On the surface, her narrative displays contradictions. At different times, she regarded MMT or her own agency or her parents and family's help as crucial for her recovery successes. With the help of others, Debbie worked to “patch together” or coordinate numerous sources of formal and informal help, including MMT, in optimal ways and at optimal times to stay alive, and then to productively leave behind substance use and find housing. When Debbie was undergoing treatment for Hepatitis C Virus, she had both informal and formal supports in the second stage housing she was living in. Indeed, her story appears unique and she described these events as serendipitous. Debbie's successes, however, could not be sustained and built upon, and she continued to struggle in poverty and experience poor health over extended periods of time. As the life stories show, living in poverty or experiencing violence or suffering from chronic addiction was each a singularly major struggle. Experiences of intersecting and accumulating struggles constituted further hardship and involved multiple social forces. Thus, women experiencing multiple and intersecting social troubles require meaningful publicly funded supportive care and resources to help them accumulate material and political assets.

<sup>33</sup> See Offer (2012) regarding network reliance and withdrawal.

## 7.8. Conclusion

Experiential evidence and sociological analysis in this study show that women's specific local, everyday experiences of MMT policy and practices and client constructions constitute an overlapping health, economic, and sociopolitical issue. The five women interviewed in this study richly narrated the ways in which MMT experiences and identities relate to marginality in society (Bourgois, 2000; Bourgois & Schonberg, 2009; Fraser & valentine, 2008; Friedman & Alicea, 2001) and revealed how they navigated various service sites and informal help in this context. The five women's addiction trajectories reveal diverse social backgrounds and everyday routines, and their diverse client experiences and social circumstances suggest there is no predictable "path" to or through MMT to improve life chances. The life stories also reveal how study participants actively navigated everyday institutional and relational demands placed on them and negotiated for social supports where available and when they deemed them to be useful. They also challenged knowledges and practices that held little or no meaning for them. As this chapter shows, Camille, Debbie, Renee, Sarah, and Mariel's struggles for autonomy and social inclusion can hinge on complex meanings of the body and care (Fine, 2005) and include contestation of knowledge at various service sites. Clientization of mid-adult women in MMT involves surveillance and self-surveillance and is a process that constructs plural intersecting identities and experiences that hinge on notions of progress.

In summary, this study argues that women's complex experiences of MMT and advanced marginalization illustrate "supervised exclusion," which is the process of being "supervised" in society while simultaneously "excluded" from full participation. Supervised exclusion implicates the contradictory care and control aspects of health treatment for criminalized drug use, and related policies and practices. Risk frames privilege professional knowledge and leave no conceptual room to explain the range of harms that impact both health and social integration. Clinicians' normative risk management practices do not acknowledge the different ways that women's health concerns can exceed drug use issues. Women who experience MMT along with health, economic, and political struggles require tangible supports. They encounter multiple services and regularly face discrimination. They also display agency in navigating the service field. Overall, their

experiences of the process of clientization show that they require far more material and political resources.

### **7.8.1. Reflecting on Troubles and Positions**

Some participants wanted to know if we shared common ground, what my substances of choice were, whether we shared any credible experience or “street” knowledge. In a discussion about diverted methadone, Mariel interrupted one of my questions to ask if I have ever “been on drugs,” meaning heroin.

SP: No, nothing heavy like that.

Mariel: Just pot.

SP: Yeah.

Mariel: Is methadone heavy?

SP: Um,

Mariel: Did you ever do coke or anything?

SP: No.

Mariel: Hmm.

SP: A quite sheltered background.

Mariel: That’s good.

Here, Mariel’s curiosity speaks to a desire to know something about what other people do, which can be a productive part of social relations or reconstitution of social distance.

