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Medical Methadone Maintenance:
The Further Concealment of a Stigmatized Condition

by

Herman Joseph

A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the requirements of the degree of Doctor of Philosophy, The City University of New York.

1995

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This manuscript has been read and accepted for the Graduate Faculty in sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

3-22-95

Date

Chair of Examining Committee

3/22/95

Date

Executive Officer

Lindsey Churchill

William Kornblum

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

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Abstract

MEDICAL METHADONE MAINTENANCE:

THE FURTHER CONCEALMENT OF A STIGMATIZED CONDITION

by

Herman Joseph

Adviser: Professor Charles Winick

This study investigates the social and historical development of stigma directed to opiate dependent persons over the past century. Stigmatizing attitudes based on class and racial stereotypes in different historical eras have found expression in theories about opiate dependency, methods of treatment and punitive, controlling legal statutes. This is most evident when groups at risk for opiate dependency included poor men from non-white minorities and, white ethnic and immigrant groups.

One hundred socially rehabilitated methadone maintenance patients enrolled in a program called medical maintenance, an advanced phase of the methadone maintenance program for the treatment of heroin addiction, comprise the focal group of this study. These patients were transferred from highly regulated neighborhood clinics to private medical practices of internists affiliated with a hospital in New York City. Their reporting schedules were reduced from once per week to once per month, and procedures for dispensing methadone are implemented in the privacy of a physician's office.

Methadone patients harbor the invisible stigma of opiate dependency and are, as described by Goffman, discreditable but not discredited. A major finding of this study is that the program was successful for seventy-seven patients including ten who were successfully withdrawn from methadone. Although they either maintained or improved their levels of acceptable social functioning, the perception of social stigma remains.

Patients continue to conceal their treatment to avoid ostracism and loss of employment. The further concealment of methadone treatment in private medical practice and properties of methadone maintenance – the absence of narcotizing and tranquilizing effects – assist patients to pass as "normals."

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Patients and physicians concurred that methadone treatment was highly effective but that stigma and concealment were major problems. Stigma and misinformation hinder the delivery of adequate methadone treatment and prevent the expansion of the program despite its effectiveness in reducing transmission of the human immunodeficiency virus.

Community attitudes and the role of media in perpetuating stigma, myths and misunderstandings about methadone maintenance are investigated. An educational campaign targeted to the media, community, politicians and the professions highlighting outcomes of successful patients is needed to change current attitudes.

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Acknowledgments and Dedication

I would like to acknowledge the much appreciated assistance of the following persons: Roberta Seigel who helped to obtain the cooperation of the elementary school teachers and administered the Stigma Scale to them; Joe Pihas for his assistance in preparing the survival curve (Figure 1); Joycelyn Woods for her computer and editorial assistance and, the time and cooperation of the medical maintenance physicians and current and former patients whose insights made this study possible.

This dissertation is dedicated to all current and former methadone patients, the medical maintenance patients, the National Alliance of Methadone Advocates and to the memory of the late Dr. Marie E. Nyswander, whose vision and courage have helped to save thousands of lives.

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Medical Methadone Maintenance:

The Further Concealment of a Stigmatized Condition

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The Sick Rose

O Rose thou art sick.
The invisible worm
That flies in the night
In the howling storm:
Has found out thy bed
Of crimson joy:
And his dark secret love
Does thy life destroy.

from Songs of Experience
by
William Blake (1757-1827)

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I

Introduction

Evaluations worldwide over the past two decades have shown that methadone maintenance is the most successful treatment for heroin addiction and one of the most effective programs for the prevention of the transmission of human immunodeficiency virus (HIV) (Joseph and Appel, 1993). Nevertheless, methadone maintenance treatment has been subjected to professional trivialization and misunderstandings, has consistently received sensationalized negative media coverage and been the target of widespread community opposition (Zweben and Sorensen, 1988). These attitudes have prevented the opening of needed clinics within the past 15 years, notwithstanding the current acquired immune deficiency syndrome (AIDS) and heroin epidemics. Methadone patients are perceived as addicts: weak willed, unemployed, untrustworthy and dysfunctional. Employed stable patients whose lives have been saved by enrollment in methadone treatment have been forced to conceal their status as methadone patients from members of their families, friends and employers for fear of losing their jobs, social ostracism and stigmatization. They are hiding a "dirty secret." (Murphy and Irwin, 1992).

Methadone maintenance was developed in 1964 at The Rockefeller University from research conducted by Vincent P. Dole, principal investigator and senior physician at the university. His co-principal investigator was Marie E. Nyswander, a psychiatrist specializing in the treatment of heroin addicts. A third member of the team was Mary Jeanne Kreek who as a research physician has specialized in studies on the long term medical safety of methadone maintenance (Joseph and Appel, 1993).

A major focus of this study will explore the adjustments and perceptions of a group of compliant and functional methadone patients who are aware of the stigma directed towards patients. Most of the methadone patients in this study are currently being treated in the hospital-based private medical practices of internists affiliated with Beth Israel Medical Center in New York City. This pilot project, called medical maintenance, is an advanced phase of the methadone maintenance program for the treatment of heroin

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addiction. In contrast, methadone maintenance programs operate in identifiable neighborhood clinics that are highly regulated by the federal government and often hinder the further social adjustments of employed and compliant patients. The medical maintenance program is currently operating from the offices of four internists with hospital-based medical practices and was implemented to demonstrate that chronic opiate dependence can be treated as a chronic disease in private medical practice. In contrast, neighborhood clinics treat a variety of patients including those with serious social and medical problems.

The medical maintenance program removes socially and medically stable methadone patients from the visible, stigmatized and highly regulated clinic system and places them within the concealment of private medical practice. Therefore, it is anticipated that patients can further improve or enhance their personal lives and resolve the stigma associated with their treatment.

To understand the type of stigma socially rehabilitated methadone patients are subjected to, the initial portion of this study will be devoted to an investigation of the development and accretion of stigma directed against opiate dependent groups within the past century in the United States. The patients who are the focus of this study will therefore be placed within a social context with a historical base. The attitudes and experiences of the physicians who treat the patients in private medical practice will also be investigated. These are the first doctors permitted to treat opiate dependent patients *on an ongoing basis in medical practice* since the passage of the Harrison Act in 1914. This is an important accomplishment. Prior to the development of methadone maintenance in 1964, many physicians who treated opiate dependent patients in their offices merely wrote one or two prescriptions. Few were able to maintain patients, as they were harassed by the Federal Bureau of Narcotics, arrested and prosecuted and subsequently incarcerated. While some of the physicians may have been unscrupulous, most were upstanding physicians who tried to treat the addict (Courtwright, Joseph and Des Jarlais, 1989). The physicians participating in this study of medical maintenance are highly capable, respected and ethical professionals with specialties in internal medicine and general medical practice.

