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## **Methadone and the Anti-medication Bias in Addiction Treatment**

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### *An Introductory Note:*

*This article is long overdue. Like many addiction counselors personally and professionally rooted in the therapeutic community and Minnesota model programs of the 1960s and 1970s, I exhibited a rabid animosity toward methadone and protected these beliefs in a shell of blissful ignorance. That began to change in the late 1970s when a new mentor, Dr. Ed Senay, gently suggested that the great passion I expressed on the subject of methadone seemed to be in inverse proportion to my knowledge about methadone. I hope this article will serve as a form of amends for that ignorance and arrogance. (WLW)*

There is a deeply entrenched anti-medication bias within the field of addiction treatment. This bias is historically rooted in the iatrogenic insults that have resulted from attempts to treat drug addiction with drugs. The most notorious of these professional practices includes: coaching alcoholics to substitute wine and beer for distilled spirits, treating alcoholism and morphine addiction with cocaine and cannabis, switching alcoholics from alcohol to morphine, failing repeatedly to find an alcoholism vaccine, employing aversive agents that linked alcohol or morphine to the experience of suffocation and treating alcoholism with drugs that later emerged as problems in their own right, e.g., barbiturates, amphetamines, tranquilizers, and LSD. A history of harm done in the name of good culturally and professionally imbedded a deep distrust of drugs in the treatment of alcohol and other drug addiction (White, 1998). This article will explore how this anti-medication bias has influenced the perception of methadone maintenance treatment (MMT) by policy makers, addiction treatment professionals, MMT consumers and the public.

### **Methadone Maintenance Treatment**

The United States has a long history of attempting to stabilize the functioning of opiate-dependent individuals with daily doses of prescribed narcotics. Nineteenth century physicians routinely provided such maintenance, and 44 communities operated morphine maintenance clinics between 1919 and 1924. Attempts at morphine and heroin maintenance were plagued by the pharmacological properties of the drugs—properties that left patients cycling each day through periods of acute intoxication and acute withdrawal. Mid-twentieth century studies of non-maintenance treatments for opiate addiction consistently reported relapse rates in the upper 90<sup>th</sup> percentiles (White, 1998).

In the mid-1960s, Drs. Vincent Dole, Marie Nyswander and Mary Jeanne Kreek pioneered the use of methadone, a long-acting synthetic narcotic, in the treatment of heroin addiction. In contrast to morphine and heroin, blockade dosages (80-120 mg/day) of methadone lasted 24-36 hours, allowing opiate-dependent patients a window of stable functioning that prevented the twin impairments of narcotic intoxication and withdrawal sickness. What was most striking about opiate-dependent patients on methadone was their “physiological normality” (Dole, 1988). The positive evaluations of these early MMT trials led to the emergence of methadone as a major opiate treatment modality during the 1970s and 1980s. Today, approximately 179,000 of the more than 900,000 opiate addicts in the United States are enrolled in MMT (Kreek and Vocci, 2002).

MMT rests on three propositions: 1) opiate addiction is a brain disorder; 2) optimal daily doses of methadone normalize the metabolic processes of persons whose endogenous opioid receptor systems have been compromised by prolonged opiate use, and 3) methadone-induced metabolic stability provides a safe, homeostatic platform upon which more global efforts at physical and psychosocial rehabilitation can be constructed.

### **The Good: Clinical and Cost Effectiveness**

No addiction treatment modality has been more extensively and rigorously evaluated than methadone maintenance. Nearly every major health policy body has reviewed the evidence on MMT, including the National Institute on Drug Abuse, American Medical Association, American Society of Addiction Medicine, Institute of Medicine, National Academy of Sciences, National Institute on Health Consensus Panel, and the Office of National Drug Control Policy. These collective reviews conclude that orally administered methadone can be provided for a prolonged period at stable dosages (without the escalation in tolerance seen with morphine or heroin),

with a high degree of long-term safety, and without significant effects on psychomotor or cognitive functioning. These reviews also confirm that MMT delivered at optimal dosages by competent practitioners: 1) decreases the death rate of opiate-dependent individuals by as much as 50%; 2) reduces transmission of HIV, hepatitis B and C and other infections, 3) eliminates or reduces illicit opiate use (by minimizing narcotic craving and blocking the euphoric effects of other narcotics), 4) reduces criminal activity, 5) enhances productive behavior via employment and academic/vocational functioning, 6) improves global health and social functioning, and 7) is cost-effective.

