

**UNIVERSITY OF REGINA
DEPARTMENT OF ANTHROPOLOGY**

FINAL REPORT

**METHADONE MAINTENANCE THERAPY
AN ANTHROPOLOGICAL ENQUIRY INTO THE
CULTURAL CONSTRUCTION OF DRUGS AS MEDICINES**

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Submitted in partial requirement for course
ANTH 853-001: Advanced Ethnographic Fieldwork
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Regina, Canada

December, 2003

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Acknowledgements

This paper would not have been possible without the generous support and help generously provided by the staff of the clinic in which research was conducted. As research concerned a sometimes controversial therapy assisting a possibly stigmatized clientele, I am deeply indebted to the clinic authorities for having allowed me to observe their daily activities and to interview staff members regarding their experience and knowledge.

I hope that this paper adequately represents their views and does justice to their genuine and sincere commitment to this therapy and to the clientele that attend the clinic. I hope that my conclusions regarding the therapy are in accordance with those of people who are more committed by their deeper acquaintance with the therapy and if possible shed some further light on the therapeutic mechanisms at work in the clinic setting and medical approach to methadone administration.

I will refrain from mentioning names and staff positions to comply with ethical requirements, but nonetheless I will acknowledge the permanent efforts to assist and ease my research which several staff members persistently offered me.

I also encourage the staff authorities to liberally make use of the finding of this report should they ever feel the need, and in the way which suits best.

Introduction

This paper is an ethnographic foray of a Methadone Maintenance clinic which operates in the city of Regina, in Saskatchewan, Canada.

Most literature on Methadone Maintenance therapy does not tend to focus on actual behavioral patterns within the clinic setting. Generally speaking, most literature is fundamentally preoccupied with statistics of success rates, the pharmacology of methadone administration and public policy constraints and approaches. It is most commonly authored by health specialists, such as medical doctors or health researchers.

This essay tends to confirm previous publications regarding the therapy, but the approach is based on the anthropological tradition of ethnography using a research method which is derived from the classical anthropological method of ‘participant-observation’.

A more refined discussion of the method is provided in a separate paper. Nonetheless it is worthwhile to mention that the dominant mode of data collection was through passive observation of the clinic during specified times from early September to late November of 2003. Thus major conclusions have been drawn from the activities in the setting as observed by the researcher. It will be seen that the clinic is quite representative of the literature which has been written concerning this therapeutic strategy.

A supplementary method involved selective interviewing of staff members. This provided further discursive interpretive statements concerning the treatment strategy and general functioning of the clinic. This method is common in antecedent studies.

Notwithstanding, the research was undertaken with specific anthropological questions in mind, and not to assess methadone therapy itself, as previous publications generally intend to. Thus, the clinic setting has been more central to the attention of the researcher than the therapy itself. Relationships, linguistic references, roles, as well as the use and distribution of space and furniture have been forefront in the attention of the researcher.

In addition as the clinic is, by definition, a dispensary for a methadone-based therapy, the way that behavior and actions relate to the fundamental objective of the clinic has been the general guideline of research.

The central objective of the research was to inquire into cultural and contextual conditions which frame the interpretation and understanding of pharmacological agents, especially those that are understood to affect health in a variety of ways. Especially of interest was the construction and use of certain agents understood to be ‘medications’. Methadone was chosen as a primary candidate because, despite that it is definitely supplied within the clinic as a medication, there has always been some controversy concerning this.

As critics of this therapy have pointed out, it is not structurally different to other opiates whose use it intends to curtail. In fact, its perceived therapeutic value rests precisely on this similarity. Other opiates, whose use is required to be suspended while on the therapy, are construed as “drugs”, with the implication that they are harmful for physiological health, and are also associated to addiction behavior which entails a non-socially adaptable lifestyle.

Although the actual pharmacological effects of methadone consumption are not entirely similar to those of the other opiates, which is part of the physiological basis for the justification of the therapy, it will be seen that the success of the therapy also relies on ‘ancillary services’ provided by the clinic, which from a different perspective also address the perceived problems of addiction and/or its non-physiological consequences.

Thus the central concern of this paper is to analyze the ways in which the ambivalent status of methadone is attempted to be resolved within the clinic setting, so that its classification and understanding as a ‘medication’ may prevail.

Ethical issues

The location of the clinic and identity of informants is not included in this report. Fieldwork did not include approaching clients, and information concerning them is exclusively about their behavior within the clinic in the public waiting area, which was the sole locus of observation. Information given by staff members that were interviewed will be used, but the source will not be identified.

This may reduce the scientific rigor of the report, as information given by staff members may depend on their specific position, task and training. The study also eliminates the possibility of confronting the fieldworker’s observations with those of clients, as they were not approached.

This practice has been preferred in view of the ethical concerns which could be raised by offering more precise and localizable information, so as to respect anonymity and confidentiality of all informed participants, and the discretion owed to clients.

1. Ambivalence

Criticism to methadone therapy rests upon the ambivalent status of this pharmacological agent. It is known that its use can lead to physical and psychological dependence (Cox et al. 1983). Other undesirable effects of use are: insomnia, constipation, abdominal pains, excessive sweating, headache, nausea and vomiting, reduced libido, increase in blood pressure, pulse and respiratory rate, and several other symptoms (Cox et al. 1983). Death by overdose is also possible (Newman 1977).

In the clinic which was studied by the researcher, morphine addiction is one of the most frequent to be treated with methadone therapy. Morphine is quoted as producing undesirable effects such as: sweating, nausea and vomiting, constipation, reduced libido, physical and psychological dependence and several other symptoms, as well as the possibility of lethal overdose (Cox et al. 1983).