Differences Between Heroin Addiction and Methadone Maintenance

The following briefly explains the differences between heroin addiction and methadone maintenance.

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This is important conceptually since heroin addiction and methadone maintenance are often incorrectly equated without taking into consideration the profound differences that exist (see Appendix for Comparison Chart).

Heroin is a short acting narcotic (4 to 6 hours) capable of producing a highly euphoric effect when administered usually by injection or nasal inhalation. Heroin, if continuously used, is also capable of impairing the functioning of the endocrine and immune systems and generating an overpowering, long lasting, narcotic hunger or drug craving. The addiction is characterized by increasing tolerance levels leading to the use of ever increasing amounts of heroin to achieve the same effect. The addiction process also creates physical dependence with a well defined abstinence syndrome. When involved with daily compulsive use driven by drug hunger and craving, addicts may accidently administer excessive amounts of the drug depressing the respiratory center of the brain with lethal results (Dole, Nyswander and Kreek, 1966). If contaminated needles are used, addicts can become infected with or transmit HIV, hepatitis and other pathogens (Novick, Joseph, Croxson et al, 1990; Novick, Khan and Kreek, 1986). The majority of heroin addicts probably can not hold down jobs and are dependent on street crime to obtain money for heroin (Courtwright, Joseph and Des Jarlais, 1989; Joseph and Dole, 1970).

In contrast to heroin, methadone is a long acting narcotic. When administered properly in a maintenance program, methadone has no mood altering effects and is effective orally, thereby eliminating the use of hypodermic needles. At adequate doses (usually over 60 to 120 mg/day), it functions not as a substitute euphoria producing narcotic but as a normalizer for a dysfunctional physiology (e.g., impaired endocrine and immune functioning), relieving narcotic craving and narcotic withdrawal symptoms. Although producing physical dependency, patients can be maintained indefinitely at the same dose level since tolerance remains constant. Patients have been maintained on methadone at the same dose level for about 30 years without toxic or long range health effects. The two minor side effects that have been reported are constipation, which subsides over time in treatment, and excessive sweating. Although some patients at the beginning of treatment complain about decreased libido, usually sexual functioning returns to normal within the first few months of treatment. Most importantly, socially rehabilitated methadone patients are protected from HIV infection (Dole, 1988 and 1980; Des Jarlais, Friedman, Novick et al, 1989; Kreek, 1973; Novick and Joseph, 1991; Novick, Joseph, Croxson et al, 1990; Novick, Khan and Kreek, 1986). The withdrawal

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syndrome associated with methadone is less severe than with heroin but more protracted, since methadone is a longer acting drug. The withdrawal syndrome, however, can be controlled by a slow reduction in dose if a patient wants to be withdrawn from the medication. However, as is with all narcotics there is a prolonged secondary abstinence syndrome that may last for long periods of time, or perhaps for the duration of the addict's life.

A major therapeutic advantage of methadone at high doses is its ability to block the narcotic effects of heroin and other opioids, including methadone itself, if the patient should administer non-prescribed opiates. Patients maintained at adequate doses can function without physiological or social impairment, provided they do not abuse other drugs such as cocaine, alcohol or benzodiazepines (Dole, Nyswander and Kreek, 1966). Since methadone maintenance does not produce overt narcotic effects, patients can function without detection of their opiate dependency and can be successfully employed within the full range of jobs and professions without impairment from the medication. Methadone patients can establish families, conceive healthy babies and lead essentially normal lives (Joseph and Appel, 1993; Joseph and Des Jarlais, 1980; Joseph and Dole, 1970).

Methadone Maintenance: A Stigmatized and Trivialized Program

Methadone maintenance is greatly misunderstood and has received extremely unfair coverage on television and in the press. The presence of clinics has been opposed in many communities, creating tension and conflict for patients that live and work in these communities. While the differences between heroin addiction and methadone maintenance are profound, methadone maintenance has been criticized and trivialized as "just substituting one addiction for another." The criticism and its many variations have denigrated the importance of the program (Zweben and Sorensen, 1988).

Media stories have usually concentrated on the sensational: patients who are dysfunctional, non-compliant, abusing drugs, loitering in the neighborhood near the clinic, selling their medication, homeless, chronically unemployed, or infected with HIV and drug resistant tuberculosis. Patients who are doing well and complying with the program are not highlighted for a number of reasons, including the fact that they do not make interesting or exciting copy. Because of the prejudice, many compliant patients avoid any publicity which could lead to personal stigmatization and loss of employment. Compliant patients usually

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conceal their status as methadone patients from employers, friends and even members of their immediate families with whom they live (Joseph and Des Jarlais, 1980; Novick and Joseph, 1991). They resent the regulations that they are required to adhere to and that were put in place to 'control' the dysfunctional patients. Compliant methadone patients are an example of patients in a double bind (Bateson, 1987). They are encouraged to be open and truthful in the clinic setting, but in their personal and business lives outside the clinic they are evasive and develop strategies to protect their confidentiality. Their past histories may include criminal behavior, in addition to their heroin addiction and current treatment status in a methadone program.

Literature Review

The major literature in this study deals with the problems of stigma related to methadone maintenance. This will include within the course of the study a review of selected of newspaper stories, books, and documentaries for television and movie theaters. As described by Erving Goffman (1963) in Stigma: Notes On The Management Of A Spoiled Identity, addicts are perceived as belonging to a particular category of stigmatized persons which includes alcoholics, homosexuals, criminals and people with mental disorders. Since methadone maintenance is considered "a substitute addiction," methadone patients in medical maintenance fall within this category. Furthermore, their stigma is invisible and they are, as Goffman describes, discreditable but not discredited persons. Some strategies that methadone patients adopt to conceal their status for fear of loss of employment, social ostracism and stigmatization have been described (e.g., concealing information from employers, not telling family members or friends) (Joseph and Des Jarlais, 1980; Murphy and Irwin, 1992).

Addiction is perceived as being self induced, rather than the result of injury or an inborn problem beyond the individual's control. This has an effect on the individual in terms of feelings of self worth and esteem (Crocker and Major, 1989) and the social perception of addicted persons. Conditions that are perceived as inborn or the result of incidents beyond the individual's control (e.g., accident resulting in loss of limb) elicit a degree of compassion while stigmas that are perceived as the direct result of a person's behavior are the target of social hostility and rejection. The stigmatization of methadone treatment is also

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reflected in the attitudes of patients and street addicts since an inaccurate folklore has developed that creates ambivalence towards methadone itself (e.g., it rots the bones) (Goldsmith, Hunt, Lipton and Strug, 1984; Rosenblum, Magura and Joseph, 1991).