The full positive effects of MMT documented in the literature are not automatic. They are contingent upon access to MMT, adequate dosages of methadone, competent staff, and a full range of psycho-social rehabilitation services in addition to prescribed methadone. They are also contingent upon continued involvement in MMT. Rates of relapse following termination of MMT are high even for clients clinically judged to have a good prognosis for recovery without methadone. The effectiveness of methadone as a biologically normalizing agent and the continued need for it by many patients has prompted addictionologist Dr. Avram Goldstein (2001) to compare the role of methadone in the treatment of the opiate-dependent person with the role of insulin in the treatment of the diabetic.

The positive evaluations of MMT rest primarily on what it reduces and eliminates (e.g., heroin use, crime, HIV transmission) rather than on what it adds to the quality of individual, family and community life. As a field, we know almost nothing about the pathways, styles and development stages of recovery for MMT patients and their families. The absence of pathology tells us nothing about the reconstruction of character, personal identity and interpersonal relationships within methadone-assisted recovery. People in stable, long-term, methadone-assisted recovery are as invisible in the research literature as they are in the larger culture. Their stories need to be told.

### **The Bad: Over-regulation and Inferior Clinical Practices**

The bad news about MMT, in contrast to much public and professional opinion, has little to do with methadone per se, but a great deal to do with the policy, regulatory and clinical milieu in which methadone has been delivered. The problem is that what we know scientifically about MMT has not been reflected in MMT-related public policies and clinical practices. The bad news of MMT is not that people are on methadone, but

that hundreds of thousands who need MMT can't get access to it and confront unconscionably long waiting lists for services. (This parallels the period in which oncology patients suffered and died needlessly from lack of access to chemotherapies with proven efficacy.) All of the major reviews of MMT have concluded that the historical over-regulation of MMT by federal and state authorities has hampered the spread and operation of MMT programs and created exorbitant demands on the daily lives of MMT patients. Other problems found in some MMT clinics include:

- exorbitant clinic fees
- suboptimal dosages (20-40 mg/day), particularly within MMT programs that serve African Americans (While suboptimal doses result in withdrawal symptoms, self-medication with unprescribed drugs, and premature disengagement from treatment, a 1988 survey found 79.5% of MMT patients receiving suboptimal doses; 35.5% of MMT patients surveyed in 2000 were receiving suboptimal doses, D'Annunzio and Pollack, 2000.)
- staff manipulation of methadone dosage to reward or punish client attitudes/behaviors
- inflexible and inconvenient pick-up/take-home schedules that interfere with employment, education and family obligations
- inadequate treatment of co-occurring physical and psychiatric disorders
- MMT staff who are ill-trained and lacking in cultural competence
- inadequate levels of psycho-social therapy and recovery support services
- tolerance of deviant behavior (drug selling, prostitution) within the MMT clinic milieu, and
- arbitrary limitations on length of MMT services (e.g., six months), inappropriate pressure for cessation of methadone use, and premature discharge.

Our greatest concern with MMT is not about the utility of long-term opiate maintenance, but on the lack of a vibrant culture of recovery to surround this pharmacological adjunct. The existence of programs that were little more than methadone filling stations contributed to the poor professional and public reputation of MMT. This is not a problem with methadone, but a problem of poor policy (MMT as a crime control strategy versus a recovery program) and poor clinical technology (the failure to imbed methadone within a comprehensive menu of habilitation and recovery support services).

## **The Ugly: Professional and Public Stigma**

The ugly side of MMT can be found in the misconceptions, controversies and stigma that continue to surround it. Myths and misconceptions about methadone among heroin addicts and even among those enrolled in MMT (e.g., “methadone eats your bones and teeth”) might be considered comic if they did not affect help-seeking and retention behaviors. (Most symptoms attributed to methadone are related to initial over- or under-dosing, untreated medical conditions previously masked by heroin use, and interactions between methadone and other drugs (Goldsmith, et. al., 1984).