As I reflect on my study of the participants’ everyday lives, I examine one of the ways in which I wielded the power to classify during the interview stage. My problems during questioning highlight ongoing concerns about difference, power, knowledge, and the local practices of research (Boyd, 2008; Culhane, 2011; Elliott, 2007; Robertson & Culhane, 2005). As Donna Haraway (2008) notes, research contributions hoping to repair socially constructed divides between women require methods that are sensitive to issues of power. My privileged position as a researcher provides me with a variety of tools to shape not only the product but also the interview interactions (Ellis & Berger, 2002; Doucet

& Mauthner, 2008). In striving to find a balance between the need to help women to feel empowered in the research process and the imperative to produce significant amounts of data, I drafted mostly open-ended interview questions. However, during our discussions I sometimes adopted an investigative stance by falling back on the use of short questions. I pointedly asked for more details, names, places, and dates. This style of questioning was often unproductive and is reminiscent of the kinds of intake questions that clients encounter in various treatment services for the poor. Overall, my lapses into awkward, investigative questioning reflect my background as a support worker in a recovery home for women in 2000–2002. My contradictory dual role there as front-line confidante and house rule enforcer also introduced me to the multiple government forms fiscally tracking the health and welfare of addicted women. These required me to ask women multiple questions upon arrival. Such questions, symbolizing organizational stealth, serve to efficiently gather as much drug use and health information as possible. Intake questioning can make clients suspicious of how the information will be used and gives them little power in determining the course of interview conversations.

In this study, shorter threads of interview discussions often reflected participants' distinct refusals to talk at length about their substance-related issues. Also, my conditioned fear that words or images might lead to feelings that trigger relapse led to some discontinuation of interviews and lines of questioning. The interviews generated much data and they also regularly produced uncomfortable silences and interruptions, and elicited participants' expressions of sorrow and grief, humour, and anger. Recognition of emotions was a central practice during life story production, being part of an empathic approach and flexible research design. The multiple interviews, phone contact between interviews, and two-way personal letter writing provided opportunities to restore dialogue, to clarify the goals of the study, and to regularly express my appreciation for the participants' diverse perspectives, concerns, and emotions. Overall, problems during the research process were of my own making, and Camille, Debbie, Renee, Sarah, and Mariel displayed much willingness to move through uncomfortable dialogue and graciously helped me salvage key ideas they raised.

## Chapter 8.

### Conclusion

This study explored women's participation in methadone maintenance treatment (MMT) in British Columbia in relation to their social, economic, and political marginality. Drawing on life stories of five women in their mid-adult years, physician interviews, and MMT texts, this study examined how drug use-associated social exclusion can be about enduring experiences. "Enduring," as a verb, connotes "suffering difficulty" while its adjectival meaning refers to "long-lasting." For Camille, Debbie, Renee, Sarah, and Mariel, their life struggles over time impelled them to seek help through MMT and other services. Their troubles were sometimes directly related to drug use and sometimes not, and arose from gendered and colonial trauma, poverty, isolation, and compromised health. Their hopes for normative participation in society through MMT were not yet realized. Given that marginality can accrue over time, the study explored several influences that intersected with the participants' struggles to curtail or end drug use, such as institutionalized violence, criminalization of drug use, medicalization of social problems, and inadequate income and social supports. In this thesis, I describe these experiences as illustrating "supervised exclusion" and identify some of the ways in which this experience of marginality relates to risk management policies and practices, the politics of care that surround MMT subjectivity, multiple meanings of progress, and persistent issues of control, surveillance, and discrimination. This chapter first summarizes the main aspects of supervised exclusion and then discusses the study's findings, to conclude that women's experiences of MMT can signify accumulating social troubles and problems, and that there are limits to how medical subjectivity can positively address these citizens' efforts to improve their social circumstances and political status.

Supervised exclusion denotes the complex and contradictory intersection of "supervision" and "exclusion." First, MMT's close supervision of patients is unique among medical care treatments in its aim to control the daily ingestion of a prescribed opioid for drug treatment purposes, and for the high level of control the program wields over clients' daily routines. Surveillance of patient behaviours through regular dosing activities and clinical consultations maintains the social relations of power that keep disadvantaged

citizens marginalized in society (Bourgois & Schonberg, 2009; Boyd, 1999; Fraser & valentine, 2008; Friedman & Alicea, 2001). Second, MMT reconstitutes the “at-risk” client at the expense of recognizing the range of harms women experience and the contexts of their drug use troubles and treatment problems. Third, women’s struggles with drug use and poverty can also directly and indirectly point to redistributive neglect, and when women concurrently experience MMT involvement and persistent economic, social, and political marginalization, this explicitly signals the lack of broader social supports.