Goffman (1973) in The Presentation of Self in Everyday Life, describes the strategies involved in the art of impression management. Methadone patients are constantly playing a role in which the management of impressions is paramount to their acceptance, namely "the normal person" who is not enrolled in methadone treatment. The major players who cooperate in this "disguise" are the patient, the program staff who will not speak to patients outside of the program, the physician who prescribes the methadone and those persons who the patients inform about their enrollment in methadone treatment.

Theories to explain compulsive addictive behavior can be placed in two categories. Addictive behavior according to Goffman (1963) is considered to be "blemishes of individual character, perceived as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty." These characteristics impute that psychosocial factors are the cause for the addiction. The second theory is derived from neuroscience and states that narcotic addiction or the daily compulsive use of narcotics has a metabolic origin (Dole, 1988 and 1980; Joseph and Dole, 1970). The belief about causality of addiction influences the formation of attitudes about addicts and the development of scientific theories (Mehan and Wood, 1975). Literature pertaining to methadone maintenance will be reviewed to develop a reliable scientific basis for claims of medical safety and the development of theoretical concepts about addiction (Dole and Nyswander 1965; Hartel, Selwyn, Schoenbaum et al, 1988; Kreek, 1988 and 1973).

This study will include a review of risk groups involved in opiate addiction in the United States for the past century, including the class and racial composition of the risk groups, the different theories of addiction, transformation of policy, and how these considerations interact to add to, or detract from the concept of stigmatization. Most importantly, the beliefs of a society find codification in statutes, law and policy that not only reflect, but encourage stigmatization, racism and discrimination (Brecher, 1972; Cooper, 1992; Courtwright 1982; Joseph and Des Jarlais, 1980; Mehan and Wood, 1975; Murphy and Irwin, 1992; Musto, 1992 and 1973).

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Hypothesis for Study

With the relaxation of reporting regulations and the individualized treatment accorded patients in private medical practice, patients are better able to conceal their status as methadone patients. Medical maintenance, therefore, should reduce the anxiety of concealing an invisible stigmatized condition. The controls of regulatory agencies still exist in medical maintenance. However, they are concealed or reduced as in reporting schedules which are extended to monthly private medical office visits rather than weekly clinic visits. Medical maintenance helps patients conceal their status as methadone patients and therefore, further conceals the possibility of their exposure, ostracism and stigmatization.

Therefore, the hypothesis for this study is as follows:

For methadone patients in medical maintenance, the further concealment of their stigmatized condition in private medical practice enables them:

1. to maintain and/or enhance their social adjustments and rehabilitation, and

2. to eliminate or reduce the perception of the social stigmatization directed against them.

Methodology

To determine the extent to which this hypothesis holds, the following multifaceted strategy of analysis will be adopted.

1. A social and historical investigation of the origins of stigma directed against opiate dependent people in the United States over the past century will be undertaken. Risk groups will be defined within class and racial contexts and described for each historical era. Included in this discussion will be the development of

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theory concerning addiction during a given historical period, and the relationship of this theory to the biases and moral beliefs of the period. This section thereby establishes the existence of stigma in different eras and the sociological changes that influence the development of addiction theory with an emphasis on the impact of class and social stereotypes.

2. The historical development of methadone maintenance treatment will be presented with a review of the major social and scientific studies that established its effectiveness and medical safety. The implications of methadone treatment for a reconceptualization of theories of narcotic addiction will also be discussed. This section will serve as a resource for the study to counteract the mythologies, misunderstandings and stigmatization that developed about methadone treatment.

3. The methadone maintenance program is organized in different phases to demarcate progression in methadone treatment. These phases are supposed to provide a structure to assist patients with their social adjustments. The medical maintenance program is the final phase in this transformation process. The patient is integrated into the mainstream of medical practice.

4. The transfer of stigma from heroin and other opiate dependencies to methadone will be analyzed. The role of media, books, documentaries and governmental agencies will be discussed as well as class and racial considerations.

5. Stigma from the streets and communities that is directed towards methadone patients will be reviewed and discussed. Included also will be the folklore and mythologies from the streets that have developed over the past 30 years.

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6. Stigmatizing attitudes and beliefs about methadone and methadone patients within the medical and helping professions will be discussed. The experiences of patients with the medical profession and staffs of clinics will be reviewed.

7. The perception of social stigma against methadone patients will be discussed in relation to other stigmatized groups. To investigate perceptions of stigma a Perception of Social Stigma Scale was developed. The scale was administered to methadone patients and a contrast group of elementary school teachers.

8. A review of the outcomes and statistics of the medical maintenance program will be discussed. Included in the discussion will be a life table analysis of retention and an analysis of active cases, favorable terminations, deaths and unfavorable terminations.

9. Interviews with four physicians affiliated with the medical maintenance program and Beth Israel Medical Center in New York City will be included with discussions of their theories of addiction and their perceptions of the methadone patients they treat as compared to other patients in their medical practices. Other physicians who will be interviewed include Dr. Vincent P. Dole, the co-developer of methadone maintenance and Dr. Thomas Payte, chair of the methadone committee of the American Society of Addiction Medicine (ASAM).

10. For this study 69 current and former methadone patients were interviewed in the following categories:

    a. Forty-four (66%) of the 67 active medical maintenance patients were interviewed about their experiences in methadone clinics and medical mainte-

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nance. Included in these interviews are their concerns about stigma, their jobs, their families and their experiences with physicians and health care workers.

b. Eight (31%) of the 26 patients who were discharged from medical maintenance were located and interviewed. Five of these discharges were in good standing and three were for cause. Their current adjustments will be noted as well as the reasons why they left medical maintenance.

c. Seventeen collateral interviews were conducted with sixteen active patients and three former patients. They were interviewed for the following reasons:

1. Nine methadone patients treated in regular methadone clinics who were either eligible for medical maintenance or had applied for the program.

2. One former patient and one current patient were officers of the National Alliance of Methadone Advocates, Inc. (NAMA). NAMA is a methadone patient and treatment advocacy group. The officers have a unique historical understanding of the development of stigma against methadone treatment and the patients.

3. Four patients were interviewed because of their gay and lesbian sexual orientations. These patients harbor two invisible stigmas. They were interviewed about the relative stigmas of being both a methadone patient and a gay or lesbian.

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4. One methadone patient was interviewed about his experiences in a 12 step program after he admitted in a meeting that he was a methadone patient.

