

# Chronic Criminal Disease: An SRV-Based Critique of Drug Addiction Services

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EDITOR'S NOTE: *The following article touches on a number of pressing issues in a wide variety of contemporary services, including the prevalence of the use of psychotropic drugs and the medical model of service. Although it is written primarily about drug addiction services in two German cities, the lessons drawn are relevant to other services in other countries. While this article is written from the perspective of Social Role Valorization (SRV), it also raises non-SRV issues (i.e., issues outside and above SRV) for consideration.*

## Introduction

CONTEMPORARY SOCIETIES define some mind drugs as harmful and as a threat to a well-functioning society, while others are seen as beneficial and even therapeutic. Some drugs are illegal and a lot of energy and resources are spent trying to prevent people from producing, selling and consuming them, while incarcerating those who do. At the same time, ever more people, even young children, are put on supposedly 'beneficial' legal mind drugs with just as much harm being inflicted on individual people, families and society by the legal drugs as by the illegal ones. (For a good overview of the harmful effects of legal mind drugs, see Wolfensberger, 2004).

Perceiving the incoherencies in this approach, some leading academics and human service professionals came up with the equally

faulty assumption that the *only* or the *major* problem with drug use is that it is illegal. Therefore, if one legalized illegal drugs (e.g., cannabis, heroin), legalized their use (e.g., by not prosecuting consumers, and providing them with a place, equipment and an illegal drug to legally consume), or replaced illegal drugs by legal ones (e.g., heroin by codeine, methadone, or polamidone), they argued, then the major problems would be solved.

Many political battles over drugs have been fought in Europe, before the first methadone and later heroin programs (i.e., programs that provide people with methadone or legal heroin as a substitute for illegally bought and consumed heroin) were implemented. They were implemented largely because many groups in society had an interest in such programs. The public and politicians did not want to be confronted with an ever increasing number of wretched-looking homeless drug addicts on the streets of their major cities. The police were tired of chasing lowly drug addicts while not having the manpower and technical means to catch the big dealers. Prisons became overcrowded with drug-addicted people, mostly from lower classes and many different countries, which made the situation in them ever more complex and explosive. Public awareness of the threat of spreading HIV and Hepatitis C increased, with drug addicts being one of the high risk groups. Some doctors and pharmacists saw a new source of income in being able to 'treat' drug addicts with legal drugs. Human

service professionals hoped to be able to 'reach' a group of people who previously had been suspicious of any kind of professional service. Some of the leading academic ideologues hoped such programs would be a step towards a 'free' hedonistic drug-consuming society, evoking sweet memories of the long-past student revolt and hippie era.

Of course, much of this debate was phrased in terms of the benefits that drug addicts would experience: their deaths would be prevented; their health would improve; they would be able to quit using drugs, or consume them in a much more controlled fashion; and they would be re-integrated into society. When the first methadone programs started, they were, like so many other human service schemes, greeted by many as *the* solution to all problems.

ONE OF THE TEN THEMES covered in an introductory Social Role Valorization (SRV) workshop is the concept of service model coherency, with its requirements of relevance and potency (see Wolfensberger, 1998, pp. 111-118). In SRV workshops, a list of common human service models gets introduced, the medical model being probably the one familiar to most people. The four components of every human service model (i.e., fundamental assumptions, the people being served, the program content, and program processes) are explained, as well as how so many human services are incoherent because one or more of these components are in disharmony. Often such disharmony is created because the conscious or unconscious fundamental assumptions which underlie the model are wrong.

In SRV or model coherency language, methadone and heroin programs can be described *first* as an effort to replace the menace-detentive model of dealing with drug-addicted people by the medical model. In other words,

they are efforts to replace the very devalued roles of criminal and menace by the less but still devalued roles of the sick person or patient. In practice, such programs are often an incoherent mixture of these two mutually exclusive models,<sup>1</sup> casting drug-addicted people into a role that one could call the 'criminally sick role,' while their behavior is treated as if it were a 'criminal disease.' *Secondly*, such programs are good illustrations of how the medical model gets used to cast people not only into the patient role but also into the long-term human service client role, creating or maintaining human service jobs in a post-primary production economy (see Wolfensberger, 1997). *Lastly*, such programs are good examples of how, like so often in human services, people tend to address complex problems by very technical means, based on faulty assumptions.

I will illustrate these realities by describing the methadone programs of two major German cities: Bremen and Bremerhaven. My experience with this topic comes from having evaluated the service systems for people addicted to illegal drugs in these two cities (see Quensel & Hartfiel, 1998; Hartfiel, 2000; Schulze & Hartfiel, 2000), and from friendships with people who have been addicted to illegal drugs for many years. The service system of the bigger city (Bremen) had the reputation of being a model system, while the smaller city (Bremerhaven) was considered backwards in terms of serving people with addictions. The studies were funded by the Departments of Health in both cities, and aimed to find out how service recipients and professionals perceived the services provided, and how service quality could be improved. In the course of the two studies, I visited numerous human service programs, clinics and hospitals, as well as the local prison. I interviewed 95 service recipients, 57 professionals (doctors, nurses, counselors, so-

cial workers, prison staff, policemen, administrators) and people from five self-help organizations in long (one to three hour) interviews. Many of the interviews with service recipients were powerful illustrations of the wounding experiences of devalued people (see Wolfensberger, 1998, pp. 12-24), perpetrated by a service system that claimed to help them.

Some of what follows is specific to Germany, but I propose that some of the lessons are relevant not only for people in other countries, but also for people in other fields, as the medical model is one of the most prevalent models in formal human services today.

