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Challenging biopower: “Liquid cuffs” and the “Junkie” habitus

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Abstract

Background—Methadone maintenance treatment program (MMTP) is associated with improved quality of life amongst many heroin users. Still, program adherence problems remain a fact.

Aim—To improve our understanding of MMTP “adherence problems”.

Methods—Using snowball sampling, two subgroups were recruited: MMTP enrollees and non-enrollees. A semi-structured questionnaire guided all in-depth interviews. Interviews were recorded, transcribed, hand-coded and analyzed using a grounded theory approach.

Findings—Of 28 participants, 23 were male and Fifteen were in MMTP. All were NYC residents. Most were Hispanic (57%) and Caucasian (32%). The average age was 38 years. Twenty-two had a General Educational Development or less. All were poor and 64% were homeless. Many do not enroll in MMTP to quit heroin but to avoid physical withdrawals. Once enrolled, problems emerge with program regulations and methadone's pharmacology. These they refer to as “liquid cuffs”. Drawing on Michel Foucault, methadone may be considered a disciplinary biopower technology that participants challenge using specific strategies. A “Junkie” habitus, crystallized by emotional and identitarian heroin-dispositions, also challenges biopower.

Conclusions—The “liquid cuffs” experience along with the “Junkie” habitus effectively challenge disciplinary biopower. Loosening program regulations may improve quality of services and reduce harm.

Keywords

Disciplinary biopower; habitus; heroin; Junkie; methadone; methadone programs

Introduction

Methadone programs are shady business. Like, if my urine is positive [to heroin], they'll raise my dose. That's why I hate them. They don't sit down with me to talk. They're just like, “Hey, sign here!” But, to ask you how you are feeling, if you are

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doing OK, my counselor has never asked about that. I really want to quit methadone (Pinto, Bronx).

Pinto is a 50-year-old Puerto Rican male who started injecting heroin at 15 years of age. He has been enrolled in the same methadone maintenance treatment program (MMTP) for the past five years. His experiences in the program are mixed. Because of MMTP, he no longer undergoes physical withdrawals in the mornings, has reduced the frequency of his heroin intake and has also reduced the amount of times he exposes himself to law enforcement and infectious diseases. Moreover, he has been able to maintain a peer stipend job at a local Bronx needle exchange. These positive changes in his life result, at least partly, from MMTP enrollment and exemplify what multiple studies have found among MMTP enrollees in the United States (Ball & Corty, 1988; Ball, Lange, Meyers, & Friedman, 1988; Dole & Nyswander, 1965; Kreek, Borg, Ducat, & Ray, 2010; Magura & Rosenblum, 2001; Stancliff, Myers, Steiner, & Drucker, 2002).

However, there is also great deal of conflict between Pinto and methadone. For one, the program does not offer the emotional support he needs. When his urines test positive for heroin, he is mandated to a 10-mg increase of methadone. For Pinto, MMTP resembles a “business” because, as others in this study also contend, the higher the methadone dose, the harder to leave the program. Methadone is a long-acting (lasts up to 36 hours) opiate agonist (with similar functions to those of an opiate) used to treat opiate dependence, particularly that of short-acting (up to five hours) opiates such as heroin. It binds to the mu-opioid receptors in the brain (same receptors used by heroin), blocking heroin from entering such receptors. As such, the higher the methadone dose, the higher the likelihood of heroin blockage (Pollack & D'Aunno, 2008) and, as Pinto adds, the harder to leave MMTP.

Enrollment in MMTP has been directly associated with improved quality of life for many enrollees. In the United States, methadone's effectiveness is measured by assessing pre, post- and during-MMTP enrollment arrest frequencies, HIV rates, secondary drug use (*via* toxicology exams), client retention rates and the individual's reinsertion into mainstream society – namely school, family and licit work (Ball & Ross, 1991; Stotts, Dodrill, & Kosten, 2010). Several studies show MMTP is indeed successful at achieving some of these goals (Ball et al., 1988; Kreek et al., 2010; Stotts et al., 2010) and how its retention rates are higher than those of abstinence-based treatment programs (Deck & Carlson, 2005). The overwhelming consensus is that methadone is the most effective opiate dependence treatment today (Schwartz et al., 2008; Strain, Bigelow, Liebson, & Stitzer, 1999).