It can be seen that both agents have similar undesirable pharmacological effects (Platt & Labate 1976). Whereas in the case of morphine they may be construed as harmful effects which may encourage a user to seek treatment, in the case of methadone these effects¹ are often quoted as “side effects” of the treatment (Regina Health District 2002). Thus there is a differential evaluation of these effects according to their role in the therapy.

These “side effects” receive a directed treatment so that methadone administration will not be interrupted due to them. Thus, patients are encouraged to modify practices to improve sleep hygiene, or to modify their diets to ease bowel movements. They may also receive prescriptions for psychiatric medications, such as anti-depressants. Thus, effectively, undesirable effects of methadone use become “side effects” because they

¹ The exception is overdose which is avoided by the practice of physicians’ prescriptions of dosage.

receive a treatment which is ancillary to the supply of methadone. Their appearance is recognized as due to methadone use, and they receive clinical attention so that they can be ameliorated.

It has been noted elsewhere in studies of medical systems, that treatment often entails a suppression of symptoms –particularly if the cause cannot be directly addressed for some reason (such as in some psychiatric disorders, or terminal patients). The treatment of “side effects” of methadone use is one of these cases. Since the interruption of methadone use is not a feasible option, “side effects” are treated as independent disorders.

Whereas in the case of the effects of morphine, the solution proposed is to interrupt morphine use, in the case of methadone, the solution for its undesirable effects is to treat them independently with a battery of strategies and continue the use of methadone.

Clients are reported to perceive the contradiction. I was told that they perceive methadone as another “drug”². They feel that they are still using a “drug”. The staff responds to this by attempting to persuade the clients to view methadone as a ‘medication’. The staff, therefore, is not less aware of the ambivalent nature of methadone.

To be admitted to the methadone program, the client must have attempted other treatments before and this must be documented. This is an indication of the dubious status of methadone therapy, as it is not allowed to be a first option therapy. Further,

² Due to the ambivalence of the term *drug*, reference to illegal substances most commonly used recreationally and often deemed harmful is clarified by the use of quotation marks.

clients must be confirmed addicts. The literature reports that this is to avoid clients that were not addicts before, becoming so due to the therapy (Platt & Labate 1976).

The ambivalence is further carried onto the objectives of the therapy. The treatment is named 'maintenance therapy' as it is primarily used to avoid withdrawal symptoms in addicts to other opiates. It does not address the addiction itself. Methadone has a cross tolerance with other opiates, so that its use can suppress the withdrawal symptoms of the other substances (Platt & Labate 1976). Users are sometimes said to be 'stabilized' with methadone. It is a substitution therapy. The cross tolerance also occurs with regards to the 'euphoria' experience. At certain doses, users of methadone generally cannot perceive 'euphoria' if administered with other opiates. The 'euphoria' experience is blocked (Platt & Labate 1976).

Essentially, therefore, the central therapeutic benefit of methadone administration is that users are discouraged from using other opiates, by suppressing the craving (and other withdrawal symptoms) and by rendering ineffective the simultaneous use of other opiates. This is a unique property of methadone. Despite its similarity with other opiates, this single aspect is the basis of the rationale for methadone therapy.

When the therapy was developed by Dole and Nyswander in the 1960s they were unimpressed with psychotherapeutic attempts and abstinence to treat addiction (Platt & Labate 1976). They judged that the craving of the addict needed to be suppressed so that the addict could restructure resources in another way to cope within community life in a competent way. Since methadone has long-term activity, it only needs to be taken daily. Its long-term effects also reduce the 'euphoric' effects, so that the user can competently perform in all other social and technical skills.

Thus, they introduced a revolution in addiction therapy, and the first ‘Harm Reduction’ practice: “The goal of treatment was not so much immediate abstinence as enhancing productive and acceptable behavior” (Platt & Labate 1976:273).

With methadone therapy, the addiction is treated with a pharmacological agent, but the goal of the treatment is actually to introduce modifications in the lifestyle of the client. So, treating the addiction itself is not the primary objective of the therapy, but rather to modify the effects of addiction on general life patterns.

This ambivalence is expressed in the long-term objectives of the therapy, which have changed over the decades. Initially, it was acceptable practice for clients to be ‘maintained’ or ‘stabilized’ with methadone for indefinite periods of time, and it was further seen that long-term “side effects” were actually minimal (Platt & Labate 1976). In the clinic under study, there are clients who have been regularly using methadone for several decades.

Most recently, though, since the change in morality in respect to “drug” use and the increased value given to abstinence, methadone therapy has begun to be seen as a temporary treatment with the eventual objective of self-termination (Rosenbaum 1997). Currently, I was told by a staff member, methadone is a treatment to prepare for abstinence. Ideally the client would spend perhaps two to five years in the therapy while they reorganize their life so that they when they are discharged from the therapy they will not relapse into “drug” use.

This ambivalence over the objectives of the treatment is expressed in several ways. I was told both that abstinence is not an objective of the treatment by one source, and by another that the therapy prepares for abstinence. Similarly, I was given the

analogy that methadone for the opiate addict is a medication much like insulin is for the diabetic, or certain pills for a heart disease. Yet, diabetes or any of the other analogies given to me (also found in the literature, for e.g. Tapert et al. 1998 in Marlatt 1998:155) are permanent conditions, whereas addiction is not. The analogy was not obviously based on a presumed permanent physiological deficiency which needs to be addressed by external medication, but rather simply because “addiction is a disease”, as I was told.

Addiction is a perceived to be a disease which requires pharmacological intervention. Yet, unlike other diseases which are treated with medications, suppression of the disease is actually not the objective of the treatment which, instead, is to alter lifestyle conditions. Thus, there is an indeterminacy and practice of displacement which is at the root of the therapy.

The simple supply of the medication does not even actually eliminate the disease (addiction). In fact, it perpetuates it. The literature reports that clients feel that they are made dependent on the clinics.