### The People Served

WHEN THINKING about methadone treatment, it is important to consider that the group of people receiving this drug is quite heterogeneous. In Bremen and Bremerhaven it included people from every social and educational background; people of very different ages (16-55); people with a very devalued identity (i.e., having lived on the streets or in very marginalized living situations for decades, having been imprisoned many times, and with practically no freely-given relationships with valued people, and often quite sick physically); as well as people whose lives were still rather typical in terms of holding jobs, being part of a family, having valued people as friends, and so on.

People also had various motivations for enrolling in the methadone program: (a) some hoped it would be a means to become sober and to regain their valued identity; (b) some who had been able to preserve their valued identity to some degree, hoped it would prevent them from entering the downward spiral of heroin addiction, debts, imprisonment, loss

of job, friends, health, etc.; (c) some wanted to use illegal drugs, but reduce or avoid some of the negative circumstances (debts, illegal acts, and/or prostitution); (d) some saw methadone as a last resort to control life-threatening diseases; and (e) some were forced into the methadone program by being imprisoned or hospitalized (where people addicted to heroin automatically receive methadone), or by authorities threatening to place their children into foster care or to prohibit contact with them. Note that many of the reasons mentioned correspond with the hopes proclaimed by professionals of what methadone programs would accomplish (as listed at the beginning of this article): abstinence from drugs, more controlled drug use, improvements in health, and (re)integration into society.

An important concept of SRV is that of service relevance. In order for a service to be relevant, it has to address (at least some of) service recipients' real and significant needs. In response to the questions of what kind of life they would wish to live, and what they would need in order to be able to lead such a 'better life,' most methadone recipients described the 'better life' they envisioned as a combination of some, or most, of the universal "good things of life" described by Wolfensberger, Thomas & Caruso (1996). In order to achieve such a 'better life,' three prerequisites were mentioned most often and considered most important by methadone recipients. *First*, something that they called a 'perspective for their lives,' i.e., knowing why they lived, what was worth living for, how they should live, and so on. In other words, people asked for answers to some of the highest-order questions of life which only a transcendent belief system can give. *Second*, a sense of belonging, that would come through relationships with valued people who

are not members of the drug subculture, i.e., especially friends and family. *Lastly*, a sense of purpose, achievement and financial independence that would come through meaningful work. Depending on individual life circumstances, addressing certain other needs (e.g., for restored health; a [better] place to live; freedom from prosecution by authorities through help with legal issues) was considered pressing as well.

In contrast to service recipients, many professionals, when asked about needs, tended to think much more in terms of what the service system had available. For instance, they would say that people ‘needed’ detoxification, therapy or counseling.

### **Assumptions Underlying Methadone Treatment**

SRV TEACHES that every human service is based on conscious or unconscious assumptions which shape everything that happens in that service. If the fundamental assumptions are wrong, then one can expect a service that is either not very relevant in terms of addressing service recipients’ most fundamental needs, or one that uses inappropriate (i.e., not very potent) means to address their needs, or both. One might even have a service that is outright harmful to recipients.

The following assumptions (and possibly others) underlie methadone treatment in Germany -- and probably in other countries as well. Some of them are not clearly stated in the professional literature, or by professionals in the field, but they are widely held nevertheless. As you will see, some assumptions are conflicting.

- Drug addiction is a disease. Behavioral expressions of that disease are things like: a

lack of self-control, lying, cheating, stealing, unreliability (e.g., not being able to be on time or keep appointments), selfishness, aggressiveness, criminal behavior, prostitution, and inability to work, keep an apartment or maintain typical relationships.

- As drug addiction is a disease, drug addicts are not responsible for their behavior.
- Drug addicts need some kind of therapy to be cured of their disease.
- If one replaces an illegal drug by a legal drug, then the problems that come with illegality (e.g., high drug prices, resulting in debts and/or criminal acts of consumers, as well as loss of jobs, apartments and relationships; drugs mixed with other potentially health-impairing substances; lack of hygiene when administering drugs and resulting illnesses) will cease to exist.
- Drug addicts lack self-control; therefore, external controls need to be imposed on them.
- Professionals are best equipped to ‘treat’ drug addicts because they have learned to keep their ‘professional distance’ and distrust the promises made by addicts. Doctors (preferably psychiatrists) are best suited to administer a legal drug and to control its appropriate use. Therapeutically trained non-medical staff (e.g., social workers) are best equipped to provide services in other areas.
- In order to motivate drug addicts to do something about their drug problem, one needs to first accept them as they are, provide them with some sort of space where they can establish contact with the professional service system, offer some basic services (e.g., needle-exchange; free food, clothes and/or condoms; a shower and/or washing-machine), and have staff on the scene who can inform about other available services if asked.
- Drug addiction is a chronic condition, and

most drug addicts do not want to change. Therefore, staff should only offer services if drug addicts explicitly ask for them and know which services they want.

### The Services Provided

MOST of the services provided in Bremen and Bremerhaven fell into the following categories:

1. *Clinics, or other kinds of programs, giving out methadone (or polamidone, a similar drug used to replace heroin).* The number of methadone patients treated in such clinics varied from just a few (two or three) to about 100. Most clinics treated other (not-drug addicted) patients as well. The doctors running them were mainly psychiatrists, general practitioners and internists. Typically, methadone patients had to come every day and consume their drug in the presence of a nurse. Most doctors had fixed times for the drugs to be handed out, usually when patients who were not drug-addicted were not present at the clinic. Many performed regular drug screenings and required methadone patients to show up for regular conversations or to sign up for counseling at another program.

On weekends and holidays, doctors and city authorities set up central locations for methadone to be given out to all methadone patients of the respective city. In Bremerhaven this happened in a day program for drug addicts, and in Bremen by using a bus that stopped at several city locations. Methadone recipients gathered around the bus stops to receive their drugs, which were handed out by a doctor and accompanying staff riding in the bus.