A number of studies have also showcased marked problems with MMTP's rules and adherence rates (Hubbard et al., 1989; Joseph & Stancliff, 2000; Magura, Nwakeze & Demsky, 1998; Magura & Rosenblum, 2001; Magura, Rosenblum, Fong, Villano, & Richman, 2002; Magura et al., 2009; Peterson et al., 2010; Reisinger et al., 2009; Rosenblum et al., 2007; Simpson & Sells, 1982; Simpson et al., 1997; Stancliff et al., 2002). Furthermore, illicit drug use among MMTP enrollees remains a problem (Magura et al., 1998, 2002; Rosenblum et al., 2007). Importantly, experts regularly recommend increasing the methadone dose to effectively solve adherence problems, particularly as these relate to

secondary (illicit) drug use (Kreek et al., 2010; Pollack & D'Aunno, 2008; Strain et al., 1999).

To better understand some of these adherence problems, this article will present some of the most conflictive experiences a small group of MMTP enrollees in NYC reported having with these programs and with the substance itself. Since study participants continue to use heroin despite MMTP enrollment, their experiences reflect those of a rather unique group of MMTP enrollees that may be best understood as non-adhered and even ambivalent around heroin use cessation. Thus, findings are not representative of the overall MMTP clientele.

Participants' experiences are discussed in tandem with the works of several scholars. First, I will use Michel Foucault's (1990) "biopower" concept, defined as the modern State's strategy to take "charge of life" by way of regulating the human body (and psyche) around a specific definition of health (Foucault, 1990: 144). In the United States, scientists define drug misuse (i.e. addiction) as a "brain disease" that requires medical treatment (NIDA, 2010). When compared to heroin use, methadone (as a state-sponsored, medically supervised drug) is a healthier alternative as it is congruent with standard medical care. Moreover, for medical providers, methadone is not only a technology that helps the individual leave the illicit drug world but one that also opens the door for mainstream society reinsertion (i.e. licit work, family, etc.). In this sense, being on methadone is what Foucault means by taking "charge of life" and compliant with normative health standards.

For MMTP, biopower is two-fold: (1) it consists of a structured State-regulated public health institution (the metha-done clinic), with (2) a specific type of medical intervention: methadone. Philippe Bourgois (2000; Bourgois & Schonberg, 2009) applied the biopower concept to the methadone clinic, providing ethnographic evidence of some of the negative impacts methadone, when used as disciplinary biopower (Keane, 2009), has over the individual (i.e. high doses, work disruptions and dwindling intimate relationships, etc.). In this article, I offer evidence to these same effects but I add there are spaces of resistance, conscious and unconscious, to this disciplinary biopower technology. This resistance explains salient treatment adherence problems.

Second, borrowing Pierre Bourdieu's (1990) "habitus" concept, I portray how life histories as heroin users and unchanged objective conditions of living shape and perpetuate heroin-dispositions, what I call the "Junkie habitus", that trigger continued heroin use despite MMTP enrollment. The habitus of a person involves personal life history within a specific type of setting, producing tendencies to act in particular ways. These tendencies, despite their grounding in history, are acted upon as if they were natural, as opposed to social. Applied to drug use, when a person has been using heroin (or any drug) for many years within an unchanged material and emotional context, perpetuating a specific type of relationship with the drug flows almost as if it were second nature. Importantly, this Junkie habitus contributes to resisting methadone's biopower by influencing continued heroin use (adherence problems) among MMTP enrollees.

Background

Since 1972, methadone maintenance has been widely available in NYC. In 2009, NYC MMTP sociodemographic data showed that 80% of enrollees were males, almost half were Black/African American (46.5%), 20.5% were Caucasian and 31.0% self-identified as “other”, which usually means Latino. Approximately 80% were between the ages of 18 and 54 (Dr. Daliah Heller,-NYCDOHMH 2011, personal communication), and many were Medicare insured. By the end of 2010, there were 80 Opioid Treatment Programs (OTPs) with 34,849 outpatient slots in New York City (Dr. Belinda Greenfield, Office of Alcohol and Substance Abuse Services – OASAS 2011, personal communication).