5. One former patient who is the director of an AIDS outreach program was interviewed because of his insight into some of the biases against the methadone program and some of the mythologies that exist.

d. In addition to the above interviews, this writer attended the 1994 National Methadone Maintenance Conference held at the Grand Hyatt in Washington, D.C. from April 20 to April 24, 1994. At this conference the methadone patients and programs in Washington, D.C. sponsored a patient advocacy meeting which was attended by about 200 people including methadone patients from across the country (Town Hall Meeting, 1994). Several African American methadone patients from programs in Washington, D.C. spoke on the podium about their experiences in methadone treatment. A tape of the meeting was obtained to study attitudes of a group of minority patients in methadone treatment.

Protection of Human Subjects

Approval to interview medical maintenance patients was obtained from the Institutional Review Board of the Beth Israel Medical Center. However, limitations were placed on information obtained in the interviews. The Institutional Review Board of the medical center and the physicians who were involved in this study are acutely aware of the stigmatization of this particular group of patients. The hospital did not permit this worker to interview patients who were both discharged for cause from medical maintenance and who were being treated in methadone clinics operated by the hospital. The interviews may prove to be

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embarrassing or traumatic for these particular patients. A compromise was reached. For patients discharged for cause, the medical director of the program would relay the patient's current adjustment without revealing the name, age, ethnicity or clinic of treatment. Since tapes were being used for interviews of patients in good standing, names, dates, birth dates, addresses, locations, names of hospitals and programs or any specific identifying information that could link a patient to a program or reveal identities could not be recorded.

Selection of Patients for Interviews

Originally a specific procedure was submitted for interviews. Every other alphabetical name was to be interviewed from the physician's records. However, this procedure had to be dropped since many patients chosen for the study refused to be interviewed. A convenience sample was then adopted. The physician explained the study to a patient with the provisions that names, ages or other identifying information would not be recorded. Those who wished to be interviewed were referred to this investigator who was in the physician's waiting room when a methadone patient was scheduled for an appointment. Forty-four patients were recruited in this manner. However, since they were employed and the researcher was unable to contact them by phone, the interviews had to be completed within about a half hour in an empty room in the hospital or in a secluded part of the cafeteria. The patient was permitted to answer freely and elaborate on his or her experiences but the interviews with medical maintenance patients were limited to the following areas.

1. Completion of a Perception of Stigma form.
2. Opinions about treatment in regular methadone clinics contrasted to treatment by a private physician in the medical maintenance program.
3. Whether being a methadone patient is a stigmatized condition and if so, how is this dealt with by the patient?
4. How has medical maintenance changed the patient's life and has it reduced the stigma?
5. If time permitted, the patient was asked to comment on certain slogans or statements that may or may not convey stigma: the term methadonians; methadone is just substituting one addiction for another; methadone takes your heart; methadone is a technological fix.

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Significance of Study

This is the first in depth investigation of the problem of stigma directed against methadone maintenance patients. In this study, the initial chapters describe the social and historical implications of stigma. The final sections examine the effects of social stigma on the behavior and attitudes of a particular focal group – socially rehabilitated methadone patients who are treated for addiction with methadone in private medical practice as opposed to highly regulated neighborhood clinics. A type of quasi-normalization has occurred that has implications for theories of addiction, of "passing" within a society and treating opiate dependency in private medical practice.

Central to this study are the attitudes that the public and physicians harbor towards methadone patients. For example, is there a difference in the perceptions of the doctor prescribing methadone to a patient in general medical practice to control a character flaw as opposed to normalize a dysfunction of the opiate receptor ligand system in the central nervous system? How do beliefs affect attitudes and medical decisions about patients? How do the patients perceive their condition, and the differences between being treated in a clinic and private practice?

This study also has important implications for public health. The successful treatment of socially rehabilitated methadone patients in private medical practice can potentially increase the number of patients treated with methadone. The stigmatization of methadone treatment has been a major factor in preventing a large scale expansion of the clinic program to treat an estimated 750,000 opiate addicts in the United States. Only 115,000 (15%) are in treatment. Stigmatization of methadone treatment has resulted in strong community opposition to the opening of new clinics. Within the last fifteen years in New York City only two new clinics have been opened, one that exclusively treats about 85 HIV infected patients in mid-Manhattan and another that treats about 350 patients in the South Bronx community. Thus, stigmatization has had a negative effect on the planning and expansion of addiction treatment, notwithstanding efforts to reduce the transmission of HIV and drug resistant tuberculosis.

As previously noted, methadone patients bear an invisible stigma. With further concealment of their methadone treatment, it is hypothesized that methadone patients can further enhance their social rehabilitation and in the process reduce the stigma associated with methadone maintenance treatment. The final

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conclusions and discussion will examine the findings and the validity of the hypothesis. Recommendations will be made concerning the expansion of medical maintenance, policy, areas of needed evaluation research and strategies for reducing the social stigma associated with methadone treatment and patients.

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II

Social and Historical Perspectives

This section of the study will examine the development of theories of addiction in relation to the transformation of the addicted population within three specific eras: 1870 to 1900, 1900 to 1923, 1923 to 1963. For this section the sources of information will be obtained from the following books.

The Epidemiology of Opiate Addiction in the United States by John Ball and Carl Chambers (1973).

Licit and Illicit Drugs: The Consumer Unions Report by Edward M. Brecher and the editors of the Consumer Union (1972).

Dark Paradise: Opiate Addiction in American Before 1940 by David Courtwright (1982).

Addicts Who Survived: An Oral History of Narcotic Use in America 1923-1965 by David Courtwright, Herman Joseph and Don Des Jarlais (1989).

The Drug Hang Up: America's Fifty Year Folly by Rufus King (1972).

Drugs and Minority Oppression by John Helmer (1975).

The Addict and the Law by Alfred Lindesmith (1966).

The American Disease: Origins of Narcotic Control by David Musto (1973).

Secret Passions, Secret Remedies: Narcotic Drugs in British Society by Terry Parssinen (1983).

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Historical eras are dominated by specific addicted groups, theoretical concepts about addiction, the development of specific treatments and the existence of particular social biases (Courtwright, 1982).[1] Therefore, a major purpose of this chapter is to trace the accretion of stigma targeted to the opiate addicted population during the various eras over the past century. Eventually, the social biases and stigma directed to opiate addicts are expressed in federal, state and local legislation whose main purpose is to control behavior that is misunderstood and feared.

During the past century, the historical, socioeconomic and political forces of a given era shaped the nature of opiate dependency in the United States. Changing technology provided the means for more efficient routes for the administration of opiates (e.g., the invention of the hypodermic needle in the 19th century) and the synthesis of more potent opiates (e.g., synthesis of heroin from morphine) (Musto, 1973).[2] The variety of social groups that constituted foci of opiate dependency suggests that causality of narcotic dependency is an availability phenomenon determined by social factors and biological vulnerability to addiction rather than the outward expression of a unique set of social or personality characteristics. Historical evidence argues against the concept of uniqueness, since widely diverse social and personality characteristics may enter into the causality of an addictive disorder.