### **8.1. MMT Organization, Knowledges, and Practices: In Flux and Preoccupied with Risk**

Among the study’s findings, several concern MMT organization and clinical knowledges. In order to examine how institutional factors, such as policy and administration, can shape treatment practices, the study included analysis of MMT texts and drew on physician perspectives. Content analysis revealed there are limited guidelines and resources available to providers and users, as evidenced by gaps in knowledge about MMT in BC. For instance, there is an absence of in-depth statistical and descriptive information about MMT provision and administration. I had expected to locate significant College of Physicians and Surgeons of British Columbia (CPSBC) reporting on client outcomes and other evidence validating MMT’s role in the harm reduction field. However, institutional documents contain little information about how MMT is practiced and utilized, or about women’s involvement in this treatment. The lack of facts and figures concerning MMT in BC maintains clients’ marginality. Underreporting reconstitutes the invisibility of clients in the health system and works against efforts to standardize an equitable treatment approach. MMT providers can be similarly elusive in the treatment field.<sup>34</sup> For example, the number of physicians with authorization to practise MMT in BC far exceeds the number of active prescribers (with patients). Physicians’ motivations for practising MMT are likely diverse and, in many cases, may not be longstanding.<sup>35</sup>

<sup>34</sup> At the time of the physician interviews, many doctors were not displaying their availability to the public, which is still the case in 2016.

<sup>35</sup> Little is known about how a physician in BC might lose or abandon authorization as an MMT provider.

The study found multiple interpretations of mandated counselling in MMT. Some practising MMT physicians counsel their patients, others hire staff for the purpose; there remains no standardized approach. Diverse meanings of counselling and the multiple ways that it is delivered, utilized, and documented point to less than optimal institutional attention to core practices. There is also the issue of MMT clients' broader health care experiences. For example, clinicians' efforts to refer clients to outside counselling can be hindered by service waitlists. Also, addiction knowledge is generally lacking among doctors in the province, which can lead to discriminatory treatment of MMT clients in health care settings. Lastly, there remains need for service coordination across the sites of MMT, primary care, mental health services, and prisons.

Physician interviewees acknowledged that clients can experience stigma through association with MMT and encounters with various health practices, and that their women clients in their mid-adult years often require more social supports than men, medical oversight of their health, timely referrals to primary health care or specialists, and further counselling. My research shows that MMT providers' mediation within a broad system of services can be a practical benefit for women. MMT physicians also spend a fair amount of time providing patients with documentation they need to apply for income assistance and disability benefits. I conclude thus far that compassionate understandings of the woman MMT client can be found in the MMT field. However, providers treat their clients with a fair amount of autonomy, and there is limited provider accountability of the full range of MMT practices. Physicians' mainly autonomous decisions and loose documentation of MMT practices suggest that physicians hold considerable power to determine their clients' experience of MMT. In turn, the lack of institutional attention to reporting and regulation devolves responsibility to providers and clients.

One can discern that the medical gaze at women's bodies, reproductive issues, and health behaviours has increased. This construction of power/knowledge obscures women's identities and complex social and cultural locations (Boyd, 1999; Friedman & Alicea, 2001; Marshall, 2005; Raimondo, 2007). Frequent use of the terms "monitoring" and "surveillance" in guidelines and physician narratives reveals the presence of risk discourse in MMT practice. The notions of risk, stability, progress, and clients' "readiness to change" especially surround clinical representations of women who use drugs and attach to discussions about pregnancy, violence, and sex work issues. When physicians

point to cumulative stresses through injection drug use, unstable housing, and abuse trauma as the primary contributors to women's health problems and social marginalization, they narrowly reconstruct these issues as a problem of the individual women's non-normative behaviours, environments and relationships, and moreover, obscure the role of policies in reducing women's options and contributing to their persistent disadvantage. By privileging biopsychosocial and risk understandings of women's drug use problems, women's concerns or circumstances which do not fit these distinct frames are likely not documented or dealt with on some level.