OASAS is the regulatory body for methadone maintenance in New York State, and all NYS OTPs must comply with these rules in order to dispense methadone (OASAS, Part 822, Subpart 822-5). For this study, some of the most relevant regulations are as follows: (1) daily clinic attendance is required unless the enrollee has three or more years of continued program compliance [i.e. no secondary drug use, good record of daily attendance, no criminal activity, etc.], (2) there are no dosage increase caps and (3) medical staff can increase dosage upon presence of illicit opioids in mandatory toxicology (urine) tests. While the first rule limits MMTP enrollees’ physical mobility, the second and third rules combine for potential ongoing methadone dosage increases.

Methods

This study was part of a broader investigation on the personal rationales informing continued heroin use among 28 NYC street heroin users. The author is a trained ethnographer with over 10 years of experience with NYC harm reduction programs performing drug use and HIV research as well as service provision.

The sample was split into two subgroups: MMTP enrollees and non-enrollees – the former were asked about their experiences within these programs. A main eligibility criterion was heroin use (and methadone enrollment) in the past 12 months. Participants were screened using general probing questions about frequency of heroin use, routes of administration and thorough descriptions of drug preparation. For methadone program enrollment, participants provided program identification cards to insure eligibility. All participants were older than 18 years and English and/or Spanish speakers.

The sample was recruited using snowball sampling. This methodology allowed the researcher to recruit initial seeds (potential recruiters) who, after their interview, were offered the opportunity to recruit a maximum of three other eligible participants. These seeds were found in public venues known for their underground drug markets, as well as in homeless shelters, and in the vicinity of methadone clinics. MMTP enrollment status was used to control recruitment and seeds were asked to recruit their peers based on this criterion. Participants were offered \$20 for an interview and an extra \$10 incentive for each eligible informant they brought into the study. Participants were assigned unique pseudonyms.

Data were acquired through one-time in-depth interviews, using a semi-structured questionnaire that covered a number of topics – “family upbringing”, “careers as heroin users”, “heroin and methadone meanings” and “drug treatment” experiences. Interviews were transcribed verbatim. Following the “grounded theory” methodology (Glaser & Strauss, 1967), data analysis began during data collection. This method effectively allowed for the identification of the convergent ideas (themes) presented in the following section. Transcripts were hand-coded by the author, who conducted in-depth reviews of each transcript (Patton, 2002). All participants gave informed consent. The study was approved by the Institutional Review Board of the New School for Social Research.

Findings

Sociodemographics

Of 28 participants, 23 were male. Sixteen were Hispanic, nine were Caucasian and three identified as Black/African American. The average age in the sample was 38 years, but ages ranged from 21 to 56 years. Twenty-two had a General Educational Development (GED) or less. None earned more than \$10,000 (from legal sources) in the past 12 months. Income sources included sex work, sidewalk and subway panhandling, stealing, drug selling, “copping” (buying) drugs for friends, aluminium recycling jobs and public assistance (food stamps, etc.). Eighteen were either homeless or unstably housed. Finally, 15 were enrolled in MMTP.

Table 1 presents dosage data on those 15 of 28 participants who were enrolled in MMTP at the time of the interview. Of these, seven were Caucasian, six Hispanic and two were Black/African American. Only three were females. Ages ranged from 21 to 56 years for an average age of 37 years. Only two were on doses below 60 mg and 90 mg is the average dose. Excluding Billy (in and out of MMTP for 30 years), on an average, participants have been enrolled in MMTP for five years.

Why methadone?

There are two convergent and not necessarily mutually exclusive MMTP enrollment rationales. The first is to avoid the “morning sickness”. Enrollees who follow this rationale felt they needed an immediate way out of a desperate, poverty-informed situation. These participants may have also been contemplating the possibility of quitting heroin, but this was not the main reason behind enrollment. For the second, there is a more defined desire to quit heroin and observe social norms (licit work and family). Tripp, a 39-year-old Puerto Rican, exemplifies the first enrollment rationale.