Despite this, statistics repeatedly suggest that the therapy is indeed effective, both in altering lifestyles and allowing clients to lead more satisfying and productive lifestyles (see for e.g.: Walters 1999:111).

Ethnographic observation becomes justified as a way to attempt to understand the complex process of social interaction between staff and clients which results in client satisfaction and success of the treatment, since extra-pharmacological factors must be occupying a fundamental role.

2. Addiction theory

The ambivalence which is found in methadone therapy is related to the complex ambivalence of theories of addiction. Informants offered differing understandings of the origins of addiction, which coincide with the variety of opinions provided by theorists.

One view, as expressed above by an informant, is that addiction is a disease. This is advocated, for example, by the medical profession. A medical intervention, of the sort that frames clinical methadone administration, would be completely justified from this perspective. This view refrains from a moralization of the behavior and perceives the addict as a victim of physiological needs which drive the behavior. The source of addiction is the craving, and this is physiologically originated as an effect of the use of the “drug”. The following quote illustrates this understanding,

“It hypothesized that... intense cravings are triggered via unknown physiological mechanisms, and these cravings lead to compulsive overuse. This mechanism is beyond the personal control of the addict” (Thombs, 1999:7)

Methadone therapy was introduced and advocated primarily by physicians. Arguments like the following given by one of the originators of methadone therapy is illustrative: “Narcotic drugs leave an imprint on the nervous system, and the abnormal drug-seeking behavior that follows may well have a neurochemical cause” (Dole 1972 in Newman 1977:4).

Pharmacological intervention appears to be completely justified. Dole and Nyswander explicitly labeled methadone as a “medication” and as “medicine” in several papers (Newman 1977:64-65). But, the apparent irony of methadone is that, although it does address the craving, it does not eliminate the addiction. This is because it does not reverse the craving; rather it calms it by supplying a long-acting substitute.

Methadone does not counter opiate addiction. It is not that kind of medication. It operates by displacing attention from it. The therapeutic value of methadone is in its effect of putting addiction into the background of the addict's concerns. As a study participant once told Rosenbaum, "Methadone removes the issue of drugs from my life" (Rosenbaum 1997:71).

So addiction, if it is to be eliminated, needs to be addressed by an alternative strategy. Even the originators of the therapy did not advocate a simple view that pharmacological administration was sufficient. Dole and Nyswander consistently insisted that ancillary services were essential to the treatment.

"...[O]ur programs are usually called 'methadone maintenance programs.' This popular label puts the emphasis on what is merely the medicinal aspect of the treatment. More importantly, the clinics should be rehabilitation programs, not merely dispensaries.... Specifically, the program must help open the way to better jobs and housing for patients, provide opportunities for education, defend the patient against injustices" (Dole & Nyswander 1973 in Newman 1977:65).

Thus, addiction behavior also entails a social and contextual component. This view still abstains from hastily moralizing the behavior and additionally perceives the addict as victim of environmental influences. Addiction is perceived to be a learned behavior. This view was expressed to me by one of my informants, who mentioned being acquainted with families in which several generations were addicts.

The theories which advocate understanding addiction as a learned behavior are varied (see for e.g.: Thombs 1999). For example, they may vary regarding which micro-environment of social interaction is the most defining (e.g.: families or peers). There is

also the behaviorist model which focuses on the reinforcements involved in consumption behavior itself.

This indeterminacy regarding addiction is at the heart of the success of methadone therapy. Statistics provided to me in the clinic (taken from *Am J Psychiatry* 154:9, Sept. 1997) show a remarkable difference in the percentage of patients who are abstinent over time if they have received ancillary services in a clinic than if they have only received methadone.

3. Ancillary services

Characteristically, the ancillary services provided by the clinic for clients are varied and cover a wide range of needs. One of the central services provided is counseling. The counselor is the first staff member that the client will meet with, and only after this will s/he be referred to a physician.

The counselor will perform an intake assessment. Primarily this is to determine whether the prospective client meets the conditions to be placed on the program. Fundamentally these are three. In the first place, the client must be a confirmed opiate addict. If the client does not have an opiate addiction, use of methadone will only create it unnecessarily. If the client has addiction to another substance, the effects of methadone will not meet the cravings or other effects (such as cross tolerance to ‘euphoria’). This intake assessment will involve a physical examination for needle marks. Prospective clients with a history of needle use have a higher chance to be admitted.

Secondly, the client must have had repeated attempts at abstention with other treatment strategies. This serves several purposes. One of these is the recognition that, of itself, methadone administration does not eliminate addiction. Another purpose is that it confirms that the client has the real intention to quit the use of “drugs”.

Thirdly, the prospective client will discuss with the counselor the process and conditions of treatment. The therapy is said to be “client-based”, which essentially means that clients are empowered in certain aspects regarding their treatment process. The treatment is intended to be tailored to suit each client’s individual circumstances.

Once admitted, the client is expected to meet regularly with the counselor to discuss the ongoing process. Typically, the counselor will offer encouragement for the

person to introduce modifications in their lifestyle so that the client can become a productive and responsible citizen. They are encouraged to pursue employment and/or educational opportunities, to attend to family responsibilities and generally organize their lifestyle in such a way that “drugs” cease to be a central referent and source of gratification.

It can be seen that the counseling service is ancillary to methadone administration and fundamentally serves the same purpose: to displace attention away from the characteristically fixated central status that “drugs” occupy in the lifestyle of the addict. Rather, an inversion is attempted. The client is encouraged to centrally focus on lifestyle itself and give “drugs” a minor place in attention.