Social and personal factors may be responsible for the introduction of narcotics to a particular individual or group. These factors may also help to understand the individual's behavior to obtain narcotics once the addiction process has started. However, neither social or personality theories explain the commonality of addictive behavior found in the variety of affected groups and personalities: the daily compulsive use of narcotics, the development of tolerance and physical dependence, the persistence of craving or drug hunger and the high rate of relapse to narcotics after withdrawal.

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1. Material in this chapter concerning risk groups was obtained from the book, Dark Paradise: Opiate Addiction in America Before 1940 by David Courtwright.
2. Historical material in this chapter was obtained from the book, The American Disease: Origins of Narcotic Control by David Musto.

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Theories of addiction reflect the ideas of a particular era and form the underlying basis upon which addictive behavior is perceived and interpreted. Social biases (e.g., class and race) that contribute to stigmatization of addicts are incorporated into the theoretical framework. Goffman's categorization of addiction as a socially stigmatized condition derived from "blemishes of individual character perceived as weak will, domineering or unnatural passions, treacherous and rigid beliefs and dishonesty" describes the underlying biases of most social and psychological theories of addiction that were formulated in the 19th and 20th centuries (Goffman, 1963). However, socioeconomic class and race also influence the perception of addicted groups. Stereotypes based on the perceptions and interrelations of class and race especially in times of economic crisis lay the foundation for the incorporation of related biases into theories of addiction and the type of legal statutes that are created to control addictive behavior (Helmer, 1975).[3]

The Era 1870 to 1900

In the 19th century opium was one of the most widely prescribed substances in the medical pharmacopeia in the United States. Effective medications were rare and the etiology of major diseases was either unknown or beginning to be systematically studied. The physician faced with a host of ineffective remedies to treat disease turned to palliative substances that were able to relieve pain, induce a degree of comfort and, if possible alleviate troublesome symptoms (e.g., diarrhea) (Brecher, 1972).[4] Dependence on opium, laudanum and possibly oral preparations of morphine (which was synthesized from opium in 1815) was not uncommon. Opium dependence affected notable figures such as Benjamin Franklin who was addicted late in life. Opium was also widely prescribed during the cholera epidemic in the 19th century.

Therefore, evidence from the 19th century suggests that the major cause of addiction was iatrogenic, the

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3. Material concerning the social and racial context of addiction was obtained from the book Drugs and Minority Oppression by John Helmer.

4. Material on the history of opiate addiction is based on the book, Licit and Illicit Drugs: The Consumers Union Report by Edward M. Brecher and the editors of Consumer Reports.

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prescribing of opiates by a physician to relieve discomfort and pain. Patients who continued to take opiates after a course of prescription by a physician during the course of an illness were regarded, in a religious sense, with moral opprobrium. Continued addiction was considered sinful, a vice, affecting weak willed but normal people who according to J. Townley Crane, a Methodist minister, "learned to love the excitement which it produces." However, there was also a sense of empathy toward opiate dependent persons since relief of pain was not only a major objective of medical practice but a major reason persons sought out a physician when little was known about the underlying causes of disease and pain.

The religious-based belief that opiate dependence is a vice was challenged by contemporary late 19th century physicians who considered addiction a form of inebriety that was characterized by an underlying mental disturbance (Parssinen, 1983).[5] Inebriety, however, merged two previous 19th century medical and psychological theories –degeneration and neurasthenia. Degeneration refers to worsening morbid conditions that are transmitted over generations within a family. Environmental factors such as alcoholism and opiate dependence may enter into the degenerative process as a catalyst for further pathology. Neurasthenia refers to inherited inadequate nervous systems that may make an individual prone to a variety of afflictions including opiate addiction. Social factors also played a part. Persons in the upper classes trying to preserve their social status may "exhaust their nervous systems" and be prone to afflictions such as opiate addiction. If a patient suffered from neurasthenia then opiates generated a craving proportional in strength to the neurasthenia (e.g., the greater the neurasthenia, the greater the addiction).

The concept of inebriation dominated the theoretical framework of addiction from 1880 to about 1915. In late 19th century Germany, however, two emerging conflicting views of addiction within the medical profession challenged the concept of inebriation -a physiological theory and a psychological theory. An important physiological concept of addiction was advocated by Dr. Eduard Levinstein of Berlin. Levinstein

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5. Material in this chapter related to theories of addiction developed in Great Britain in the 19th century is based on the book, Secret Passions, Secret Remedies: Narcotic Drugs in British Society by Terry M. Parssinen.

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promulgated the idea that addiction was caused by physiological reactions to the administration of morphine and that any person could become addicted. He completed a follow-up study of addicts in his practice who were withdrawn from morphine and found a 75% relapse rate, which is comparable to relapse rates reported in follow-up studies in the twentieth century. Levinstein was of the opinion that addiction was at most difficult if not impossible to cure. He also noted deviant changes in behavior of previously upright persons to obtain narcotics after withdrawal.

The psychological theory described the addict within the newly emerging concept in German medicine of the psychopathic personality which evolved from an early 19th century English theory of moral insanity. In this theory, persons were not mentally ill with delusional fantasies but acted without a moral sense. They were capable of antisocial behavior and committing criminal acts without guilt, conscience or restraint. These two theories - the physiological and psychological - were further developed in the early 20th century to help explain addictive behavior.

The overwhelming majority of addicts (about 60%) in the late 19th century were white middle and upper class women addicted by their physicians who in turn also had exceptionally high rates of addiction because of their access to narcotics. Geographically, the greatest prevalence and incidence of iatrogenic addiction was in the southern United States.

Wounded veterans of the Civil War constituted another group of medical or iatrogenic addicts. During the Civil War, morphine salts were directly administered into wounds and opiates were orally administered. Opiate addiction, so prevalent among Civil War veterans was known as "soldier's disease." The hypodermic administration of opiates to wounded soldiers was minimal during the Civil War and came into general acceptance in the late 1860s and early 1970s.[6] Once the hypodermic needle was a fully accepted instrument within medical practice, it was freely used by physicians to inject morphine for a variety of conditions

6. The hypodermic needle invented in Great Britain in the early 1850s to facilitate the administration of morphine was available for use in the United States by 1856. However, the device was not fully accepted by the medical profession until after the Civil War in the late 1869s and early 1870s.