The MMT system in BC has always been in a state of flux and has become increasingly so in recent years. Recent dismantling of an MMT client registry may reorganize how opioid substitution is practised and experienced in upcoming years and may lead to unintended consequences, such as increased surveillance of clients by their physicians. In the interviews, the four physicians retrospectively cited positive developments, such as increased societal recognition that addiction is a health issue and not a criminal one, and institutional recognition that MMT clients need counselling. Also, the interviewees expected that buprenorphine type of prescriptions, such as Suboxone®, would improve access to opioid substitution and decrease clients' experiences of stigma. One of the key claims made for prescribing buprenorphine rather than methadone to clients is that the practice can reduce associated stigma by reducing the frequency of supervised dosing. For some time, the lack of policy and funding attention to buprenorphine in BC had left methadone as the major modality of substitution treatment. Suboxone® is increasingly prescribed in Western countries and obviates many of the health systems' concerns about safety arising from methadone diversion to illicit markets (Fraser et al., 2009). Netherland (2011), who studies the interplay between neuroscientific discourses and buprenorphine treatment experiences within U.S. HIV treatment settings, has argued that clients are less stigmatized through alternate opioid substitution prescription because of the different ways the medicine is classified and delivered. In BC, the recent promotion and availability of prescribed alternatives to methadone will improve patient access to treatment, and yet the long-term influence of this substitution in the lives of women on MMT is unknown. At the time of the study, none of the participants had been offered it as an alternative. For Debbie, Renee, and Sarah, daily methadone dosing especially re-constituted some demoralizing clinical arrangements and pharmacy

practices. Moreover, there remains no broadly empowering “magic bullet” for delivery of treatment for opioid addiction. For instance, Suboxone®, in the end, provides only partial relief from clinical surveillance (Fraser et al., 2009). Additionally, the general problem of lack of resources for physicians and clients continues.

To summarize, local knowledge of the MMT client is typically gained through physician/client consultations and underreporting reconstitutes the invisibility of clients in the health system and works against efforts to standardize an equitable and less controlling opioid treatment approach. As this dissertation shows, MMT reconstructs the woman client as a patient lacking agency (Fraser & valentine, 2008; Friedman & Alicea, 2001). More recent use of risk frames in MMT policy and practice perpetuate narrow constructions of the “drug user.” In the case of women, this approach often directs attention to their reproductive issues at the expense of understanding broader health and social concerns. My study further revealed some of the problematic ways in which women and their marginality are rendered visible and invisible through local MMT texts and practices, and these institutional responses to opioid use obscure the various ways that experiences of treatment and marginality intersect. The everyday politics of care is a major analytic theme I explored in Camille, Debbie, Renee, Sarah, and Mariel’s narratives, and in the following section, I summarize experiences of MMT, other types of health treatment, income assistance, and services targeting the poor, and how they overall contribute to women’s experience of supervised exclusion.

## **8.2. MMT Subjectivity: Navigating, Negotiating, and Speaking Out**

In Chapter 6, I analyze five women’s trajectories to and through MMT in BC in the context of policy trends and sociocultural conditions. Life stories provide a method to explore the links between women’s involvement in MMT and their advanced marginality. Women’s struggles related to drug use and treatment are socially constructed and contingent on culture, historical conditions, structures, discourses, and practices. The research draws on social constructionism, which is an approach that can challenge dominant and narrow understandings of women’s lives (Fraser & Moore, 2011). In

addition, the use of life stories seeks to include women's knowledge about their worlds to facilitate connections.

First, this study highlights that the participants' backgrounds, drug use trajectories, social circumstances, and experiences of drug use and treatment are diverse. Second, findings show that participants enrolled in MMT for diverse reasons, including the major reasons of experiencing sicknesses, such as general health problems and/or withdrawal sickness, and increased stresses, such as those arising from experiences of violence. I argue that there is no "typical" woman MMT client in BC. However, broad patterns can be discerned in their stories. Camille, Debbie, Sarah, Renee, and Mariel turned to medical drug treatment for drug use to improve their life chances and social circumstances and, of course, their stories did not end there. Participants' narratives further specify the ongoing need for multiple services, illustrate ambivalent experiences of clientization, and provide a rich context for understanding why negotiation, navigation, and speaking out as clients was necessary. They also shared experiences of poverty resulting from inadequate disability or income assistance. Participants had been financially struggling for some time, regardless of what type of income assistance they were receiving. Furthermore, their lives displayed the effects of marginalization and traumas accrued over the years (Debbie; Renee; Sarah; Mariel), including trauma arising from institutional violence (Camille). Intersecting life troubles, which included job loss, meagre income assistance, health problems, and growing drug use illustrated the need for and experiences of a range of services.