The broader social stigma of methadone traps the MMT patient in a marginal world. MMT patients are rejected by the addict culture whose members chastise the MMT patient for having “sold out” (surrendered their autonomy to the “orange handcuffs” and the oppressive bureaucracy in which it is contained). They are rejected by the mainstream recovery culture (e.g., MMT patients can attend NA meetings, but only those who are abstinent from all drugs, including Methadone, are welcome to speak). Finally, they are rejected by the civilian culture (persons with no addiction/recovery experience) whose members continue to see MMT patients as “junkies” who have done nothing but replace an illicit drug with a licit substitute.

Studies find the lives of even the most stable MMT patients “shrouded in anguish and secrecy” not because of their past addiction or current treatment, but because of how both are socially and professionally perceived. At a concrete level, this stigma subjects MMT patients to discrimination related to employment, housing and public benefits, and denies them access to a broad spectrum of human services, including access to treatment for co-occurring psychiatric and substance use disorders (e.g., alcoholism and cocaine addiction). As a result, people in methadone-assisted recovery carefully hide their patienthood from their employers and co-workers, their friends and even their own family members (Murphy and Irwin, 1992).

Ironically and tragically, the one place MMT patients might be expected to find tolerance and empathy—within the addiction treatment and recovery community—they are all too often castigated, viewed as not being abstinent, and denied the status and legitimacy of a person in recovery. Such anti-methadone attitudes even infect some MMT programs! MMT patients are particularly prone to internalize the negative judgements of addiction

professionals, given the purported “expert” source of such critiques. Within the worlds of addiction treatment and mutual aid societies, recovery for the person in MMT is often viewed as beginning when the individual stops taking methadone. Paradoxically, addiction scientists view such cessation as a potential and often predictable precursor to the reactivation of heroin addiction. And perhaps most tragically, stabilized MMT patients, uneducated about the purpose and pharmacology of methadone, interpret their lack of craving, not as a sign of treatment effectiveness, but as a sign that they no longer need treatment.

## **The Future**

The winds of positive change in the world of MMT are clearly evident in an altered framework of regulatory monitoring that promises a more patient-centered focus, new accreditation standards and processes that are intended to elevate the quality of MMT, the re-evaluation of anti-methadone policies by American drug courts and probation departments (see *Ending Discrimination Against People with Alcohol and Drug Problems 2003*--a publication of Join Together), improved training of MMT staff, the growing consensus that methadone dosages should be set not by regulatory fiat but based on objective, quantifiable individual factors (differences in methadone metabolism as determined by serum blood levels, for example), and in efforts to enrich the available psychosocial and recovery support services within MMT programs. Change is also evident in efforts to expand the pharmacological adjuncts (e.g., buprenorphine) used in the treatment of opiate addiction and in the growing number and sophistication of MMT-based professional advocacy groups (e.g., the American Association for the Treatment of Opioid Dependence), consumer advocacy groups (e.g., National Alliance of Methadone Advocates, Advocates for the Integration of Recovery and Methadone (AFIRM), (Woods, 1997), and methadone-based recovery mutual aid societies (e.g., the more than 600 Methadone Anonymous chapters).

We envision a future in which a growing vanguard of people in methadone-assisted recovery will step into the public light to offer their own transformed lives and their renewed health and retrieved citizenship as living proof of the potential benefits of MMT. We envision a day in the near future when stable MMT patients will be cared for in office-based settings by their primary care physician or addictionologist. Challenging these positive signs are two troubling conditions: 1) the great misconceptions that continue to surround MMT and 2) the many opiate-dependent people who

are denied access to care or who continue to receive substandard care (D'Aunno and Pollack, 2002).

As addiction treatment evolves into a field of evidence-based clinical practices, addiction professionals will encounter scientific findings that challenge bigotries and biases that have long masqueraded as professional wisdom. It is time for all of us look at the evidence on MMT and recognize its potential value and legitimacy. It is time we work to upgrade the quality of MMT. It is time we warmly welcome people in medication-assisted recovery through the doorways of local communities of recovery. It is time we end the pariah status of those in methadone-assisted recovery.

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