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including cholera, dysentery, insanity, cancer, headaches and most frequently, physical and emotional problems affecting women.

Elderly iatrogenically addicted women and wounded Civil War veterans were considered legitimate medical patients to be treated with empathy and compassion. Others within the upper classes who were addicted to opiates such as successful businessmen, physicians and other professionals were considered to be individuals who had exhausted their central nervous system reserves to maintain their status and successful social positions. Explanations of addiction for these groups of opiate dependent persons appeared to fit the neurasthenic theory of inebriation and, in some upper class families affected by numerous mental disorders and incurable conditions, progressive degeneration another aspect of the theory of inebriation.

Opiates that could be administered orally were obtained through prescriptions namely morphine salts and opiate concoctions such as laudanum which consisted of a combination of opium and alcohol. Various nostrums containing opiates, advertised to relieve pain and migraine were available over the counter without prescriptions in pharmacies. As physical dependence on opiates increased among the middle and upper classes, numerous sanatoria were established at the end of the 19th century to treat addiction among the upper classes with bogus claims of "cures."

In the 19th century, however, there was a low prevalence of opiate addiction among blacks. It was hypothesized that blacks did not have the organized "delicate nervous systems" or stress related neurasthenia found among upper class whites to develop widespread addiction to narcotics. Also, among iatrogenically addicted white women (the modal group), physicians, businessmen and others, addiction occurred late in life usually after a middle age illness. Blacks who had little access to physicians, thereby avoiding iatrogenic addiction, and lived shorter lives on the average.

However, another group of opiate addicts existed in the late 19th century, namely opium smokers, as opposed to patients who administered opium orally in available mixtures. Opium for smoking and the opium pipe were brought to the United States in the 19th century by indentured Chinese laborers working in mines and on the construction of the railroads. These workers were forced into oppressive conditions of work and were in debt to Chinese merchants and investors who brought them to the United States. Most were poor peasants who had hoped to save money and return to their families in China. However, most

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failed to do so because of low wages, exploited conditions and mounting debts to their sponsors. Furthermore, dens, established within the locality of their housing, were available for smoking opium and the services of Chinese prostitutes who were probably also addicted to smoking opium. Opium dens were established in Chinese settlements or "Chinatowns" throughout the country.

Opium for smoking was legally imported and eventually found its way into the white marginal groups which included con or "sporting" men, gamblers and prostitutes. Although initially smoking with Chinese smokers, they eventually established their own smoking dens in cities throughout the country. This group of addicts, however, elicited strong feelings of rejection and stigmatization by the larger community, resulting in restrictive local ordinances and state legislation concerning opium smoking and the existence of opium dens. In some cities, the possession of opium pipes was prohibited by law, thus antedating the criminalization of possession of a hypodermic needle in many states during the 20th century. Legislation, however, did not decrease opium smoking. The main impact was increased prices of opium and the moving of dens to localities that had less restrictive or no ordinances.

Helmer indicates that groups at risk for addiction and identified as such by the government are related to the race and class structural conflicts within American society. As an example, he asserts that the anti-opium statutes in the late nineteenth century were enacted during periods of economic crisis. They were directed against Chinese workers who were not only in competition for jobs with whites but were paid lower wages than whites.

Social Paradigms of 19th Century Opiate Addiction

Social class, race, type of behavior, source of opiate, type of opiate, its route of administration, and voluntary or iatrogenic initiation into addiction are the factors that determined paradigms of addiction in the 19th century. For the group that was iatrogenically addicted, there was empathy and narcotic maintenance, for the others (opium smokers) there was legal control and stigmatization. It is estimated that by 1900 there were perhaps 300,000 narcotics addicts in the country, consisting primarily of two previously described groups: 1) the iatrogenically addicted, and 2) the opium smokers. The majority of the addicts (about 60%) in the 19th century were iatrogenically addicted females in group 1. Both groups had the same

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condition -the compulsive use of an opiate with a withdrawal syndrome upon cessation of use and relapse after withdrawal.

In the first group, iatrogenic opiate addiction was a condition that was socially tolerated, eliciting empathy, concern and shame. The group, as previously reported, was basically drawn from sick white middle and upper class females and wounded Civil War veterans. Both were regarded as nonthreatening to social values or the social order. Their addiction to basically orally administered and injected opiates was considered a personal tragedy, and the prescribing of opiates within private medical practice was considered a viable treatment option. When indicated, patients entered sanatoria for "cures." Their opiate conditions "fit" into the previously described theories that attempted to explain addiction (e.g., inebriation, neurasthenia, incurable painful physical condition).

However, poor Chinese laborers and white marginal criminal groups who smoked opium comprised group 2. This opium smoking group was subjected to the stigmatization of race, class and blemishes of character as described by Goffman. Addiction was another manifestation or symptom of the traits of an "inferior stigmatized group." The addictive behavior of group 2 threatened social values and, if allowed to persist, the social fabric of the greater society. They were not considered "sick" within the theoretical framework promulgated to explain addictive behavior in group 1 although their physiological symptoms were the same as those in group 1. Local ordinances and restrictive legislation were employed to control what was essentially perceived as degenerate hedonism.

In the 19th century, bacteria were discovered and the germ concept of disease evolved. Where possible, alternate therapies to prescribing narcotics were developed to treat disease and offer patients relief from painful symptoms. Nineteenth century physicians also reported about the dangers of morphine and opium addiction, including descriptions and reports about withdrawal, craving and relapse. Leading physicians in the 19th century began to caution practitioners about the danger of the indiscriminant widespread prescribing of opiates. Iatrogenic addiction, therefore, began to subside by the end of the century.

In summation, a medical condition based on theory (inebriation, neurasthenia, chronic painful condition) is the basis of continued narcotic maintenance (oral ingestion or injection by hypodermic needle) in group 1. However, a weak will and immoral behavior is assumed to be the basis of continued addiction (smoking

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opium) in group 2. Persons in group 1 are considered legitimate medical patients but not those in group 2.

The theories and attitudes of the 19th century were further developed and modified in the 20th century. These developments would reflect major transformations in the addicted population and the availability of addicted substances. Two technological advances in the late 19th century would transform addiction in the 20th century –the invention of the hypodermic needle in the 1850s and the synthesis of heroin from morphine in 1898.