I went into methadone because I was having trouble getting money at a certain time. It was very hard and I'd wake up very sick. It was so hard to get the money, and I didn't want to have to assault or kill anyone. That's not who I am. I just wanted to fix my situation. Someone told me about methadone and I went there and drank a pink solution. But then I realized that they increase your dose. They want to keep you 'hooked'. They want to make sure you come back. Methadone is a business and no one can make me believe otherwise. (Tripp, Bronx, author's translation).

Tripp has been living in NYC for 10 years and using heroin for 22 years. Currently on a 120 mg methadone dose, he has been enrolled in a MMTP for the past six years. Despite MMTP enrollment, he did not stop using heroin. His enrollment was primarily informed by the lack of money and the hardships and negative repercussions attached to getting money while undergoing withdrawal symptoms. Poor heroin users in the streets of NYC make a living by panhandling, stealing/selling merchandise from stores, sex work and a number of other legally risky activities. Every morning, they wake up feeling “sick” and without money. Eventually, they grow tired of having to hunt for heroin-money, of exposure to law enforcement, HIV/AIDS and of judgment from subway commuters. As an opiate agonist, methadone helps them avoid withdrawal symptoms while allowing for continued heroin use. However, Tripp’s “dirty urines” (urines with traces of heroin) caused methadone dose increases, influencing the tripling of his heroin dose to trump methadone’s blocking effects.

Exemplifying the second rationale, Billy is the only methadone program enrollee who has maintained a family and a legal job. He is a 47-year-old male from Puerto Rico and started injecting heroin at 12 years of age. He is a gardener in the Bronx and lives with his wife and children. He attends church every Sunday. When I asked him what led him to enroll in the clinic, he responded, “In the beginning, my wife and my sister-in-law. . . now it’s more my wife”. Billy enrolled in MMTP to comply with family duties.

Interestingly, after many years on methadone and no heroin use, his wife questioned his lack of libido suggesting he was being unfaithful:

Fifteen years later, I was on 40 mg because I wanted out. My counselor told me “although you’ve been many years without using heroin, you should stay on methadone to avoid going back to heroin. If you quit methadone you’ll go right back to heroin”. I had a wife back then, very pretty, green eyes and when we were about to make love I couldn’t do it. She used to ask me, “Are you seeing anyone else?” I said I wasn’t, that it was probably the methadone. I came to the clinic with my wife and I spoke to the doctor and he prescribed Viagra. I used them and it worked. But she continued criticizing that the methadone was making me fall asleep. (. . .) She was on my case every day until I got so angry that I left the house and went straight to the drug spot and copped (Billy, Bronx).

Billy wanted out of methadone. Using the discourse that heroin addiction is a “lifelong disease” and that “relapse” is unavoidable without methadone, his counsellor convinced him to stay. His sexual drive was addressed by adding Viagra to his medication portfolio. But his wife also had problems with his methadone “nod”. Billy was so tired that he decided to use heroin again. Divorce papers followed shortly after.

Methadone’s quality as disciplinary biopower manifests in both cases. While heavily reliant on a narrative of improving health and program adherence, Tripp’s dosage increases are disciplinary biopower insofar as they seek to control his neurological response to pleasure (i.e. heroin) and creating a compliant subject/patient. As with Pinto, for Tripp, this situation feeds into the not uncommon perception that MMTP resembles more a “business” than treatment. Arguably, Tripp’s consent to take methadone may have been driven by the physical and material circumstances surrounding this decision. He enrolled in MMTP not

because he wanted out of heroin but because he could not afford it any longer while undergoing painful withdrawal symptoms. This is an experience that is too often overlooked in most literature and that highlights how poverty may heighten an individual's vulnerability to consent to methadone.

In Billy's case, while he joined methadone with the goal of quitting heroin and did so for 15 years, methadone compromised his libido, leading eventually to divorce. Even after sharing his intimate troubles to his case worker, his request to be tapered-off of methadone was rejected. Revolving around the "addiction is a lifelong disease" idea, his case worker focused solely on helping Billy avoid going back to heroin (e.g. remain a compliant patient). Disciplinary biopower is again manifest and regardless of personal troubles. From the outset, it becomes clear how program adherence is already jeopardized by these disciplinary aspects.