Other ancillary services are provided too, which extend the influence of the clinic into the very life commitments of the client, beyond the clinic setting. For example, when a client seeks employment, the clinic will provide referrals. Similarly, when a client seeks to pursue education, the clinic will also provide referrals. The clinic also offers advocacy services, for example if they suffer discrimination due to their status as methadone users and/or former illegal “drug” users.

Here it can be seen that the clinic itself can progressively become an important part of the lifestyle of the client, serving as a fundamental support to assist the client in their reorganization. Again, there is an inversion of the centrality of the “drug” towards the supportive role of the health institution. As a coping mechanism, “drugs” tend to be individualistic and conform to the logic of consumerism and the magic solutions offered by the commodity. In contrast, the clinic offers institutional support which rests on relationship commitments.

4. Contract

When the prospective client is admitted into the program, they are required to agree with the counselor on a treatment plan. Essentially the treatment plan is a declaration by the client on what goals they establish to achieve or maintain recovery, how they can be implemented and what kind of supports will be needed.

Thus, already upon admittance, the client is induced into the supporting mechanisms of the therapy. The ‘ancillary’ services are really fully integral to the therapy, and as far as I could establish, also a condition for continuation within this clinic. The client will, by large, remain with the same counselor from then on. Thus a personal relationship of commitment, albeit professionally framed, is established from the beginning.

This is not the only commitment required of the client. In addition, the client (most of whom, I was told, are poli-“drug” users) must refrain from use of other opiates, and also certain other “drugs” (cocaine, benzodiazepams, Ritalin and in some cases, alcohol). No substitution pharmacological therapy is provided for the treatment of the addiction to these other substances, and occasional use is also disallowed. The therapy offered for treating addiction to these other “drugs” is fundamentally provided through counseling. As an informant told me, the client is encouraged to “make other choices” and to “say no”. The clinic will refer the client to an abstinence program if requested.

This is another case of ambivalence regarding therapy. The methadone clinic is not able to supply a pharmacological substitute to address the craving for other “drugs”.³ Yet the indeterminacy of the nature of addiction allows the resort to other strategies (in

³ I was informed that soon there will be an experimental single case of a trial pharmacological treatment for cocaine.

this case, verbal counseling). In this situation addiction, contrary to the argument put forward for methadone administration, is perceived as a matter of choice and motivation.

The clinic influences motivation and choice through a reward/penalty system which is included in the contractual relationship which the client engages in with the clinic. The urine of the client is periodically and randomly screened for evidence of other “drug” use. If evidence of other “drug” use is found, then the client can be penalized with suspension from the program.

There are other reasons for suspension. One of these is inconsistent unjustified attendance. If this is a long-term situation and conversations with the client do not improve it, then the clinic will interpret that there is no real commitment to the program and no real intention to follow the therapy. Rather, in the extreme case, the client is using methadone only when they are unable to have access to the “drug” that they need or desire. Most probably to suppress withdrawal symptoms, as methadone does not offer the ‘euphoria’ that is normally desirable to “drug” users.

The ‘reward’ system fundamentally refers to the privilege for long-standing responsive clients to take weekly batches of methadone to be consumed in their home, and avoid the daily trip to the clinic. They are called ‘carries’ and their authorization depends on the improvement and commitment to the program that the client has displayed.

It can be seen that there is a contractual relationship between the client and the clinic. Essentially the clinic offers a safe and controlled way for the addict to displace attention from fixation on opiate use caused by craving and short spans of time before the onset of withdrawal symptoms, in the understanding that the client will rearrange and reorganize their life in such a way that they can become functional citizens.

The contract aspect is, of itself, an organizational element which is being imposed onto the lifestyle of the client. One of the ways that the clinic achieves its therapeutic purpose is to define elements according to a perceived teleological goal in the face of indeterminacy.

Thus, the client is required, in the least, to attend the clinic on a daily basis and refrain from use of some other “drugs”. This is an incipient mode by which the clinic encourages lifestyle changes and extends its influence into the organizational aspects of the client’s life. The following section will provide further examples of how actual participation in the clinic setting contributes to the therapeutic intentions of the therapy.

5. Clinic setting

My fieldnotes contain many references to the clinic setting, as the main method of fieldwork was to remain passively sitting in the waiting area of the clinic, which is also the most public of areas. Clients are required to attend the clinic daily to take their dose of methadone. They are further required to see a physician (roughly monthly), and every so often to see a counselor.

Behavior and roles are rigidly predetermined, even though individual personalities are also expressed. I was persistently impressed by how the clinic could easily look like a modern Western clinic for any other kind of biomedical treatment.

The most evident role distinction between people in the clinic is the existence of two basic categories: clients and staff. The client category is not internally distinguished, but there are a handful of staff categories. There is a third professional role, which has a degree of autonomy, and the implications of this are discussed further below, and it is the role of physician.

All of the observations were conducted on days and times that physicians were attending, thus the observation is biased in this way. But, I am under the impression that it is also the day that role distinctions were heightened.

The most basic distinction between staff and clients is regarding access to space. Most typically, clients were to be seen either outside on the street smoking cigarettes and talking, or inside the waiting room which is the first space upon entering from the front door. Normally they would be sitting in the waiting room on chairs which were for this purpose. This is the most public space of all.

Clients would be called successively, either to see a counselor or a doctor (or both). The consultation rooms are in the back, and they would go in alone. Even mothers with small children would leave them in the waiting room. Thus these are the most private of all rooms. Even though clients could freely walk in and out of the waiting room, it was not the case for the consulting rooms. They were called upon individually.

Some rooms are completely unavailable to clients, such as the nurse's office or the room with files, and most probably the rooms in the back (at least in practice if not in principle). These spaces are only available to staff.

The dose of methadone is administered to the client by the nurse through a window which connects her office with the main waiting room. Clients line up outside this window to take the dose. This further emphasizes the spatial segregation.