This research presents an intense case of clientization that can be implied by MMT involvement (Järvinen, 2014), one that intersects with the research participants' addiction trajectories. The study calls attention to the range of their social, economic, and political disadvantages (Bourgois & Schonberg, 2009; Friedman & Alicea, 2001). In both Chapter 6 and Chapter 7, the thesis provides experiential evidence of how medicalization and criminalization of drug use over time is experienced and how the participants draw on multiple meanings to purposefully navigate services in this milieu. MMT-related client identities are also multiple (Ning, 2005; valentine, 2007) and have implications for clientization in general (Järvinen, 2014). Camille and Debbie identified as having a chronic drug use problem while Renee, Sarah, and Mariel resisted that characterization. MMT participation can animate women clients' efforts to be treatment compliant, or in their

words, to “be good” (Friedman & Alicea, 2001; Rosenbaum, 1981). MMT subjectivity also intersects with participants’ other roles as mother, grandmother, daughter, and partner, which suggests the need to negotiate identities across both formal and informal spheres.

Methadone is situated on a continuum of pharmaceuticals, meanings of methadone are unstable, and distinctions between licit and illicit methadone have increasingly blurred (Bourgois & Schonberg, 2009; Keane, 2013). This thesis similarly reveals diverse meanings of methadone, and participants, like MMT physicians, describe it as a useful medicine but also note it was a unique substance for its desired and undesired effects on their bodies. For various reasons, methadone had utility for the participants.

One key meaning in the MMT field that this study explores is the notion of progress. While normative constructions of the MMT experience typify progress as requiring a tightly controlled, physician-monitored path, the five women participants often spoke of success as largely out of their immediate reach. Rewards in their lives seem absent or quite delayed in that their poverty prevented them from participating fully in society on their own terms. Meanings of progress were multiple among the narratives. Progress could be related to recovery, or to achieving goals for one’s self or one’s family. The participants displayed a stronger sense of the social in this respect, largely because they were speaking from lived experience of frustrated goals. Yet what society has come to value—such as knowledge, expertise, networks—is defined through a discourse that places labour market participation high on the list of ways these can be accomplished. Thus, participants’ concerns about improving their daily lives and life chances and reaching goals often exceeded immediate health concerns and were related to material resources and efforts to strengthen family bonds. The participant narratives support the conclusion that MMT physicians should not be the only credible source of information about a client’s progress.

As previously shown, the participants’ income assistance experiences, health issues, and drug use issues intersected. Health conditions were not always linked to substance use. Some participants had more health problems than others, and some who heavily used drugs did not have serious illnesses or disorders. Thus, women’s health problems could arise from drug use or be unrelated to it. Either way, history of drug use

could complicate their health service experience, and when participants found their concerns and embodied knowledges dismissed because of their drug use histories, this constituted another stressor in their lives. Women's health is also a shifting concept that provides space to challenge dominant knowledges (Raimondo, 2007). Neither before nor after provincial health authorities re-conceptualized MMT as a harm reduction program in BC in the 1990s has there been a meaningful mechanism for the women in this study to challenge the stigma that they experienced through this treatment. The study shows that practices can partially alleviate women's experiences of stigma, and yet health policies and discourses re-constitute experiences and understandings of discrimination in specific ways. In its broadest iteration, the medical focus on women's drug use histories can obscure the links between health, and poverty and other forms of deep exclusion.

