Methadone experiences

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Users' experiences highlight strengths and weaknesses and lead to critical questions about the drug policies' and the treatment system's relationship to methadone and treatment.

A greater understanding of the users' situation and their experience of treatment - and, to a high degree, of methadone - can improve the debate about, and planning of treatment and overall efforts. It was the point of departure for a qualitative interview-survey among 40 users of the district centres in the Borough of Copenhagen's drug treatment system - a survey upon which this article is based. The importance of the users' experiences isn't confined to just one institution because their experiences and opinions also point to the need to deal with certain basic problems in handling methadone treatment.

Thirty four of those interviewed were receiving methadone at the time of their interview and this influenced their view of treatment. The conditions they face as methadone users can, among other things, be seen as expressions of a number of dilemmas in treatment efforts, four of which will be dealt with here.

Double addiction

Faced with the possibility of going into methadone treatment, the drug user finds him- or herself in the dilemma of addiction in two directions. On the one side is the addiction to illegal drugs along with the life that this addiction forces most people to live and which sooner or later leads to physical, emotional and social problems, crime and/or prostitution, rejection by the community, etc. On the other side they face addiction to methadone as well as an institution and its staff, and the treatment system as a whole. Methadone treatment is a way to deal with heroin addiction for shorter or longer periods of time when other methods become unbearable. However the price is having to buckle under to a system's rules, demands and control, and the fact that the evaluations and decisions of treatment staff have a decisive influence on the user's life. The price for treatment is that you become a client.

For some, this dilemma is very hard to overcome. Some even say that going into treatment is a defeat because it means that you've given up on "taking care of yourself". Others, however, see it a

relief, a victory to be able to express a need for help.

Many users say that the dilemma isn't solved by going into treatment, but remains as a constant conflict. Methadone is seen as a relief, freedon from the constant fight to get money and drugs. But even though methadone - if you get enough - means that you don't have to worry about withdrawal, it and the treatment can't fill the space and time that drugs and life as a user have occupied. Most people agree that continuing the use of drugs to some degree or other is a fact of life for most users in methadone treatment, at least for several years. The dilemma has become double addiction to both illegal drugs and methadone. A double addiction that the individual user can only deal with by balancing the two sides at a level that they can live with. The treatment system calls this continued drug consumption "side abuse", in other words, drugs which users "take on the side" and which "they don't really need". This consumption can be regarded by treatment workers as "a lack of ability to control abuse" or even "lack of motivation for treatment". For the users however, this on-going consumption is more likely the result of the double addiction built into the system.

Methadone until further notice

Based on their own and others' experiences, users know that methadone is difficult to stop once you've started using it. However, many express a desire to "get off methadone at some point", usually at some non-specific time in the future. An agreement about reducing the methadone dosage has been part of the treatment plan for most in the beginning. This is based on the view that methadone can replace illegal consumption and then be withdrawn until the user becomes totally drug-free.

However, many users taking part in this survey say that the goal of withdrawal has gradually, and often without any decision being made, been replaced by long-term treatment, often after a period where the methadone dose has been moved both up and down.

Methadone is generally regarded in two distinct ways. One, as a method for withdrawal where the idea is give less and less methadone, thereby gradually reducing addiction. And, two, as part of "long-term methadone treatment", where the goal is to give a dose that is large enough to prevent "side abuse". The problem is that categorising methadone in this way works better in theory than in practice. "Withdrawal" is based on the opinion that a small amount of methadone is better than a lot because the user is then closer to being drug-free. According to users, however, you can reduce the methadone dose - but you don't become drug-free, at least not for long because the need for, and the abuse of drugs remain.

Instead of having the reduction of methadone as a goal, the maintenance of the methadone supply can be an important and absolutely meaningful reason for being in treatment. While reduction is based on comparing current conditions with an unknown or risky future without methadone, users are more likely to want to maintain the results (such as greater calm and reduced abuse) that they've achieved on methadone - in comparison with their situation "on the street". "You know what you have, but not what you get," as one user put it.

These users' methadone treatment cannot be called either short-term or (consciously) long-term, either withdrawal or replacement treatment. It's more like methadone until further notice. From the user's point of view until other realistic possibilities turn up and from the treatment worker's point of view until the user becomes "motivated to change".