Clients wanting to see a doctor or counselor must wait for their turn. And, so they must follow an order of arrival. They must announce their intention to a staff member, so that they can be put on a waiting list.

Many clients do not interact with each other or with staff, but some do. Conversations are of public matters. Very little mention is ever made of methadone, effects or the program. It is assumed by the researcher that in the private consultation rooms this situation would be inverted.

Violence, threats and other disruptive behavior was also not observed. I was told by an informant that this would be cause for suspension.

Thus, it can be seen that, while in the clinic, clients are required to adjust to basic protocols of behavior which stress order, politeness and a public/private dichotomy. There is a degree of formalization of interaction which channels the client into certain

cultural standards of behavior in Western institutions. The addict is required to adhere to these basic canons.

This behavior also legitimizes and reinforces the medical nature of the therapy. There are other aspects of the clinic setting which also reinforce the impression of medically framed interaction. A central element of this is the behavior associated to the drinking of methadone.

As said before, methadone is given to the client by a nurse, through a window. The clients line up for their drink. The dose is drunk in public view in a public space. The drink is witnessed by the nurse, a medical representative. The doses are provided in little brown plastic bottles, in which pharmaceutical medication is commonly stored. There is no ceremony associated to the drinking. In short, the setting suggests the distribution of a medication, and does not at all bear resemblance to the behavior associated to “drug” use. As noted by Cox et al. the fact that methadone can be taken orally makes it “less harmful with regard to initiating and reinforcing the ritual-like habits related to needle administration of drugs” (1983:341).

In full view of the client, there is an intense record-keeping and filing activity. The nurse is persistently keeping records and monitoring different actions. The room with filing and archives is normally kept open, and staff can be seen periodically walking in and out with files. Again this not only resonates with general Western clinical practice, it is also a statement for the client about order, monitoring and the seriousness of the therapy.

6. Doctors

Physicians occupy a fundamental role in the clinic, and their presence is decisive. Yet, characteristically they are rarely seen outside of their own consulting room. I have included remarks on their effect on interactions in the clinic, precisely because, despite being the most absent category of people in interactions, their existence is made to be one of the most strongly felt.

Physicians are necessary to the clinic, as they are the only authorized personnel that can prescribe methadone. They are needed for their prescriptions. Doctors also are expected to attend to other medical issues of clients, such as “side effects” of methadone use.

Doctors are not employed by the clinic, and so have a certain degree of autonomy of action. But they are also set apart into a category of their own by the very different kind of interaction that they have with clients and staff.

Doctors are referred to by clients and staff alike by their title and surname, thus, for e.g., “Dr. Farmer”. The use of the title evidently brings to the forefront their professional status; the use of the surname guarantees a social distance. They carry the prestige of biomedicine, and their presence in the clinic legitimates the medical nature of the therapy. Characteristically their presence in the clinic is felt through their mediations and metonymic signifiers.

The doctors’ autonomy is expressed in several ways. For example, although admission to the program is first given by the counselor, who performs a test to assess the addict identity of the prospective client; the doctor will perform his/her own assessment again when the client is then referred to him/her.

Another signifier of the absence and autonomous nature of the doctor is a tendency to have arrived late on many of the days that I performed observation. This creates a line up of people, and sometimes there are insufficient chairs in the waiting room. It is also a strain on mothers with small children and people who are taking leave from work to see the doctor. Talk about the doctors will occupy some degree of attention on such days. Clinic staff was also relatively stressed by this situation.

The most obvious signifier, though, is the written prescription and the main reason why doctors are perceived to be needed. The written prescription metonymically carries the prestige and weight of the health specialist that prescribed it (van der Geest & Whyte 1989). It is a material proof of the encounter which transcends and remains beyond the transient moment of consultation.

It is also the legal legitimation for the therapy. It is the definite mark that sets methadone apart from “drug” use. It is the defining medicalizing act. Typically patients would come out of the consultation with the prescription in hand, and then give it to the nurse via the window used for methadone administration. Thus, the therapeutic process is objectified as medical practice. The patient has only a mediator role in a relationship which is between the doctor and the nurse, by transporting the written prescription from one to the other. The prescription must be renewed periodically (roughly monthly). This ensures that the client must receive a constant medical and legal reapproval to remain on the program.

Doctors are also required to follow standards of practice which are determined by the provincial college of physicians. Their medical autonomy is rather limited, in the case of methadone therapy, as compared to other therapies. Thus, the whole college of

physicians is quite literally influencing the way that the therapy is provided in this clinic. The college of physicians not only affects the practice of the doctors, but the clinic in general abides by the guidelines set out by the provincial college.

7. The State

The influence of the State is also a determining element in the therapy. Like the doctors, only more radically, it is the most absent of all players in daily interaction yet the most decisive. The State places a constriction on the program for example by sanctioning only medical practice that follows its requirements.

The clinic itself is State-funded, and thus follows a public health policy which, in the end, is a matter of political decisions. The State also tends to fund the provision of the service for the majority of the clients, who receive welfare State health benefits.

The State is also responsible for requiring much of the duplicate and triplicate record keeping and close monitoring of the provision of the service. The provision of methadone by an independent pharmacy and even the lack of storage of methadone within the clinic premises after hours is probably also due to State policy.

At the same, in the interactions, the State is not a personalized presence. Rather its existence is felt in the metonymic signifiers through which it presentifies itself, such as regulations. The clinic staff is well aware of the lack of autonomy of the clinic from the State's interests in the functioning of the clinic. For example, one informant told me that one of the purposes of the duplicate and triplicate record keeping was so that if there was a legal problem concerning a client, they could trace whether the client had been in the clinic at the said time.