Prisoners received methadone through the prison doctor.

2. *Programs that provided counseling or 'therapy,' meaning that staff talked with recipi-*

*ents about their personal situation and how to change it.* Some such programs also informed about or arranged for other services, such as detoxification in a hospital and long-term abstinence therapies (meaning institutional-type or group home-like facilities that are typically located out in the country, in which people who want to live without drugs are engaged for 6-18 months in various kinds of therapy and a bit of work).

3. *Programs that provided some sort of space for methadone patients to 'hang out' and to receive some basic services.* These fell into two categories: (a) day programs, and (b) residential programs.

a. Day programs were typically opened a few hours a day, several days a week, and provided services such as: coffee and/or meals; the opportunity to shower or to wash clothes; sometimes free condoms; needle-exchange, and basic medical care (e.g., disinfecting and bandaging wounds). Some day programs provided work that courts would accept in lieu of paying fines,<sup>2</sup> and some individual staff visited methadone recipients when they were hospitalized or imprisoned.

b. The residential programs were group homes for four to eight people, all receiving methadone.

Both day and residential programs had in common that staff tolerated service recipients' use of other drugs besides methadone (e.g., alcohol, cannabis, cocaine, and/or legal mind drugs, such as barbiturates or antidepressants), as long as it did not interfere with the program's operation. If it did interfere (e.g., by somebody being aggressive), people typically were kicked out of the program. Sometimes, such people were given the option to detoxify (from drugs other than methadone) and come back.

The three types of programs just described made up about 95% of the services provided to people receiving methadone in Bremen. The rest of the methadone-related services in that city consisted of a small program which tried to foster relationships between prisoners and a local soccer fan club by engaging both groups in shared soccer-related activities (described further below); and of an agency which helped five or six people find apartments and provided help with problems as they arose. Bremen also had two short-term shelters for people addicted to illegal drugs which were available to people receiving methadone. Bremerhaven only had programs of the types 1, 2 and 3a.

Both cities had of course a number of programs either aimed at the general public (e.g., unemployment offices that among other things are commissioned to help people find jobs, debt counseling programs, hospitals), or at specific groups (e.g., prisoners or ex-prisoners, people with HIV) which people receiving methadone theoretically were able to use as well. Practically, this was sometimes impossible, either because potential service recipients did not fit the criteria (e.g., had not been imprisoned recently), or because programs aimed at the general public refused to serve them, once the programs learned that they received methadone.

## Consequences

IN THE GERMAN professional literature, methadone programs are generally celebrated as great success stories and as accomplishing almost everything they claim to accomplish. The studies cited to support such claims usually have three fundamental flaws. *First*, they are typically quantitative empirical studies with nontransparent methodological processes, rais-

ing questions of reliability. *Second*, they miss a number of important issues by not examining certain questions. *Third*, they are almost always funded by parties who have strong political interests. Practical research studies in which powerful parties have an interest rarely produce honest results because funders tend to put enormous pressure on researchers to get the results that match their political goals.

If one talks to service recipients and professionals in the field, observes what is going on in human service programs, and uses common sense as well as SRV as an analytical tool for analyzing the services provided, then a very different picture of the many problems, and few benefits, of methadone treatment evolves. I do not suggest that the consequences of methadone treatment which I will describe below automatically apply to each and every methadone program in every location. But I do think that although some problems might vary depending on *how* such programs are implemented, others are inherent in the medical model, and can therefore be expected to exist everywhere methadone is handed out to people.

### *More But Different Drugs*

Abstinence from drugs for some people, and reduction in drug use for others, was one of the hopes associated with methadone programs. It turned out to be utterly unrealistic, for many reasons.

*First*, methadone as a drug is more addictive than heroin, meaning that its withdrawal effects are worse, making it harder for people to quit.

*Second*, people who use drugs either enjoy their effects, or they lack the inner strength and maybe outside support to quit. So if one replaces a drug that gives people a positive feeling (as heroin does) by a drug that does not create positive feelings but has a number of unpleasant 'side-effects' and strong withdrawal

effects if not taken very regularly (as is the case with methadone), then people certainly experience a lack of positive feelings. Methadone is an opiate, just like heroin. If it is used as a substitute for heroin, it prevents heroin withdrawal effects, and if people consume heroin *after* having received methadone, they no longer experience the positive feelings that typically come with heroin use. Therefore, heroin becomes an ineffective drug for them. As a consequence, many switched to other drugs (like alcohol, cocaine, legal mind drugs) because the effects of these drugs could still be felt. In other words, people became addicted to yet more drugs (methadone *plus* additional legal and/or illegal drugs), and to drugs that are potentially more harmful to their bodies and minds than heroin. Mixing different kinds of drugs, as many started to do, is also more harmful than taking just one drug. Many people who are part of the drug subculture believe that (at least some of) the increase of cocaine and crack consumption in previous decades has to do with methadone recipients switching to other drugs.

A *third* reason why abstinence or reduction in the overall consumption of drugs was not achieved was that the doctors who gave out the methadone often also prescribed legal mind drugs (e.g., barbiturates, antidepressants), especially so if they were psychiatrists. As their professional approach consisted in treating 'mental illness' (which is what they considered drug addiction or its effects to be) by prescribing drugs, this made sense to them, but it also made a great variety of new drugs easily available for methadone patients. Often, doctors prescribed them to people who did not really want them. As a consequence, the black market became saturated with legal mind drugs, because they became a quick source of income for

methadone patients who often were economically poor. In Bremen, several local pharmacists traded methadone patients' prescriptions for HIV medication against prescription mind drugs and a bit of cash, making huge profits because HIV medicine is very expensive. This too increased the availability of legal mind drugs sold on the streets.