The Era 1900 to 1923

This era is marked by a major transformation of the addicted population and the introduction of heroin as a street drug of abuse in addition to morphine and cocaine; the emergence of the United States as a world power in Asia confronting the opium problems in the Philippines and China; the prohibition of alcohol; an era of repression of civil liberties after World War I associated with a fear of a Bolshevik revolution as in Russia; further developments in theories of addiction first proposed in the 19th century; major federal legislation (the Harrison Act) and related Supreme Court cases; monitoring by the government that virtually prohibited the treatment of addiction in the practice of medicine; the opening and closing of a system of maintenance clinics to service addicted persons. Major population transformations occurred in American society (e.g., increase in poor urban and immigrant groups). Class conflicts within American society coupled with the worldwide social and political events of this era had a profound impact on the perception of addictive behavior, theoretical formulations about the causality of addiction, the type of treatment that was made available, legislation and the stigmatization of not only addicts but of the condition of addiction itself.

First Transformation of Addicted Population

With advances in medicine, physicians at the turn of the century were more cautious in the prescribing of narcotics than in the 19th century. Therefore, the incidence and prevalence of iatrogenic addicts in the South decreased. This decrease was further accelerated by the deaths of elderly opiate dependent females and wounded Civil War veterans. Both groups were regarded as legitimate patients and were not subjected to

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stigmatization because of their addictions. However, with the rise of industrialization and the waves of European immigration to northern cities starting in the last decade of the 19th century, the addicted population was gradually transformed. The immigrants themselves were not addicted nor did they succumb to addiction but their young male offspring in the slums and tenements began to smoke opium, snort heroin and cocaine and inject morphine.[7] Also included were the poor youth of native born persons who immigrated to cities for employment in the newly emerging industries.

However, by the end of the first decade of the 20th century, a distorted perception of the prevalence of opiate addiction in the United States was presented to the U.S. Senate by Dr. Hamilton Wright, a reformer with considerable political influence. Wright was the American delegate to the Shanghai Commission (1909) and the Hague Opium Conference (1911). His distorted statistics, presented to the Senate in 1910, exaggerated the prevalence of opiate addiction among the lower economic classes: general criminal population (45.48% addicted), Chinese (25% addicted), prostitutes and companions (21.6% addicted), prisoners (6% addicted), physicians and nurses (3.38% addicted), other professionals (0.684% addicted) and the general population (0.18% addicted).

This distorted picture of opiate addiction among the poor, the Chinese, the criminal classes and the male offspring of recently arrived Eastern and Southern European immigrant groups, especially in the slums of northern cities, was perceived as a major threat to the social order. The southern female iatrogenic addict, now perceived as the "minority addict," was regarded with compassion and the prescribing of narcotic drugs was continued as in the 19th century. In contrast, the counterparts of opium smokers in the 19th century, notably the poor males in northern cities who injected morphine and inhaled newly synthesized heroin, were considered a social menace and became the objects of control through legislation.

The proportion of nonmedical street addicts continued to grow during this period with the emergence

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7. Technically, cocaine is not a narcotic. However, it was included with narcotics as a drug to be controlled under the Harrison Act.

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of street dealers. Although dealers existed prior to the Harrison Act of 1914 in the slums of the cities, narcotics could also be obtained legally over the counter in pharmacies and through physicians' prescriptions. Restrictive legislation, therefore, helped extend and increase an underground illegal market.

The shaping of attitudes that denied legal narcotics to nonmedical addicts reflects the overall political and social thought of the post-World War I era. The fear of class conflict colored the perception of the government of those addicts from the lower socioeconomic classes. Unnerved by the success of the Bolshevik Revolution, the militancy of the labor movement and specifically the struggles of the International Workers of the World, the presence of a strong socialist movement led by Eugene V. Debs, an anarchist movement led by Emma Goldman and the antianarchist passions elicited by the Sacco-Vanzetti case, immigrants became suspect as a potentially revolutionary group.[8] Opiate use (e.g., opium smoking, morphine, heroin and cocaine) among the offspring of European immigrants, the poor in the cities and the Chinese, was seen as an individual degeneracy that could not be tolerated in a society enmeshed in fears of a possible successful revolution.

Also, if alcohol were prohibited by constitutional amendment, then maintenance drugs for addicts could not be tolerated. Furthermore, the failure of the scientific community to prove that addiction had a physiological basis gave impetus to the acceptance of psychological theories of addiction. Continued addiction, implying the presence of psychopathology, was perceived as a problem of moral degeneracy that would wreck personal and social values. It could not be supported by the medical profession or the government.

Legislation 1900 to 1926

The addictive qualities of narcotics were recognized by the end of the 19th century. Unlabeled patent medicines were a major source of narcotics and many individuals became addicted to opiates unknowingly. These patent medications were sold over the counter in groceries, general food stores as well as in pharma-

8. The Sacco-Vanzetti involved two Italian immigrants who were anarchists. They were falsely accused of murder, convicted and executed.

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cies. The first important national legislation that controlled the distribution of narcotics was passed in 1906 as the Pure Food and Drug Act. The administration of this act was placed in the Bureau of Chemistry of the Department of Agriculture. The act required that the contents of patent medicine sold over the counter and shipped in interstate commerce be labelled for the narcotic and marijuana content. Although a sharp decrease in sales of medications containing habit forming drugs was reported following the passage of this act, sales continued in general stores and groceries. Therefore, pharmacists successfully lobbied to amend the 1906 act in 1908 by prohibiting the sale in interstate commerce of patent medicines containing narcotics without a medical prescription. The distribution of patent medicines containing narcotics and marijuana was thereby placed under the control of the medical profession and pharmacies.

Perhaps the most important change in the United States position on foreign policy concerning opiates followed the Spanish American War in 1898. The acquiring of the Philippines as a result of this war at the turn of the century transformed the United States into a world power rivaling the European colonial nations. The United States looked to Asia for the expansion of markets and influence on a par with Britain, France, Germany, Japan and the Netherlands.

However, the opium traffic in both the Philippines and China diminished these possibilities. Britain, in particular, controlled the opium traffic in China which was a major impediment to the opening of new markets for the United States. To bring the opium problem in Asia under control, the United States not only participated in but sponsored several conventions to reduce or eliminate the trade of opiates for nonmedical uses. The Shanghai Convention of 1909 and the Hague Convention of 1911 brought together nations to create agreements to end the opium traffic in Asia or at best lessen British control over this traffic.

To honor its international obligations, the Congress of the United States passed in 1909 legislation that banned the importation of opium for smoking. As indicated above, opium smoking was associated with poor indentured Chinese laborers and the white marginal underclass – two highly stigmatized groups. Local ordinances prohibiting the establishment of "opium dens" and possession of pipes already existed. The federal legislation supported local ordinances. However, the net result was not the elimination of opium smoking, but an increase in price and exclusivity. Eventually an interesting opium smoking culture evolved in the United States that included persons from the arts, music, the theater, politics, the newly emerging

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movie industry and white marginal groups including con men, gamblers, prostitutes and gangsters.