Legal problems are indeed a constant issue for clients. Several times I heard clients commenting on their need to go to Court, for some reason or the other. Most clients also receive State-originated welfare assistance. This produces discomforts, such as one morning where I heard a client claiming the welfare money that was owed

concerning his children to someone over the phone. Many clients also have to fill in forms to maintain their welfare benefits.

In effect, when they commit to the program, clients are not only committing to a medical therapy which addresses their addiction-related problems, in a very practical manner, they are committing to the State. They are placing themselves under the patronage of the State, which is the decisive source of legitimation and legal sanction for the functioning of the program.

8. The Drug War

Due to the State-originated constraints on the functioning of the program, methadone therapy is bridged halfway between medical autonomy and social control. Two of the most common justifications given for methadone therapy are, on the one hand: that it improves medical conditions and “saves lives”, as one informant told me, for example by eliminating health risks associated to needle injection of substances.

The second common justification is that it reduces crime. It is reported in the literature, that reduction of crime was at the forefront of political interests when the therapy was popularized in the late 1960s. For example, “U.S. President Richard Nixon’s war on street crime was at the core of his domestic policy. Nixon and the U.S. Congress saw methadone as a potential strategy for reducing crimes committed by addicts” (Marlatt 1998:153).

Often these two justifications are given simultaneously. Thus, “Complaints to the police for crimes associated with drug abuse, such as robbery, burglary, and larceny, dropped from 350,000 to 273,000. Drug dependence deaths and hepatitis cases among drug injectors also dropped during the period between 1971 and 1973” (Marlatt 1998:153).

In a presentation pamphlet used by the clinic that was provided to me by an informant, under the section which lists benefits of the therapy, the treatment is quoted as beneficial not only for exclusively health related reasons (HIV/AIDS prevention, and improved pregnancy) but also because “methadone treatment reduces criminal behavior”.

There several reasons why a methadone program can be beneficial to the interests of the State. On the one hand, as quoted above, criminal activity derived from the

individual addict's need to acquire "drugs" is eliminated. By reducing the demand for illegal "drugs", other criminal activity related to the production and distribution of such substances is also limited.

The origin of the substances legally provided to sustain the client derive from State controlled and monitored sources, which are divided in their legal competence. The pharmacy prepares and distributes the methadone. But only the authorized doctor can prescribe it. And it must be taken within a clinic context under witnessed conditions. Even the costs are mostly State-funded for the whole process. The net result is that the State has its own share in the production, distribution, costs and conditions of consumption of a synthetically produced opiate which a certain proportion of the population are encouraged to use. With methadone, the State is a legal competitor in the "drug" market and in this manner reduces the impact of its competitor, the black market.

Although the client's status as an addict is not reversed by the pharmacological agent, certainly the client's status as an illegal addict is. Effectively, with methadone maintenance, the State has much more control over its "drug"-using population.

The presentation pamphlet also declares that an untreated opiate addict costs Canadian 'society' on average \$49,000 per year, whereas a client maintained on methadone only costs \$6,000 per year. Although this figure is not broken down, it can be supposed that this economic saving could be derived from two basic State expenditures: a saving in criminal-justice resources and a saving in medical resources (Hannan 1975).

Aside from the purely medical issue, then, there are political and economic reasons for the State to approve of methadone therapy. Methadone therapy addresses a

problem, which although it has its medical connotations, has been increasingly come to be perceived as a ‘social problem’, a matter of public policy and public health.

This tension between perceiving addiction as a public problem while it is simultaneously construed as an individual medical issue is played out in the dynamics of the clinic. The purely medical issues are treated individually and in a private manner. So, for example, the doctor attends the client in a private consultation room and all tests remain private and discreet. Whereas the actual consumption of methadone is a public event, witnessed by clinic staff and in full view of other clients and people in the clinic’s most public area. Also in full public view is the extensive filing and monitoring practices. This public-private polarity, which reflects the medical-State tension, is materialized in the practices and spatial segregations.

Monitoring of the client is exerted in the private space (in the consultation room, whether of the doctor or the counselor, and in the individualized exhaustive triplicate filing), but it is exposed publicly (thus the witnessed drinks in the public space, and the open filing room).

The individual prescription is the mediating element between these two poles of interest (the intimate-medical and the public-social). In a very illustrative manner, the client is given the prescription by the doctor, and then physically carries it to the office of the nurse and hands it to her. The doctor (representing the private-medical pole) does not interact directly with the nurse (who represents the State and control). Rather, the client (the locus of encounter of the private-medical with the State’s interests) performs the mediation.

9. Mediation

It would appear that one of the primary functions of the clinic, both in the perspective of the State and that of clinic staff is to perform mediation during the process of lifestyle change that is encouraged in the client. This is exemplified in the advocacy and referral role that the clinic will take on behalf of a client who is attempting insertion into the productive areas of society.

It is also at stake in the goal of the therapy which: is to maintain the client 'sustained' with methadone for as long as is necessary for significant lifestyle changes to be introduced and to promote these changes. Methadone therapy is justified on the grounds that straightforward abstinence therapy does not suffice to avoid relapse. The client needs to have the physiological addiction addressed first, before other lifestyle changes can be introduced. Specifically this means eliminating the craving and rapid onset of withdrawal symptoms.

The elimination of the 'euphoria' experience probably has to do with this intention of 'sustaining' the client, so that they can be socially functional. It is probably not the 'euphoria', as such, which is intended to be eliminated, but the distraction which it entails. The cross-tolerance of methadone with other opiates further discourages the attempt to seek 'euphoria'.

The use of a pharmacological agent, therefore, materializes and condenses this mediation service. This is both because of the proneness to conceptualize a medication as a mediating element (van der Geest 1989) and because the actual pharmacological effects of methadone promote a displacement of attention.