And *lastly*, what made it additionally difficult for people to quit using drugs was that after detoxifying from methadone (and possibly other drugs) in a hospital, and being released, there were few services available to them, other than the service systems' standard response of sending people to 'abstinence therapies.' If people were not willing to spend many months in an institutional or group home setting being engaged in 'therapy,' (i.e., if they rejected the patient role), and if they did not have competent valued people in their lives who were able to help them find jobs, homes, relationships with valued people, etc. (which most did not have), then it was very difficult for them to stay away from their addicted friends and acquaintances who tempted them to continue using drugs. In other words, hospital detoxification helped people to leave their very devalued roles as drug addicts and members of the drug subculture, but the service system offered them very little support to replace these devalued roles by more valued ones. As people can not be without roles (this is the concept of role avidity within SRV; see Lemay, 1999, p. 233), they hurry to fill such a role vacuum created by the loss of devalued roles with new roles. If valued roles are not available, they are forced to (re)enter devalued roles.

### ***Socializing People Into Devalued Roles***

Reintegration into society turned out to be an illusion as well. The service system had many

ways of making it difficult for people to re-enter their previously lost valued roles or to safeguard their still existing valued (work, relationship, etc.) roles.

Several clinics served a big number of methadone patients, and forced them to pick up their drugs all at the same times. Those who served fewer methadone patients often also made those few come to their clinic at the same time. During weekend and holiday distribution, hundreds of people gathered at the day program and the bus stops, drawing drug dealers who tried to sell them drugs. These congregations of methadone recipients constituted constant temptations for people to consume other drugs besides methadone that were widely available through the dealers on the scene. They also forced people who had kept some of their valued roles and who had previously not been part of the drug subculture to have daily contact with that subculture, socializing them into it. Additionally, these congregations were very image-impairing, especially for people who tried to keep their addictions secret from their employers or friends who were not drug-addicted, fearing that they would lose their valued work or relationship roles if such people found out. Some clinics were widely known as methadone clinics; therefore, if one was seen in them, maybe even next to some wretched-looking fellow patients, ordinary people almost automatically assumed that one had a serious drug problem.

People who had a job, or tried to find work, often found it difficult to work while receiving methadone. Pickup times at the clinics regularly interfered with work schedules, especially when, as was sometimes the case, pickup times changed from one day to the next without advanced notice; or when at certain times, due to long waiting, people could not get back to their jobs in time. Many doctors did not want to

give their patients methadone to take home for several days at a time, assuming they were unable to control taking the right amount regularly. Another problem was that methadone, especially if overdosed, makes people tired. If underdosed, withdrawal effects start before the person gets the next dosage. Many doctors therefore tended to overdose, rendering people tired and lethargic, which makes most jobs more challenging.

Another way that re-entry into valued roles was prohibited was that the methadone programs effectively socialized people into the patient role. Methadone recipients had to go to a clinic every day; their drug abuse was called a 'disease;' many were engaged in some kind of counseling or therapy, and so on. For many drug addicts, the patient role was not only a role imposed on them by the service system, but also one that they themselves preferred to other devalued roles, such as the drug addict, criminal, burden or menace roles. One of the privileges of the patient role is that people are not considered responsible for their condition and for actions that are caused by that condition. The patient role made it much easier for many people to blame their 'disease' for some of the bad things they had done in their lives, and not feel responsible, ashamed or embarrassed for them. If people do not feel responsible for their lives and for what they have done, then they typically also do not feel in charge of making positive changes. Instead they wait for others to change things *for* them. These others are often professionals (especially doctors and therapists) because they claim to be experts in treating illnesses, including 'mental illnesses.' If what the expert does, does not work, then one of the possible explanations is that one is a hopeless case, or that the 'disease' is so serious or chronic that one will never recover from it.

Additionally, the patient role itself typically



comes with low expectations in terms of what people can do and accomplish. For instance, a disease might prevent one from being able to work hard, follow a challenging schedule, and so on. This is especially true for a long-term, or chronic, illness, as drug addiction is considered to be. As people tend to live up to positive, or down to negative, role expectancies held by others, this was a powerful negative expectation, convincing methadone recipients that they were not able to do much. This expectation was reinforced by the non-medical service system that provided spaces where people could 'hang out,' while receiving none or only few relevant services, essentially wasting their time. "Life-wasting" is one of the common "wounds" of devalued people described in SRV theory (see Wolfensberger, 1998, p. 21).

### *Healthier Through Methadone?*

Another hope was that through receiving methadone, people's health would improve. This seemed to be true for the minority of methadone recipients who *only* took methadone but no other drugs. Even if methadone is more addictive than heroin, there are at least three reasons why it is healthier. *First*, heroin bought on the black market is always mixed with other potentially health-impairing substances that are unknown to the consumer.<sup>3</sup> *Second*, in contrast to heroin that most consumers inject, methadone is given orally which is less dangerous than injections that can cause infections and abscesses. And *third*, if health insurers finance substances that people 'need' to satisfy their addictions, then the people are less likely to prostitute themselves in order to earn money for drugs. Apart from its negative emotional and moral impacts, prostitution is also one of the major health threats, especially to drug-addicted women.

METHADONE RECIPIENTS who took additional drugs certainly did *not* enjoy better health. Here again, several reasons worked together:

*First*, as mentioned, mixing several drugs, and consuming legal mind drugs in addition to the illegal ones people consumed before, was certainly health-threatening, especially if practiced long-term.