Use of services, especially services for low-income citizens, varied among the participants. Those who required the most services did not necessarily access them. Renee and Camille were quite service resistant at the time of the interviews. Debbie had the most experience with services. Harm reduction services such as needle exchanges and short-term services such as street nurses, drop-ins and shelters helped Debbie and Camille at times of severe crisis. Accessing women-centred services did not always result in long-term supports, but they were highly valued nevertheless, and Debbie's involvement with supportive programs designed for women helped her gain disability assistance and social housing. This suggests that care meant different things to the participants who were at different stages in their treatment involvement. Some programs were not utilized because of where they were located, or because they were short-term and/or did not adequately address their needs. Sometimes, participants wanted to avoid other program clients who triggered them to use drugs, such as men or women who presented in a state of euphoria. Program avoidance could also arise from a desire to protect privacy or dignity. Lastly, being keenly aware of the competition for dwindling resources, participants were not generally hopeful that their social circumstances would soon improve through programming.

Participants sporadically received informal help from family members or friends, typically at times of crisis, and offered help to others. Help given to or received from family mainly involved occasional material resources and care work. Overall, exchange of informal supports between participants and their family members and friends were

insufficient replacements for absent structural supports. Informal help is not straightforward exchange. It can indicate expressions of altruism and a web of interdependencies or impositions on one's resources or energies. Also, reciprocity can involve at times a person's refusal to give help or accept help (Offer, 2012). Participants' narratives reveal they had few resources to share but endeavoured in various ways to maintain connections to others. To reiterate, the presence of both formal and informal supports in the participants' lives starkly reflect the experience of intersecting struggles.

Methadone involvement is also heavily stigmatized (Fraser, 2006). Stigma is multidimensional (Link & Phelan, 2001) and its continued presence in the participants' lives implicates a range of legal and social policies. Participants could experience stigma as overt discrimination through categorization and labelling, and those who navigated discrimination in health service encounters and beyond could find it debilitating and sometimes strategized to avoid it (Debbie; Renee; Sarah) or challenge it (Mariel). Overall, stigma was an issue that required identity work to negotiate access to health care and formal and informal supports (Debbie; Sarah), including distancing one's identity from association with neighbourhoods with heavy and visible drug use (Debbie; Renee).

In BC, the DTES neighbourhood of Vancouver is regarded as a site of concentrated poverty and visible drug use, and is also associated with biomedical strategies of containment (Elliott, 2007) and a pastoral relationship between numerous service providers and impoverished clients located there (Roe, 2010). While the politics of addiction, health, and poverty can be shown to be geographically concentrated and historical in the case of the DTES, it cannot be assumed that opioid use problems in BC begin and/or end there. Alternately, the study participants' everyday struggles have at times been directly and peripherally connected to the justice system and the DTES or a similar neighbourhood of disadvantage. Like many, Camille, Debbie, Renee, Sarah, and Mariel experienced the dramatic shifts that harm reduction ushered in and have since struggled to make sense of why stigma was a constant presence even as they experienced a somewhat less criminalized identity over time. Moreover, many of the participants' experiences were not limited to particular places, reminding us that, like drug use, identities are variable, negotiable, and portable across place and time. My study explores women's social, economic, and political exclusion and posits that there is

evidence of an integrated form of containment that is less fixed to place than to policies and practices that affect women as embodied client subjects wherever they reside in BC.

### **8.3. Conclusion and Recommendations**

The primary purpose of this study is to build understanding of women's experiences of the politics of care at the intersections of MMT and income assistance participation, health care, and formal and informal supports. The research draws especially on participants' narratives to understand drug use-related social problems in these multiple contexts. Experiences of deep exclusion in this case relate to drug use and treatment in both broad and specific ways. It is argued that MMT in BC constitutes "supervised exclusion". In other words, being under medical surveillance and labeled as a methadone client, and concomitantly experiencing social, economic, and political marginalization is evidently a restricting condition for women struggling to improve their lot in contemporary society.