Help and control

Treatment as a conflict between help and control is a well-known problem in social/treatment work, and this is particularly true with methadone treatment. Methadone treatment is - and is generally

regarded as - a way of offering and receiving help, but various forms of control are connected with it.

This control can be expressed visibly, for example in the shape of urine testing to trace any side abuse and checking the users' behaviour and possible intoxication when they pick up their methadone. Users' experiences and opinions of these control measures vary greatly - from those who don't feel the control or take it for granted to those who regard control as intrusive and a sign of "guilty until proven innocent".

But control is more generally also an expression of the user's situation as being dependent upon the institution and its staff, not least with regard to the supply of methadone. This is mirrored in the users' characterisation of treatment workers as "the ones holding the bottle" and "the ones with the power". Thus "control" covers not only the users' feelings that the methadone supply lines are fragile. Concrete methods of control are not just given weight because they can result in sanctions (for example, no methadone on a day you show up under the influence) - they are also seen as the treatment workers' degree of mistrust in relation to the individual user.

In this situation the goal of maintaining the methadone supply can totally dominate the user's view of treatment. "It's a matter of protecting your medicine," as one user expressed it. The fear of losing your methadone supply - short-term or permanently - overshadows treatment, even though expulsion from treatment is rare (at the centres in question).

Since the balance between help and control is an unavoidable dilemma in treatment, it is of decisive importance which attitudes and signals are expressed by those staff members who meet the users on a daily basis. How do staff members regard the drug users and the possibilities for treating them?

The relationship between - and the emphasis put on - help and control is not an abstract problem. It comes to view daily, among other things in the way that treatment workers "steer" or support users. If you put the emphasis on "steering" you underline aspects such as "behavioural adjustment" of users and this can include a willingness to use methods of control and methadone supply as punishment and reward - or, as it is often put, methods meant to "put more structure into users' lives". On the other hand there are the efforts where the emphasis is put on "support", where the goal is a closer relationship with the user, calling for the more demanding establishment of mutual respect and trust. User experiences show that control can take second place to help when focusing on the user's condition - including problems with abuse - is seen by users as a response to their situation rather than an expression of mistrust and supervision.

If you ask users about what works, they are usually not in doubt: a good, trusting relationship with the treatment worker is a decisive factor in having a positive view of treatment.

Methadone and doubts

Users' experiences can cast light on concrete dilemmas and problems in treatment. In addition they can also point out fundamental questions about the object and content of methadone treatment.

Because it's thought-provoking how often rules and regulations about methadone treatment contain a contradiction which is also mirrored in the general debate about methadone. On the one hand it is pointed out that the importance of methadone in treatment should by played down, backed by phrases such as "methadone must not stand alone", "it's only a method of achieving contact", "it only supports treatment", etc. On the other hand much throught has gone into the supply of methadone - who should get it, how, when, how much and for how long, and under which conditions. At the same time there are seldom any clearly formulated demands about the sstructure and content of that part of treatment which is said to be the most important - the psycho-social effort.

This is a reflection of a fundamental ambivalence - not to mention half-hearted opposition - in relation to methadone as a method for improving the lives of drug users. In the rush to play down methadone's importance in treatment and for the user, the supply of methadone has been covered by a very detailed and, to a large degree, control-oriented set of rules. But the greater the efforts to push methadone into the background, the greater the treatment system's need to focus on it. In direct opposition to the stated objectives, methadone is becoming the decisive element in treatment.

Most users - according to the interviews - feel that treatment focuses on methadone and drug abuse ("side abuse"). And methadone has the most obvious and concrete advantages. In addition, there are a number of individual, and usually valued, possibilities for help, guidance or care of one kind or another. These various possibilities are expressed in the multi-functional composition of the treatment teams.

But the users don't usually have an overall impression of objectives and directions in treatment. Most of them see methadone treatment as having put them in a sort of no-man's-land where they are no longer drug users "on the street", but they have still not solved their problems with drugs.

In light of this, it is of decisive importance how methadone users are regarded - by the users themselves, by treatment workers and by the community. If methadone is to be the starting ramp for resocialisation and rehabilitation, which must be assumed to be the overall objective, then methadone users should at a minimum be accepted as "drug abusers undergoing treatment", rather than be stigmatised as "addicts on government junk", or whatever demeaning expression is currently being used. Users' experiences can be seen as an expression of the fact that methadone given with pleasure works better than methadone given against the giver's will.

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