*Second*, methadone too became a street drug, through people who either smuggled it out of clinics and hospitals, or sold some of the methadone that had been given to them to take home.<sup>4</sup> When methadone is given to people in clinics or hospitals, it is mixed with fruit juice for people to drink. When people buy it on the streets they tend to inject it, because they are used to injecting heroin as well as dissolved legal mind drugs. Injecting a drug mixed with fruit juice multiplies the risk of life-threatening abscesses.

And *third*, many doctors regularly became nervous when they saw that their patients took many non-prescribed drugs besides methadone. Their typical response was to tolerate it for a time while augmenting the methadone dosage, hoping that this might help their patients to reduce other drugs, then to set a deadline when they had to stop taking additional drugs, and if they did not meet the deadline, to kick them out of the methadone program. If such people did not find another doctor who would give them methadone quickly, they had to consume either heroin or black market methadone in order to combat withdrawal effects. Not having consumed heroin for a while, such people often misjudged how strong the heroin was,<sup>5</sup> which sometimes led to life-threatening overdoses.

ONE WOULD HOPE that people who show

up daily at a clinic, and who see a doctor regularly, would have at least their physical diseases monitored and treated. This was true for some, but not for the majority of methadone recipients. A major reason was that, even if their doctors were general practitioners or internists, people often did not want to be examined and treated by them because they were afraid that their drug abuse would be discovered and that they would be kicked out of the methadone program. If their doctors were psychiatrists, physical diseases fell outside their purview. Other programs combined methadone distribution with a day program, but the doctors working in these programs were not licensed by health insurances to diagnose and treat physical conditions.

Another major problem was that many doctors assumed that their methadone patients would lie to them and pretend to be sick in order to receive prescription mind drugs. In numerous instances this resulted in serious illnesses not being treated in time, people not being admitted to hospitals when they should have been, and consequently life-threatening situations and sometimes even deaths.<sup>6</sup>

### ***Bringing Out the Worst in People***

Giving out methadone in most instances destroyed any positive doctor-patient relationship. In the eyes of most methadone recipients, doctors became the major powers in charge of their lives. They controlled their schedule and time (when to show up at the clinic, how long to wait, when to have conversations with their doctors, when to be able to leave the city for more than a day, whether keeping or finding a job was an option); their drug use (dosage, kinds of drugs, when to or not to withdraw); and the people they associated with (other drug addicts, often drug dealers, sometimes counselors or therapists). All of this resulted in

huge resentments by methadone recipients towards their doctors, who often blamed the doctors for their bad situation in life. It also resulted in endless power struggles between doctors and patients, and the doctors being the more powerful party, sometimes in humiliating procedures.<sup>7</sup> On the part of methadone recipients, this power struggle often brought out the worst behaviors in them (e.g., lying, aggressiveness), which in turn reinforced the doctors' negative assumptions about drug addicts.

Similarly, many of the accompanying counseling and therapy services, as well as the 'hang out' programs, brought out and reinforced people's bad behaviors. For instance, the counseling and therapy programs expected their clients to be on time, to come regularly, to stick to previously made agreements and so on. As most of their clients did not like to go to their counseling or therapy sessions, but saw it as an obligation, they had very little motivation to be reliable. Again, this reinforced the counselors' and therapists' negative assumptions about methadone recipients (e.g., that they were unreliable and therefore unable to have a real job, or to maintain typical relationships with ordinary people). The main reason why people resented counseling and therapy was that they hoped for some kind of practical help (e.g., in finding a better place to live or a job, in dealing with authorities and/or doctors, etc.), but were instead given endless talk about what was wrong with them and with their lives. Sometimes counseling and therapy programs referred their clients to other programs for practical help, but only few other programs actually provided any practical help, and so people moved around in the service system keeping staff busy talking about their problems. In other words, most programs were essentially irrelevant to what they needed, and therefore methadone recipients did not respond posi-

tively.

The 'hang out' programs too rarely referred people to relevant services, but instead conveyed powerful expectations that methadone recipients would continue to be members of the drug subculture. Why would people need to exchange their syringes, receive free condoms, or hang out with other drug addicts, if their goal was to enter more valued roles? By setting up such negative expectations, these programs perpetuated the negative behaviors they claimed to address.

### ***Criminally Sick or Sick Criminals?***

One of the goals of methadone treatment was to replace the very devalued roles of criminal and menace by the role of the sick person. Within SRV theory, this would be considered a positive achievement because the patient role is generally less devalued by society than the criminal or menace roles. What happened though was that the service system successfully socialized drug addicts into the patient role while not freeing them from the menace or criminal roles, essentially adding another devalued role to their already very devalued identity.

Prisons kept being overcrowded with people imprisoned for drug-related offenses. In other words, drug addicts were still in the roles of criminals, menaces, prisoners and ex-convicts. The main difference to pre-methadone-times was that people were prosecuted more often for offenses related to drugs *other* than heroin. A minor benefit of methadone treatment was that *some* methadone recipients committed *fewer* illegal acts, which had to do with using only or mostly legal mind drugs besides methadone paid by health insurances. As a result, such people did not use illegal means to make money to pay for their addiction, or they did so less often, which resulted in fewer

conflicts with authorities.

The stereotypes surrounding methadone recipients were essentially the same stereotypes surrounding other drug addicts. They were perceived as dangerous, uncontrollable, criminal, unreliable and so on. Ordinary people who were not able to understand the difference between somebody receiving methadone and somebody consuming heroin treated both groups very similarly. If they found out that somebody received methadone, they would not rent apartments to them, not hire them, distance themselves from them, refer them to addiction services (instead of general ones), assume they were criminals and so on.