Challenging biopower: strategies and the Junkie habitus

During data collection, several convergent strategies emerged that help study participants feel the effects of heroin despite methadone. The first was maintaining the methadone dose below 60 mg.

There are people that stay in a low dose, they don't go over 60mgs because 60mgs is the blocking dose. If you do more than 60mgs of methadone you won't feel the heroin. So, they remain lower than 60 so that they can get the cure [methadone], then you stretch your body and can proceed to hustle more relaxed. So, they are not like me, like I wake up in the morning and I say "Oh, fuck man!" (Luis, Bronx, author's translation).

Luis is a 43-year-old Puerto Rican male who has been using heroin for 25 years. When we discussed that others on methadone doses higher than 60 mg report continuing to feel the heroin effects, Luis replied, "Nah, that's just a routine, a habit. They don't really feel the heroin". In fact, convergent injection practices among those in this sample attest to this statement. For instance, Charlie is a 34-year-old Puerto Rican male who has been using heroin for 17 years. He is currently on 100 mg of methadone. Regardless of methadone dose, he continues to inject heroin (and sometimes even water) due to the embodiment of an injector's identity overtime.

I use heroin to get my mind to think that I am still using something. To see my blood go in, although I don't feel anything, even if I am only injecting water (Charlie, Bronx, author's translation).

For those in this study who are in MMTP, continued injection drug use may not solely be about getting high on heroin per se but rather a process to which they have become habituated. An identity was shaped during all the years of active injection drug use and those who are now on methadone miss that identity. It is an important part of their history, of their sense of self, of their habitus. Long histories with a ritualized injection process and with heroin-specific sensations continue to be a part of their dispositions, what they tend to like and dislike. In this study, we notice how the Junkie habitus, as a system of embodied and

naturalized heroin dispositions, is unchanged by methadone and informs continued heroin use.

Exponentially increasing the heroin dose (to trump methadone's effects) was the second strategy. John is a 21-year-old Caucasian male from Denton, TX, who has been in MMTP for a year.

Before methadone I was doing 5 bags of dope and after I started methadone, since I am back on 70 mg, I can do five bags now, all in one shot. And then after that I can taste my dope and start feeling really good (John, Tompkins Square Park).

Uncertain about the effects that mixing these two powerful narcotics may have over his body and health, John subjected his body for testing these drugs' interactions. Through these self-tests, he was able to determine the amount of heroin he would need to cut through methadone's blocking effect. But it is perhaps Ponder who portrays best this phenomenon. Ponder is a 30-year-old Caucasian male from Los Angeles, CA. He is a veteran who started using opium while deployed in Afghanistan. Upon arrival in the United States in 2005, he started using heroin to placate his "war nightmares". He explained, in order to overcome 190 mg of methadone, "this is going to sound fucked up, but I have to try and overdose each time. It takes this much heroin to feel the effects". In this group, these are not atypical individually led "clinical trials".

Penelope, a 51-year-old Caucasian female from Brooklyn, offered a third strategy for effectively "cut through" methadone's blocking effect. She is on 120 mg of methadone and has been injecting heroin for 40 years. Penelope explained that she "skips her methadone program for 3 consecutive days" to insure feeling heroin's effects. Still, her narratives also denote emotional aspects behind her continued heroin use.

[Heroin] made me feel like I was at home. Even today, I feel that way. If I got the right stuff, I do, I feel like home. Like you can put your feet up and lay back and be home. (. . .) [On methadone] I can walk without getting tired after five steps. I can sit up, I can actually make it somewhere. I can think a little clearer. That's all it does (Penelope, Brooklyn).

Penelope refers to heroin as "the best hug you could imagine". Throughout her interview, she felt more comfortable explaining why she continues using heroin in an "intimate" manner, and this is because it better suits her individual history. Hers has been an extremely lonely life full of familial and other social disappointments. She ran away from home at 15 years of age after being gang raped (at 14 years of age). Her father was always working, and her mother had pronounced mental health and substance use problems. Penelope felt alone and her home no longer felt like a safe space.