Significantly, even though the actual therapeutic strategies which are employed are several (pharmacological, counseling, scheduling, State-originated bureaucratic constraints, the clinic setting, the contractual relationship, penalty/rewards, and so on) the program is publicly known by a synecdochal reference to only one of these elements, the pharmacological one.

For the general public, the program is ‘methadone therapy’. In reality, it is much more. Moreover, in the therapeutic process, methadone itself is not considered to be the central therapeutic agent which eliminates addiction (since it does not), but which facilitates the operation of all the other mechanisms which do.

Ethnographic observation revealed that there are several mechanisms at work in the social interaction which actually displace attention from the pharmacological agent itself *qua* medication, and even from the clinic setting *qua* clinic. These are fundamentally, but not only, linguistic.

Characteristically, methadone is usually only referred to as a ‘medication’ in official communications. Thus, when I was required by the Research Ethics Board of the university to satisfy them with a letter of authorization from the clinic authorities to perform research, despite already having received explicit verbal authorization from the clinic authorities, the relevant staff member kindly complied with this procedure, and wrote a letter to them which explicitly labels methadone as a ‘medication’.

Within the clinic context, methadone is more usually called “drink” and very often “juice”. These terms are used both by staff and clients alike. “Juice” is a metonymic cum synecdochal reference for the methadone dose, which has the explicit effect of depharmacalizing the substance.

Methadone is administered orally, specifically in a drink. This drink is mixed with Tang or Lemon-aid. Thus, the 'juice' component, although a part of the drink, is the least important from the pharmacological point of view. The validity of the reference relies on the metonymic relationship of the juice component to the methadone component. But the interesting trope play is that this singular, least important aspect is then taken for the whole and replaces the mention to methadone.

Clients, therefore, drink "juice", not a "drug", when they are in the clinic. From the legitimacy point of view, the term "juice" displaces attention from the actual drink *qua* opiate, and makes it appear to be a banal quotidian children's drink.

Although, as has been mentioned in this paper, actual actions and spatial distributions resonate of biomedical clinical practice, other linguistic references also displace attention from the medical suggestiveness of this formal environment. Another example is the use of first names. It has been mentioned before that the physicians are indistinctly referred to both by clinic staff and by clients by their title and surname. This contrasts with the way that staff and clients treat each other. Instead, they use first names. I have observed that this is a mutual practice. I myself was referred to by my first name by a staff member, the one time that it was necessary, when I was being presented to another staff member, who was introduced to me by his first name.

Thus there is homogenization of identity, in which the category of physicians is kept distinct from all other persons in the clinic who refer to each other by their first names. It is fair to say that I repeatedly observed a genuine interest and concern on behalf of clinic staff for the well-being and general conditions of the clients. The staff do not relate to the clients with the focalized attention of the physician, but to the broader

concept of the person as a whole. As I realized from observations, the staff has knowledge of the general life conditions of the clients, family situations and employment circumstances. This proximity even extends to looking after the babies of mothers while they are busy doing something else in the clinic, if requested. Similarly, I witnessed several times immediate concern to assist clients in resolving problems, such as accommodating them to see a doctor when this was not convenient, arranging for a client to pick up his dose of methadone in the pharmacy as an exception, and other examples.

This puts the clinic staff in the aforementioned mediating position. They are not doctors and cannot prescribe and control the administration of methadone, yet they are the actual dispensaries. Although they are clinic staff they horizontalize their relationships with the clients (within the general constraints of their professional commitments). Their role, it would seem, is to mediate and ease the transition of the client from a non-socially functional individual to the opposite.

This is exemplified in other actions which can be observed in the clinic setting. One of the most salient is the use of a telephone which is placed at the disposition of clients in the public waiting room. Without a doubt, clients make a frequent use of this facility. The phone, quite literally, is a mediating technology.

Although I did not listen in the conversations, sometimes the loudness of the speaker or other actions indicated the matter of conversation. For example, the phone was once used to call a taxi to pick up two clients and transport them somewhere else. Another time, a client was making a claim about welfare money for his children that he had not been paid. Another time a client was expressly declaring that she was ringing from the clinic. The mediating role of the phone is exemplified with these cases.

It is interesting to note the lack of stigma which must entail declaring that one is coming 'from the clinic'. This therapy which is framed as a medical and state-sponsored intervention, in which attention is displaced from addiction as the problem to be treated, possibly reduces the stigma which may be otherwise associated to recurring to addiction therapy.

It is common for clients to bring their small children to the clinic, who play and run about the waiting room. Mothers and fathers attend on them, and their presence cannot go unnoticed. Several references in my fieldnotes denote the 'family atmosphere' that I perceived. This is surely a relevant difference with many other treatment programs, such as therapeutic communities which seek to isolate the addict and to focalize even more an already fixated awareness on the substance and substance-use behavior. Instead, the methadone clinic is promoting integration into the wider social milieu, and the integration of family relationships.

The methadone clinic setting, with its linguistic references to "juice", and other practices of displacement, generally persuades the client to avoid the fixated hope that pharmacological substances of themselves are the sole cause and cure of problems.

10. Methadone is not a “drug”

Thus, in view of the general undefined nature of addiction and the ambivalent status of methadone as an adjunct to therapy, there are several defining elements of the setting and general procedures which tilt evaluation and judgment in favor of viewing methadone as a ‘medication’, or at least, that it is not a “drug”.

Many of these have been mentioned throughout the paper. It is appropriate to single out several others. For example, linguistically, urine analysis screening is judged to be “clean” or “dirty”, and these terms are used by staff and clients alike. These terms also appear on several signs which are posted to inform the client of basic clinic regulations. Traces of opiate use in urine would render the analysis “dirty”, unless it is only methadone which has been found.