As a result, methadone recipients found themselves in an incoherent and confusing situation. The professional service system considered them to be sick, while the 'world' treated them as criminals. What added to the confusion was that the professional approach was very incoherent as well. For instance, most doctors punished methadone recipients' continued non-prescribed drug use by withdrawing or reducing methadone. If such doctors really believed that heroin addiction was a 'disease' that can be 'healed' by substituting heroin with methadone, then it would make no sense to withdraw the 'medication' (methadone) that can cure the disease (addiction). This would be like asking sick persons to give up their diseases before receiving medication, which in every other case of a (real) disease would be considered absurd by everybody involved. Hospital detoxification units also typically kicked patients out who were discovered to have consumed non-prescribed drugs. If one thinks along the logic of the medical model of addiction, such patients were kicked out for showing expressions of their 'disease.' This would be like cancer patients, when showing

signs of growing cancer, being cut off from chemotherapy. Addiction is probably the only existing 'disease' that patients have to keep secret from their doctors if they want to avoid being cut off from 'treatment.'

Despite such obvious contradictions, most medical and human service professionals kept insisting that heroin addiction was a disease, while other authorities (e.g., police, courts) insisted that heroin use was a crime. As a result, methadone recipients were stuck in a very confusing devalued identity, feeling either unjustly prosecuted (if they accepted their patient role), or perceiving doctors and other medical staff as 'drug dealers in white coats' acting like 'drug-dealing policemen.' SRV teaches that roles often come in complementary pairs (e.g., teacher and student; doctor and patient). If drug addicts are a mixture of patients and criminals then of course it makes sense that they perceive those who serve them in a role that is a mixture of doctor, drug dispenser and policeman.

### *A Place to Live Paid by Clientage*

One of the few benefits of the methadone programs was that they enabled many methadone recipients to have a place to live. They often helped people to leave the devalued role of homeless person and replace it by roles such as tenant or group-home resident. Even people who took a lot of other drugs besides methadone were often able to avoid becoming homeless because their basic 'need' for drugs was covered by health insurance companies. Therefore, they required less money for drugs than before they entered the methadone program and were able to pay rent more regularly. Group home residents had their rent taken out of their monthly welfare automatically which ensured regular payment.

The downside or 'cost' of this was that be-

coming a methadone recipient almost automatically meant not only patienthood but also clientage. Especially people who had hoped that methadone would help them to regain their valued identity found that now they were stuck in the service system. Instead of working, volunteering, receiving an education, making new friends or being engaged in other kinds of activities that might lead to valued roles, they now spent their days waiting in clinics, hanging out in day programs, talking to counselors, and walking from program to program hoping for services that often turned out to be nonexistent, provided at another time or place, or only after many weeks of waiting. Before receiving methadone, most people's time was filled with 'making' money, consuming drugs and avoiding being caught by police. Methadone treatment freed up a lot of this time which could have been used in constructive ways. Instead, the service system told them that now they were patients who needed to recover and solve all their problems before they were able to live like ordinary people. Most never 'recovered' or solved all their problems, and therefore 'ordinary life' never became a reality.

### *Glimpses of Beneficial Service*

As always, there were a few glimpses of hope in a chaotic system. They came mostly from individual people who managed to use the system in constructive ways and to relate to people in positive ways. I will give a few examples as an illustration of things that helped people enter more valued roles or at least avoid some very devalued ones.

As mentioned above, a social worker set up a project that brought members of a soccer fan club and a small group of prisoners receiving methadone together. The prisoners were allowed to leave the prison once a week for a few hours. The group spent time together each

week in soccer-related activities: renovating parts of the local soccer stadium which the fan club was occupying, attending soccer games, preparing for the fan club's annual celebration, and so on. At one point, the fan club's activities were proudly featured in the local newspaper, which was very image-enhancing for the fan club itself as well as for all its members, especially because soccer is the most important sport in Germany and the local team was quite famous nationwide. This small project not only helped prisoners to form relationships outside the drug subculture to which they could return once they were released from prison, but it also accorded them the valued roles of soccer fans, fan club members, workers and friends.

A psychologist who worked in one of the day programs served a woman who was very sick. The woman had been addicted to drugs for almost 20 years and lived a very marginal life with no relationships to family or other valued people. The psychologist decided to befriend her, and spent much time sitting at her bedside when she was in the hospital, making sure she received good care. As the psychologist was a respected professional, hospital staff were attentive to her requests. When the woman finally died, the psychologist was with her, after having spent many nights at her bedside. She also had managed to find some of the woman's remaining family members and convinced them to visit before she died. In this way, she helped the woman to regain her role of family member and to be in the role of a friend.

A policeman who patrolled an area of the city where many marginal people, including many methadone recipients, met started to watch out for people. He stored their important documents in his office so they would not get lost. He negotiated with the local transpor-

tation company and the state attorney to prevent people being sent to jail as a result of not being able to pay fines for riding without tickets. He convinced people who looked sick to go to the hospital. He searched for people whom he had not seen for several days and made sure everything was all right. With his service he protected many people from entering the devalued role of a convict, and he saved at least one man's life by having him transported to a hospital.

Several doctors provided excellent medical care. These doctors made sure to not congregate methadone recipients with other people receiving methadone. They treated them very respectfully as their valued patients, and they took much time to diagnose illnesses and to talk with their patients. If they did not treat patients themselves, they followed up with fellow physicians to whom they had referred them and made sure they were treated correctly. Such medical service not only protected or enhanced people's health, but also afforded them the role of respected citizen who happened to be a patient like others in that doctor's clinic.

A group of citizens, including some service workers and lawyers, set up a group who observed what was going on in the local prison and advocated for reforms. Members of that group either visited the prison or kept in touch with people who had regular access to the prison. When a woman prisoner died after a prison doctor who was notorious for not treating severely ill drug addicts had repeatedly refused to see her, they documented evidence of his neglect. Although they were unsuccessful in getting this doctor removed, their activity at least conveyed the message to prisoners that other people cared about them and considered their lives valuable. It also was an effort to

counter the better-off-dead or the deserving-to-die roles into which these prisoners had been cast (see Wolfensberger, 1998, p. 16).