Unlike methadone, heroin makes Penelope feel "at home". It is heroin's pharmacology that transports her to this safe zone. Despite methadone, she continues to like and need what heroin gives her. She is physically comfortable with methadone but existentially, heroin is the only thing that makes her feel good. These stories show how the Junkie habitus, with its peculiar emotions, identities and rituals, resists a disciplinary biopower intervention (MMTP) that arguably aims to strip those identities and emotions from the individuals.

More specifically, these strategies revolve around trumping methadone's pharmacology, the main barrier to fulfilling the existential needs that heroin provides.

Withdrawing from the “liquid cuffs”

Often because of the problems faced within MMTP, many decide to leave these programs. Raúl is a 43-year-old Puerto Rican male who has been living in NYC for 37 years. He has been self-detoxifying from methadone with heroin because his methadone clinic would not let him travel to Puerto Rico to visit his dying mother. Understandably, he is frustrated and is also undergoing extreme physiological pain in the process. Methadone's withdrawal symptoms are many times harsher than heroin's. Raúl is using heroin to detoxify from 130 mg of methadone. In fact, for the first time in his 29 years using heroin, he resorted to the injection route because it relieves the methadone withdrawal pain more effectively than sniffing. Before beginning this process, Raúl was a compliant program enrollee with over a year of no illicit drug use and a stable stipend job in a needle exchange program.

It feels like an 18-wheeler running over you. Your back hurts, your bones hurt, it's hell. It's death. It takes 37 days to kick. With heroin, it takes three days to get a habit and three days to kick. “This is bullshit man, it's like liquid cuffs” (Raúl, Bronx).

For Raúl, withdrawing from heroin is a much better alternative. He refers to his mother as “the love of my life”. While methadone allowed him to stop using heroin, it also took away his freedom— a freedom he is not willing to cede. His mother is dying in Puerto Rico and he refuses to be forbidden from saying goodbye to her. The emotional and physical pain he goes through is likely to be unbearable for most people. The impressions that Raúl now takes away with him from methadone programs are likely to taint this drug as an alternative to heroin in the future. These are only a few examples of the multiple stories around what they like to call the “liquid cuffs”. These experiences help explain MMTP adherence problems and continued heroin use. Importantly, these are the drug users' experiences and points of view that tend to be overlooked in much of the literature.

Discussion

Methadone, as disciplinary biopower, aims at controlling the internal environment of heroin users to deter heroin use by blocking its effects. In a way, this pharmacological blockade seeks to deny these individuals important aspects of their selves (heroin identities, emotions for heroin and injection rituals): the Junkie habitus. Habitus speaks to an individual's disposition to behave and feel in certain ways (Bourdieu, 1990). An individual who has been using drugs for many years within a specific type of context (i.e. the Junkie world) is disposed to sustain a specific type of relationship with the drug. In these cases, methadone does not do away with the meanings these individuals attribute to heroin and what this substance does for them. This, however, does not mean that the Junkie habitus cannot change – habitus is a “structured and structuring disposition” – (Bourdieu, 1990: 41) but it does mean that it will exert its influence over continued heroin use until it has been restructured toward something else. These data show that this something else is yet to take place among these individuals and many continue to be disposed to use heroin.

Two disciplinary aspects are evident: program rules and methadone's pharmacology. Both are barriers to program adherence. These individuals not only resist program rules but also miss what heroin did for them, how it made them feel. For them, heroin may not simply be a hedonistic bullet. They have developed an intimate relationship with a substance (i.e. heroin) that has a pharmacological aspect that turns existential. It helps them reclaim their identities (Charlie), deal with emotional pain (Penelope) and war nightmares (Ponder). It became a friend, a companion in an otherwise lonely life. Thus, the Junkie habitus, as an unchanged disposition, challenges disciplinary biopower.

