The Penal Attitude and Methadone Treatment

Methadone treatment has been in existence now for over thirty years returning to society more productive individuals than any other treatment modality. Yet, despite this success it is disparaged and misunderstood which has translated into bias and discrimination not only for the consumer of the treatment as even those who work in the modality experience prejudice.

Intolerance towards methadone has resulted in many professionals entering the field with no training at its best or what training they do receive containing bias and prejudice towards methadone. The Director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) cites methadone maintenance as an example of "Good science, but policy obstructed" (Gordis, 1989). He goes on to state:

"the widespread provision of methadone-maintenance therapy for narcotic addiction --is a policy that does not lack for scientific justification of its effectiveness. Nonetheless, it is a policy that has been blocked by many obstacles since its introduction as a therapeutic technique for narcotic addiction. ....Part of this battle has to do with a failure to educate the public about methadone, a very complex educational challenge."

Gordis identifies the following four obstacles that have impeded the expansion of methadone treatment in the face of an expanding AIDS epidemic:

1. Attitudes, biases and preconceptions by the public about heroin addicts and their perception of a character disorder, defect and emotional problem as the driving force of an addiction. While some addicts may have a character flaw others do not. Nevertheless, methadone is criticized for not addressing the addict’s perceived personality defects. However, programs that have attempted to address the preconceived character disorders to change the addict have generally not validated their claims over extended periods of time with large numbers of addicts. The public does not understand that they have a misconception about the basic nature of addiction.

2. The second problem is one of semantics and is an example of language as the purveyor of stigma. The most frequent criticism of methadone treatment is that it substitutes one drug for another or as a variant, one addiction for another. The word drug has an ambiguous connotation. A drug can be either a legal or an illegal substance. The word substitute in an arithmetical equation implies the preservation of an equality. Addiction in the verbal variant implies a mood altering or euphoria producing substance. In the verbal equality substitute becomes an equal sign thereby in a verbal sense blurring or lessening the meaning between the two nouns separated by a verb connoting equality. Thus, the carefully researched medical regimen of methadone maintenance is reduced to a trivialization. The word addiction itself leads to ambiguous connotations. In one sense
it is associated with alterations of mood, compulsive use and criminal behavior. In another sense, it is the strict biological phenomenon of physical dependence, tolerance and withdrawal. In the public's mind both intertwine semantically to conceptualize a nebulous state defined or labeled addiction.

3. The public does not understand the differences in pharmacology between heroin and methadone. There is a general misperception that methadone is a euphoric drug when used in maintenance programs. Furthermore, the public has little sense that addiction is a chronic relapsing condition and that the probabilities for relapse are high if patients are withdrawn from methadone.

4. The public misplaces a moral quality to drugs. Narcotics which includes methadone are perceived as inherently evil. A philosophical orientation is placed within structure of heroin and methadone and the social stigma is therefore not only transferred to individuals but to the medications they are taking to control their addiction. Methadone, itself becomes stigmatized. The political and social roles of drugs and medications influence the perception of the pharmacology. Therefore methadone is perceived as a narcotic to legally continue an addiction and not as a researched medication prescribed to control a chronic condition.

According to Gordis, these concepts influence the thought and action of government policy makers and administrators. And included within this group one can include educators, physician, nurses, administrators of methadone programs, social workers and counselors.

Some patients in spite of the prejudice that they experience in methadone treatment have educated themselves about methadone, addiction and theories of addiction to a greater extent than most counselors, nurses and physicians in the clinics. They find their treatment experience frustrating and especially in their dealings with a clinic staff whose beliefs are in direct opposition to their rehabilitation and well being. One such patient eloquently indicated the following:

"...my opinions of methadone and the programs that administer it could not have been farther apart. Methadone itself had been a Godsend, literally saving the lives of myself and my friends, allowing us to reclaim ourselves and rejoin society...a life indistinguishable from those of 'normal' people. Of the clinics' staff and policies however, I could not have had lower expectations. By and large, they succeeded in demeaning and dehumanizing their patients, mixing open disdain for the treatment they dispensed with such ignorance that many patients came to feel trapped by a 'poison' worse than heroin. While some staff members showed genuine compassion for their patients and a few were even good therapists, even these exceptions demonstrated such a lack of understanding of methadone as to negate their good intentions. The system seemed hopeless and I resigned myself to the fact that any progress I made would be in spite of it, not because of it. That counselors working for methadone maintenance programs would feel this way confused me until I learned that the vast majority of counselors who had themselves been addicts were graduates, not of methadone programs, but of anti-methadone therapeutic communities and twelve step programs.” (Joseph, 1994)

What has occurred to methadone treatment? The practices described above have been given a name, “The Penal Attitude.” One only has to look to the terminology that is used in methadone treatment today for further evidence. Methadone treatment is a medical procedure and yet recipients of this treatment are consistently called “Clients” (see NAMA’s Policy Statement on Client vs Patient for more information). Lawyers have clients. social workers have clients, but doctors have patients and patients have a “Bill of rights.” One can only see the use of client as an unconscious attempt of staff to further disempower the patients that they already feel contempt towards. Another word that has crept into methadone treatment is the use of “termination” instead of the medical term discharge and
one can only assume that the use of termination is a Freudian slip when considering what occurs to
the majority of patients who are discharged.

Methadone treatment as developed by Dole and Nyswander was a caring and compassionate
program and patients were proud to be a part of it. As any patient today if they are proud of their
program. The contempt that patients feel toward the program is expressed by patients when they sell
their methadone in front of the clinic unconcerned about the impact that this can have with the
community. It is a way of saying this program does not care about me so why should I care about it.
In the Dole Nyswander program this would have never happened with the exception of perhaps a
patient with mental problems. Patients would have immediately said something, either to the patient
or to the program. For these early patients the program had saved their lives and they were very
protective towards it, the staff who cared about them and in particular Drs. Dole and Nyswander.

The atmosphere created in the early program was very important for patients and staff. It created a
community in which all persons - patients and staff alike - felt that their roles were as important as
the next person. However with the growth of the program one of the detriments was the loss of a
community. It is not the purpose of methadone advocacy to create the sense of community however
when patients and staff work together for a common goal the outcome is positive.

References

Gordis E. From science to social policy: An uncertain road. Journal of Studies on Alcohol 52(2):

Joseph, H. Medical methadone maintenance: The further concealment of a stigmatized condition.

Notes

1. This statement was prepared with the assistance of Greg Keller, President of the Wisconsin
Chapter of the National Alliance of Methadone Advocates who coined the term Penal Attitude.