### **What is Wrong With the Medical Model of Addiction?**

MUCH IS WRONG with the medical model of addiction. I will limit my critique to a few general points which are relevant to other service fields as well.

1. *The most fundamental assumption of the medical model is wrong.* Heroin addiction, just as drug addiction in general, is *not* a disease. Drugs can *lead* to many diseases (e.g., harm to bodily systems and the brain); drugs can impair people's functioning which can cause accidents that *lead* to diseases; the methods through which drugs are administered can *lead* to diseases (e.g., various kinds of infections through contaminated needles); and people who are addicted to heroin or other mind drugs experience withdrawal effects for a period of time when they stop taking them, including bodily symptoms. But by itself drug addiction is not a disease.

If one asks drug addicts why they *started* to take drugs, one is most likely to get one or several of the following answers: (a) hedonistic pleasure: people wanted to enjoy euphoric feelings, party, have fun, etc.; (b) curiosity; (c) wanting to have 'religious experiences;' (d) wanting to suppress negative feelings (such as stress, confusion, anxiety) and/or wanting to forget unpleasant realities in life; (e) peer pressure from friends or other important people; and (f) in very rare instances, in order to combat physical pain.<sup>8</sup>

All these reasons have in common that people try to manipulate their experiences and feelings by material means, sometimes imitating

others who do the same. Doing this, they treat themselves a bit like machines that can be made to function exactly according to their wishes. If one does not like certain negative feelings (and maybe does not know why one should have to suffer at all in the first place), one decides when to stop these feelings and with what other feeling to replace them. If one wants to experience new feelings, one decides when and how to experience them. If one does not like certain unpleasant realities, one can get away from them in an instant. And if one wants to experience a certain other kind of reality, one can have it in an instant as well.

Underlying such practices are mindsets of (a) wanting to always be in control; (b) wanting things 'fixed' in an instant, and without much effort; (c) putting oneself and one's feelings first; and, as already mentioned, (d) perceiving oneself and one's life (and probably other people as well) like a manipulable machine. Such practices and mindsets are not unique to drug users. Many people in Western countries hold similar mindsets and engage in similar practices. For instance, people's obsession with extreme sports, fast cars, sex, material wealth, health and beauty of their bodies, etc. are often expressions of such mindsets. Among other things, they are expressions of interior emptiness and restlessness, of 'needing' external thrills to fill that emptiness and restlessness; of having no explanations for human suffering and hardships in life and therefore rejecting it at all cost; of longing for a different kind of life and different kinds of relationships, but without knowing how to bring it about or without wanting to pay the price (i.e., making the effort) for bringing this about; of lacking positive orientation and/or values that are life-sustaining and the discipline needed of working through hard times, or going through long periods of effort without instant gratification.<sup>9</sup>

It is true that humans have always enjoyed mind-altering drugs and experiences -- that is why, for instance, alcohol prohibition never worked. They also have always enjoyed hedonistic pleasures. Yet what is different today is that our culture has accepted drugs and hedonistic pleasures as legitimate means for dealing with almost any kind of problem and situation in life.

Once people have been addicted to illegal drugs for some time, and have experienced continued wounding and devaluation as a result, they have even more reasons to use drugs in order to suppress suffering and to 'escape' from a terrible situation in life -- at least for a certain period of time. One of the paradoxes with drug abuse is that people who first tried to be in control at all cost then completely lose control, and get controlled by drugs, by their bodies, by drug dealers, by service structures and by authorities. Sometimes, if people do not find true answers to their most existential questions in life, and some form of hope that is life-sustaining, then their continued drug abuse becomes an expression of a death wish (or of playing with death), of wanting to be freed of a life that has no positive meaning for them.

The most fundamental problem of the medical model is that it assumes drug abuse to be a material problem and a disease, when it is fundamentally an existential, spiritual and moral problem. Drug abuse is not a disease but a personal and cultural disorientation.

*2. From this fundamental faulty assumption flow many other problems.*

*a. Promoters of the medical model of addiction believe that drug abuse is a material problem and therefore they respond to it with material means.* Drug abuse gets treated by drugs, and by technocratic counseling and therapy. By trying to manipulate people's bodies and

minds by material means, professional services essentially follow the same approach which drug addicts themselves have used -- an approach that has not 'worked' in the first place.

Similarly, if what people need most in order to be able to abstain from drugs are a 'perspective for their lives' (i.e., answers to their most existential questions), belonging (to family and friends), and a sense of purpose and achievement (through work), then giving them drugs and talk about how things are not working out in their lives is not going to address these most fundamental needs.

*b. Inherent in the medical model of addiction are negative assumptions about people's characteristics and future prospects.* Because so many service systems are based on such negative assumptions, they set up structures and patterns which will confirm these assumptions. SRV teaches that when negative expectations are communicated through service processes, they set in motion a powerful feedback loop that over time generally brings out in people what was expected of them. For instance, if one expects people to suffer from a chronic condition, part of which includes not *wanting* to change, then one will provide services to them that will make it very difficult for them to be *able* to change. Instead one will offer services that trap people in their present state and condition. If only professionals are considered 'experts' in dealing with a certain group of people, then they are not likely to recruit ordinary people to be with such people. Instead they will set up artificial 'professional' environments that separate their clients from the typical world. If one expects people to always lie and cheat, then one will set up patterns of distrust and control, and people will tend to revolt against these patterns. One of the ways to avoid control is to actually lie and cheat. And

so on.