These heroin-meanings are absent from methadone. Methadone is simply a substance that keeps them from withdrawing. It is not a friend and it is not a life companion, even after they use it for years. They do not love methadone, and it is not a part of their identities. They continue to use heroin because of the Junkie habitus and because overly rigid program regulations trigger deep discontent. As Bourgois (2000; Bourgois & Schonberg, 2009) has already noted, MMTP violate participants' self-respect. Billy is unable to have sex with the woman he loves – methadone is in his bed. Raúl cannot visit his dying mother. As such, this type of disciplinary biopower not only controls the body but also negatively impacts their most intimate personal relations. That many, like Tripp, enroll in MMTP out of financial and physical desperation further complicates this problematic, bringing to the surface important elements of vulnerability to consenting to a medical intervention they would otherwise avoid. Overall, these are the kinds of personal experiences and insights that need, and perhaps urgently, more attention.

For mainstream society reinsertion, these individuals' menu of options is limited – and this is so regardless of MMTP enrollment. Rewarding jobs are not likely, even after completing GED programs. Criminal records shut any chances they may have at a College degree. A plethora of unresolved emotional turmoil is not uncommon while simultaneously, access to mental health service providers that are not overburdened with large caseloads is slim. Even while on methadone, these individuals' lives continue to be disordered both materially (still jobless, homeless, poor and with long criminal records) and emotionally (unresolved trauma, estranged from family, etc.). These data show how these kinds of histories do not change overnight and pharmacotherapy does not suffice – it takes time and perhaps contextual changes (Zinberg, 1984) to restructure the Junkie habitus.

Admittedly, one of biggest challenges MMTP face is the Federal regulatory system. Methadone is a schedule II drug under the Control Substance Act and requires strict monitoring. This translates into hardships of loosening mandatory daily clinic attendance rules. While NYS regulations provide for allowing “take-home” methadone (OASAS, Part 822, Subpart 822-5), clearance could take months, leaving little room to effectively deal with exceptional circumstances. On the human level, as in Raúl's case, this translates into feeling disrespected by the system.

Importantly, these regulations can trigger dangerous responses. Methadone withdrawals are painful, and detoxifying from it without medical assistance is unsafe. For those who continue using heroin while on methadone, potentially fatal self-led clinical trials are common. They become their own guinea pigs, exponentially increasing the heroin dose to

overcome methadone's pharmacology. In NYC, overdose is the primary cause of mortality among substance users (Heller & Stancliff, 2003). Because dosage increases are not mandated by Federal regulations, MMTP administrators in NYS should consider eliminating these, working with these human beings individually to address their service needs and avoid more harm. In fact, as scholars have suggested, a form of treatment that includes heroin in its portfolio may be more effective (Bourgois, 2000; Bourgois & Schonberg, 2009; Gartry, Oviedo-Joekes, Laliberté, & Schechter, 2009; van den Brink et al., 2003).

Finally, while findings from this study are not generalizable, they shed light over specific problems that some program enrollees encounter within MMTP and that render this intervention ineffective for some. Not only do these findings clarify some of the rationales behind MMTP adherence problems but they also help highlight the need for future policy-specific research that addresses the impact of methadone's pharmacology, programs' regulations, and the Junkie habitus over treatment adherence.

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Table 1

Current methadone dose (descending order) and time (consecutive years) on MMTP; $n = 15$.

Name ^a	Race/ethnicity	Gender	Age	Dose	Time on MMTP
Ponder	White	Male	30	190	6
Zeppelin	White	Male	23	120	1
Tripp	Hispanic	Male	39	120	5
Penelope	White	Female	51	120	10
Charlie	Hispanic	Male	34	100	1
Flea	White	Male	23	100	3
Sid	White	Male	39	100	5
Vince	Black/AA	Male	56	80	15
Jay Jay	Black/AA	Female	50	80	13
John	White	Male	21	70	1
Antigone	White	Female	25	65	3
Skip	Hispanic	Male	24	60	2
Pinto	Hispanic	Male	50	60	5
Gary	Hispanic	Male	47	40	5
Billy ^b	Hispanic	Male	47	40	30
				Average dose = 90 mg	Average time = five years

^aPseudonyms.

^bNot consecutive years.