Policies, practices, and experiences illustrate the complex constructions of addiction and treatment (Raikhel & Garriott, 2013). As discussed in this study, MMT is a shifting set of policies and practices that serve, control, and reconstitute the methadone client. While MMT is in flux, in some ways, change has been slow. For instance, historically, methadone was associated with claims to socially rehabilitate the "criminal addict," and this association existed for many years and even after MMT was positioned as a harm reduction tool. Also, biomedical and clinical constructions of multiple addicted identities shift and clients have used this to advantage in some settings (Ning, 2005). The diagnosis of addiction and the label of "at risk" suggest the need for increased self-management of identity, and this situation raises the issue of harm reduction as concept and practice. Harm reduction applies another layer of meanings to the disease theory of addiction because it links a particular healthcare regime to notions of risk and control in the care of "hard to reach" groups, ostensibly for the health of society. Supervised exclusion is by no means a "fixed state of being," but results from reconstitution of social inequities and lack of supports when women most need them. Well-meaning expert practices can mediate their effects to a limited extent on a practical level (Bourgois & Schonberg, 2009). As noted in the first chapter of this study, a significant majority of MMT

clients in BC relies on inadequate income assistance benefits and, in this context, the study participants experienced the intersection of MMT and economic insecurity in patterned ways. They could not make ends meet each month. They encountered surveillance through MMT technologies and clinical management, but also through income and disability assistance policies. Too often, they had to rely on others for resources when they would have preferred to be financially secure and independent.

As this study shows, women's health and poverty, rather than strictly their drug use, require coordinated policy attention in BC. This proposition may seem daunting because of the low priority given by governments to remediating criminalization of drug use, violence against women, and poverty in general.

My first recommendations concern MMT policy. Physicians and clients in BC would benefit if the College's administration of MMT was more transparent and if non-identifying statistical and evaluation data on program activities was publicly available. As well, there is need for a substantial revision of MMT guidelines for physicians, one which represents women in more equitable terms and accounts for the diverse contexts of their lives. This would require removing risk-based language in discussions about women in MMT. The College might consult community groups, such as the British Columbia Association for People on Methadone (BCAPOM) and women's advocates, such as the province's Elizabeth Fry Societies, for their informed perspectives. I see such groups as valuable resources for the College's MMT program in general. Also, counseling training for methadone-prescribing physicians should be mandatory, especially as new prescribing regulations seek to draw from a wider pool of physicians, and some of these new prescribers may have little experience in addiction medicine. Counseling education in this case should align with mental health counseling standards in the community. Another recommendation concerns the type of clinics serving MMT clients. As the study shows, the quality of MMT provision in BC varies widely. I suggest that without limits to how many addiction clients a private MMT physician can treat, efforts should be made to increase the number of publicly-funded clinics in BC as these are service-oriented rather than profit-focused, and likely provide more consultation time and resources.

Furthermore, in terms of MMT practices, another recommendation is that physicians treat women clients individually and not consult with them in tandem with other

family members. I further suggest that given time constraints of each clinical visit, physicians might develop a standardized set of questions that follows up on women's health concerns and facilitates timely referrals to other healthcare providers.

Lastly, given the considerable gender gap in knowledge about MMT, there is need for further qualitative research on women's experiences of this treatment. Feminist and participatory action research seem most relevant in this case. Research might explore the particular experiences of rural women seeking treatment for opioid use. Increased uptake of opioid substitution in Canada and changing MMT regulations provide additional focuses for empirical study of women's circumstances at various ages. For instance, knowledge of how the youngest women or parenting women are faring in MMT may be useful for redeveloping addiction health and social policies given the recent demographic and cultural shifts in opioid use.

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# Appendix A

## PowerPoint Presentations

### Methadone 101/Hospitalist Workshop

Agnew, J. D. (2014, September 13). Introduction [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Corneil, T. (2014, September 13). Non-illicit, non-methadone, prescription opioid overdose deaths in BC's interior: Findings from a retrospective case series, 2006–2011 [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Joe, R. (2014, September 13). Methadone maintenance: A practical guide to pharmacotherapy. Based on presentation by Dr. Jeffrey Dian [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Joe, R. (2014, September 13). Urine drug testing. Based on a presentation by Dr. Patricia Mark [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Ketch, J. (2014, September 13). Further options [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Manak, M. (2014, September 13). Rural delivery of opiate agonist therapy [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Manak, M. (2014, September 13). Substitution therapy for opioid dependence: The role of Suboxone [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Rieb, L. (2014, September 13). Triage, assessment & treatment [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Rieb, L. (2014, September 13). Methadone and pregnancy [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Rothon, D. A. (2014, September 13). Addictions overview [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Rothon, D. A. (2014, September 13). The 7 habits of highly effective methadone prescribers [PowerPoint presentation]. Methadone 101/Hospitalist Workshop. Kelowna, BC, Canada.