*c. Putting people who are not sick into the patient or the chronic patient role makes it impossible, or at least extremely difficult, for them to enter certain other more valued roles.* As mentioned, people in the chronic patient role are often perceived as being unable to work or at least to only have limited competencies. Therefore many valued work roles become unavailable to them. People in the chronic patient role are not considered responsible for their condition and the behaviors resulting from that condition. They are considered dependent on other people, especially on medical professionals, who take over many aspects of their lives. Therefore, many roles that require its incumbents to assume personal responsibility become unavailable. People in the role of short-term patient tend to evoke care and compassion in others. Yet if they are in the patient role too long and do not have many other valued roles as a compensation, other people tend to feel threatened because they assume the condition is hopeless, getting worse, or is maybe even fatal. When people feel threatened, they are apt to distance themselves from the source of the threat; therefore, many valued relationship roles become difficult to maintain or to enter. And so on.

*d. The medical model, if applied to people who are not sick, will always be in competition with conflicting assumptions and conflicting service models.* This happens because at least some people and/or authorities perceive its obvious incoherencies and try to impose their own interpretation. Sometimes older interpretations continue to exist and conflict with the medical model. When the medical model gets used to serve drug addicts, the most common conflicting model is the menace-detentive model. Services then become a mixture of contradicting expectations for service recipients,

hence role conflicts, which is a sure way to perpetuate their confusion about their own identity, further their social devaluation and confuse observers.

## Conclusion

IT IS INTERESTING to consider that the services which accompanied methadone treatment in Bremen for many years had no conditions whatsoever attached to their funding. In other words, they received public money and were allowed to do whatever they wanted, i.e., what they thought would be beneficial to the people served. Many service workers truly believed that drug addiction was a disease and did their best to serve people. Such servers are good examples of the enormous amount of unconsciousness that exists in human services (see Wolfensberger, 1998, pp. 103-104).

However, on a societal level, it is obvious how much many parties benefitted from casting drug addicts into the sick role. By replacing illegal mind drugs with legal ones, the pharmaceutical industry developed a new market. Pharmacists were able to sell more drugs. Doctors recruited a new group of patients. Although some truly meant to be helpful to individuals and serve them well, other doctors served a huge number of methadone patients, basically handing out drugs and doing little else. Without methadone and other legal mind drugs as a mean to control inmates, most German prisons would have probably collapsed years ago, because the majority of inmates were -- and *still* are, according to prison experts -- drug-addicted. Many administrators, social workers, counselors, therapists, nurses and other human service workers made -- and, despite recent financial cutbacks in human services in Germany, are *still* making -- a living



dealing with an ever increasing number of 'sick' or 'chronically sick' people. Because they and society were -- and *still* are, as evidenced by the continuous demand for *more* professional services and *bigger* prisons -- so efficient in perpetuating social devaluation, policemen, state attorneys, judges, prison staff and others were -- and *still* are -- ensured of their continued employment as well. The problems related to drug addiction and methadone treatment were intensively researched by academics and endlessly discussed at conferences. When enough experts finally admitted that methadone turned out to *not* be *the* solution to heroin addiction, another drug -- legalized heroin -- became the new hope. It is not difficult to predict what is likely to happen to such legalized heroin recipients, if more relevant and potent services are absent.

The medical model applied to serve people who are *not* sick seems to be the most prevalent service model today. Almost every imaginable human behavior has been defined as a psychiatric condition and therefore considered a disease. If things do not change, soon everybody will be on mind drugs and people will no longer know what health is.

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**Note:** All resources on drug addiction, methadone treatment and the related service system on which this article is based are written in German. People who are interested can get a list from: Susanne Hartfiel, SRV Implementation Project, 74 Elm St., Worcester, MA, 01609 USA; or: susanne@srvip.org.

## Endnotes

1. They are mutually exclusive because if a certain behavior is the result of a disease, one is not responsible for such a behavior; however, if it is *not*, then typically adults *are* considered responsible, and if they break laws they might be prosecuted.

2. In Germany, small offenses (such as stealing items of little worth, or riding public transportation without a ticket) are punished by fines. If people are unable to pay these fines, they can either go to jail, or work a certain

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amount of time in a charitable, environmental or cultural organization.

The work provided for methadone recipients typically was either cleaning, or packaging syringes for distribution in exchange for used ones.

3. Drug dealers do this in order to extend the amount they can sell, making more profit. In Germany, only 5-10% of the substance bought in a bag on the black market contains actual heroin.

4. In order to avoid the problems associated with congregating methadone recipients, or with forcing people who worked to show up at the clinic every day, some doctors gave their patients dosages for several days to take home.

5. The concentration of black market heroin varies. People who consume it regularly usually know how strong it is, and how much they 'need,' but people who have not consumed it for a while can easily misjudge.

6. In one instance, when a prison doctor refused to pay attention to a woman with high fever, paralyzed limbs and constant vomiting until she was found dead in her cell, all possible authorities (police, State Attorney, General Attorney, Justice Department, parliament, medical examiner, Justice Minister) worked together to cover it up and to prevent investigation, even though there was much documented evidence and many witnesses.

7. For instance, some doctors required people to undress and urinate in front of a nurse in order to make sure that the urine sample for drug screening was not fake.

8. Sometimes people received morphine or some other opiate in order to combat pain. When the condition causing the pain was healed, they switched to heroin after having become addicted to opiates. Such people are rare; most are able to quit once they do not need opiates as pain medication.

9. In a seven day workshop entitled "How to Act With Personal Moral Coherency in a Disfunctional Human Service World," much more of the societal background of such mindsets is explained. The workshop is offered every other year in North America; for further information contact the Training Institute (315 473 2978).

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