The term is metonymically extended to the client themselves and also to their lifestyle. A client is considered “clean” or “dirty” according to whether they have been using prohibited “drugs”. Although this would appear to fixate attention back onto substance use, the point to be made here is the decidability which is imposed onto the pharmacologically ambivalent situation. Using methadone is “clean”.

Another difference with “drugs” is that methadone is not a commodity. It is supplied through a different mechanism which keeps it away from market logic. Instead, its production, distribution and consumption are kept within the medical and pharmaceutical framework. This not only means that it circulates according to different rules of economic exchange, but also that it is unlikely to condense the fetishistic qualities of the commodity. Typically, “drugs” condense the magical desires of the

consumer who is promised that consumption of the commodity will automatically solve his problems, which solely derive from a material lack of access to the commodity.

As ‘bastard medications’, “drugs” further condense the magical and fetishistic associations of all pharmacological medications (van der Geest 1989), which are often perceived to be “magic bullets” whose action specifically targets the cause of a disease or symptoms. The following quote recognizes this, and also illuminates why clinic staff possibly attempt to revert “side effects” of methadone use by suggesting lifestyle changes,

“Overemphasis on medication, especially methadone, sleeping pills and tranquilizers, will tend to reinforce an orientation which many addicts have prior to entering the Program that most, if not all, problems are solved by drugs. The Clinic staff must recognize that complaints due to sleep, sexual function and most other causes of anxiety (in the population at large no less than among our patients) usually are neither due to nor cured by medication” (New York City Department of Health “Methadone Maintenance Treatment Program Policy and Procedures Manual” 1974 in Newman 1977:61).

Another important aspect of the therapy, which also distinguishes it from other addiction treatment strategies, is that it is said to be “client-based”. Of course, this is within the restrictions which have been set by the State and physician practice, but the general idea is that the client’s acquiescence is sought and a degree of empowerment is offered. The client, generally speaking, engages in the various stages of the treatment process voluntarily and this process is reviewed periodically. It also entails tailoring the treatment to the actual individual conditions of the client. Thus dosage, moment of discharge from the treatment and other aspects are determined in accordance with the

client. This aspect of empowerment is an important difference with the typical effects of addiction which tends to the contrary.

Other practices that have been mentioned previously explicitly distinguish methadone consumption from typical “drug” consumption behavior and reinforce its status as a medication. These include, the mediation of the doctor’s prescription, the public aspect of consumption within a clinical setting, the dispensation by a nurse in small brown bottles ordinarily used for medicines and detailed record keeping and filing, among others.

Further, unlike “drug” consumption, there is a long-term contractual relationship with the suppliers of the substance. The client must adhere to a treatment plan, visibly show attempts to introduce modifications in lifestyle, consistently provide “clean” urine analyses, frequently see a counselor and a physician concerning the ongoing treatment process, and generally adhere to the formalized environmental conditions of the clinic setting.

The clinic, further, extends its organizational influence into the client’s lifestyle, by imposing schedules and attendance commitments, for example. In contrast to the generally isolating and ‘subculture’-producing effects of illegal “drug” consumption, the clinic also serves as an important mediator to reinsert the client within the productive and functional arenas of society.

All of this inclines a resolution of the ambivalence and indeterminacy of the status of methadone and the nature of addiction towards a definite direction, that of perceiving methadone as the pharmacological component of a complex therapeutic process –that is, a ‘medication’.

11. Conclusion

The research has intended to enquire into the processes and cultural patterns which transform an inherently ambivalent pharmacological agent into a defined 'medication'.

The conclusion to this question, for the case of methadone in the methadone maintenance clinic which was the fieldwork setting, is that this is achieved, firstly, by an appropriation of some of the many effects that consumption of the agent produces. Those that are useful for the therapy are highlighted as the justification for it, whereas the others are construed as "side effects" and treated as independent disorders.

In the case of methadone, the central effect which is appropriated by the therapy is that it facilitates the operation of other therapeutic mechanisms, which are brought into play in the clinic setting. Consumption of methadone reduces or eliminates the craving for other opiates that the client is addicted to, and also has no significant 'euphoric' effects sufficient enough to focalize attention. Thus methadone consumption displaces the attention of the addict from his/her addiction. By achieving this, the other adjunct therapeutic strategies acquire more relevance and reasonability of success.

In the second place, the clinic setting and biomedical framing of the consumption behavior and the general patterns of interaction can also influence client perception of the pharmacological agent as a 'medication'.

Ambivalence and indeterminacy regarding, not only the pharmacological agent but also the nature of addiction are resourcefully used, as it allows a wide and diverse scope of adjunct therapeutic strategies to be employed simultaneously and as the occasion demands, all mutually reinforcing each other.

Nonetheless, the defined teleological goals of the therapy affect the decidability and tilt ambivalence of interpretation towards therapeutic objectives.

In this therapy there is a practice of displacement which is at work and which counters the fixated nature of the addict's perception. Addiction, as such, is not countered directly by the pharmacological treatment, but nonetheless the treatment silences the cues which trigger addiction behavior (such as craving, or the promise of 'euphoria').

Resolution of addiction, rather, is addressed by a battery of 'ancillary' mechanisms which tend to displace attention from magical pharmacologically-centered thinking. This is possible, curiously, by the use of a pharmacological agent which performs this displacement of attention.

Thus the clinic setting and methadone therapy, actually, are mediating elements of a complex therapeutic process. They gradually ease the client's transformation of lifestyle and gratification-seeking behaviors.

This mediation is affirmative. It rests on the indeterminacy and displacement effects which are inherent to the treatment, and thus allows for plasticity to adapt the therapy to each individual client's needs. But it is a process which is teleologically guided and so, influences elements of undecidability towards therapeutic objectives.

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