Tupper, K. W. (2014, September 13). Drugs, language and stigma: The power of words in health policy and medical practice [PowerPoint presentation]. Methadone 101 Workshop. Kelowna, BC, Canada.

### **Methadone 201 Workshop**

Expert Panel. (2013, October 18) Coroners' cases [PowerPoint presentation]. Methadone 201 Workshop. Vancouver, BC, Canada.

Mark, P. (2013, October 18). Urine drug testing [PowerPoint presentation]. Methadone 201 Workshop. Vancouver, BC, Canada.

McNestry, A. (2013, October 18). Methadone 201 Workshop. Introduction [PowerPoint presentation]. Methadone 201 Workshop. Vancouver, BC, Canada.

McNestry, A. M. (2013, October 18). Regulatory expectations: Physicians treating chronic non-cancer pain (CNCP) with opioids [PowerPoint presentation]. Methadone 201 Workshop. Vancouver, BC, Canada.

Melamed, J. (2013, October 18). SUBOXONE® for opioid addiction medication assisted therapy [PowerPoint presentation]. Methadone 201 Workshop. Vancouver, BC, Canada.

Rieb, L. (2013, October 18). Methadone as an analgesic. Methadone 201 Workshop. Written by Dr. Jeff Dian, modified and presented by Dr. Rieb [PowerPoint presentation]. Methadone 201 Workshop. Vancouver, BC, Canada.

Rieb, L. (2013, October 18). Chronic pain and addiction. Some slides courtesy of Dr. Mark Phillips [PowerPoint presentation]. Methadone 201 Workshop. Vancouver, BC, Canada.

Rieb, L. (2013, October 18). Caring for pregnant women with substance dependence [PowerPoint presentation]. Methadone 201 Workshop. Vancouver, BC, Canada.

Sobey, P. (2013, October 18). Booze, benzos, stage II recovery and MMT [PowerPoint presentation]. Methadone 201 Workshop. Vancouver, BC, Canada.

Tu, D. (2013, October 18). Opiate dependence and HCV and HIV [PowerPoint presentation]. Methadone 201 Workshop. Vancouver, BC, Canada.

## Appendix B

### Physician Interview Schedule

Could you tell me about your educational background?

Why did you choose to work in the field of addiction medicine?

How did you been involved in providing methadone maintenance treatment?

What was training like?

Do you have a family practice as well?

Do you practice in another office?

What do you see as being the trends now in addiction medicine?

What are the trends in methadone maintenance?

How does methadone fit into the broader picture of addiction treatment?

What has surprised you about methadone maintenance?

How easy or difficult is it for clients to enter the program?

What is involved in an initial consultation with a new client?

How many methadone clients do you see?

How long are typical appointments?

How many of your clients are women?

How do women clients differ from men clients?

And how many of your clients are women over the age of 50?

Can you tell me more about these older women clients?

How long have they been in MMT?

How often do you see them?

What are their challenges?

What sorts of health problems are they having?

What sorts of social problems are they having?

Do any of them live in the DTES?

What other things are discussed during appointments?

What are your thoughts on how long clients should stay in the program?

How has methadone helped your clients? How has it not helped them?

How do you record client circumstances?

Do you keep figures on how long clients stay in the program?

Is that information shared with authorities?

What are your thoughts on methadone carries?

What sorts of changes or improvements would you like to see in the methadone maintenance program?

Is there anything else that you would like to add or mention?

## Appendix C

### Life Story Interview Schedule – Interview One

When did you first become a methadone client?

Who first told you about methadone treatment?

How many times have you been on methadone?

How long were you on methadone each time?

Where do you go to get your methadone dose?

How often do you see your methadone doctor?

What does your methadone doctor do when you meet?

Is she or he your family doctor as well?

Where do you go for appointments?

Can you tell me a bit about your everyday routine?

What types of health conditions do you have? How are those being treated?

Who do you talk to about problems?

Tell me about some of the things they help you with.

What are some of the ways you help yourself?

Have you lived here long? Where do you want to live?