The Harrison Narcotic Act of 1914 was passed by Congress to fulfill obligations of the United States to uphold the international agreements of the 1912 Hague Convention to curtail the opium trade in southeast Asia and China. Although mercantile and trade interests of the United States were at stake, the class transformation of American addicts to the white criminal underclass and the Chinese immigrant workers in the first decades of the century was used as an additional powerful rationalization for the enactment of the statute.

This act was not originally intended as a prohibition law but instead as a measure to regulate the manufacture, distribution and prescribing of opiates, coca and their derivatives. Those involved in these activities (i.e. manufacturers, pharmacists, physicians) had to be licensed, keep records for inspection, and pay a modest fee to the Internal Revenue Bureau of the Treasury Department. However, the Harrison Act did not deal directly with the question of physicians prescribing narcotics to maintain addicts. The bill and an amendment in 1919 allowed physicians to prescribe narcotics for "legitimate medical purposes" in the course "of their professional practice only." The 1919 amendment made possession of narcotics without a properly stamped package or proof of a medical prescription also a violation of the Harrison Act. This amendment, although continuing the prescription of narcotics for legitimate legal purposes, extended the act to include the addicts themselves who were excluded under the jurisdiction of the Harrison Act. Under the Harrison Act addicts could possess narcotics without proof that the narcotic was originally registered, packaged or prescribed. Therefore, a loophole was closed.

The Harrison Act, however, did not define the two phrases –"legitimate medical purposes" and "in the course of medical practice." Since the Narcotic Division of the Prohibition Unit of the Bureau of Internal Revenue within the Treasury Department took the position that addiction was not a disease and addicts were not legitimate patients, it followed from their interpretation that physicians who prescribed drugs for maintenance were not legitimately prescribing to patients in the course of their professional practices. Hence, the Treasury Department adopted an anti-maintenance attitude which eventually resulted in the harassment and imprisonment of doctors who continued to treat addiction by prescribing opiates.

The drug policies of the United States during the major part of the twentieth century were essentially created by administrators within the Treasury Department in the second decade of this century.

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Lindesmith (1966)[9] observes the following:

> "It is a program (policy) which to all intents and purposes, was established by the decisions of administrative officials of the Treasury Department of the United States. After the crucial decisions had been made, public and medical support was sought and in large measure obtained for what was already an accomplished fact. Another unusual feature of the federal narcotic laws is that, while they are in legal theory revenue measures, they contain penalty provisions that are among the harshest and most inflexible in our legal code."

The anti-maintenance position of the Treasury Department was upheld in two cases heard before the U.S. Supreme Court in March of 1919 (Webb et al v. United States and United States v. Doremus) (King, 1972).[10] The Court was of the opinion that the physicians were over prescribing narcotics. Dr. Doremus, in particular, was accused of prescribing narcotics for one Alexander Ameris alias Myers, described by the Supreme Court as a "dope fiend." The ethnic surname of the addicted Ameris alias Myers, his use of heroin and the use of appellation "dope fiend" reveal the biases of the time. However, in two subsequent cases, the Court distinguished between physicians prescribing 'in good faith" in the course of medical practice to alleviate the discomfort and suffering caused by addiction (Lindner v. United States, 1925), and those who prescribed to "enable addicts to indulge their acquired longing for the drug and its effects" (Boyd v. United

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9. Material in this chapter concerning government policy and the law is based on the book, The Addict and the Law by Alfred R. Lindesmith.
10. Material on Supreme Court cases and legal issues in this chapter were based on the book, The Drug Hang Up: America's Fifty Year Folly by Rufus King.

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States, 1926). The Court reversed the conviction of Lindner indicating that the Harrison Act did not describe methods for treating addicts. However, in contrast to Lindner, the Court upheld the conviction of Boyd who prescribed abnormally large prescriptions with little concern about how the drugs were to be used. Taken together, the two cases repudiated the previous arguments in the Webb case and allowed physicians to treat addicts "in good faith" and "in the course of medical practice." This represents a subtle and precocious recognition of significant features of opiate maintenance with methadone, namely, the prescribed use of an opioid to relieve the discomfort and suffering of addiction. Notwithstanding the favorable decision in the Lindner case and the distinction between prescribing "in good faith" and prescribing without concern for the patient, the Prohibition Unit of Treasury Department continued its anti-maintenance policy as set forth in the Webb and Doremus decisions.

The immediate effect of the Harrison Act and the "physician's cases" was the creation of a criminal underclass of narcotic addicts who were separated from legal and medical sources of narcotics and forced into the street black market to purchase needed drugs. However, physicians were also harassed. With the Bureau of Narcotics adhering to its anti-maintenance stance, the harassment of physicians who prescribed narcotics to the opiate dependent eventually resulted in the arrests of about 38,000 physicians by 1938 and the imprisonment of about 5,000 (De Long, 1972).

The Prohibition of Heroin.

Heroin was synthesized from morphine in 1898. Initially the drug was hailed as a "cure" for morphism and was an ingredient in patent cough medicines as a suppressant. Within a decade, however, its addicting qualities were recognized. Nonmedical addicts began to snort heroin, and with injectable morphine it became a street drug. Depending on availability, the two drugs were used by street addicts.

By the 1920s, heroin supplanted morphine as a street drug. Although initially snorted, injection of heroin, which may have started in the 1920s, eventually became the preferred route of administration by the 1930s. The concern about its addictive potential, its favored use by nonmedical addicts and the rising number of addicts in jails who preferred heroin to other addicting drugs including cocaine, prompted the passage of legislation in 1924 by Congress that prohibited the importation of opium for the purpose of

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manufacturing heroin.[11] This legislation, however, was not emulated by other countries. Since heroin was not available legally in the United States, smuggled heroin became the alternative source of the drug for street addicts. With subsequent decreases in street purity, the addict was forced to inject the drug to experience its potent effects. Eventually injectable street heroin became the major drug of abuse for opiate addicts supplanting opium and morphine. Street crime related to the use of injectable heroin became a major concern beginning in the 1920s after the prohibition of heroin and the subsequent dependence on the organized crime as the sole source of heroin. Control of the international traffic in injectable heroin was a dominant organizing factor of international crime and the inter-criminal warfare for control of the distribution of heroin in the 1920s and 1930s.

Theories of Addiction 1900 to 1923

The physiological theory of addiction was supported by a number of American physicians who treated addicts in the late 19th and early 20th centuries (e.g., Drs. Jansen Mattison, Charles Terry, Austin J. Pressey and Ernest Bishop). Similar in viewpoint to these physicians was Dr. Willis Butler, who operated a maintenance clinic in Shreveport, Louisiana. Since many of the addicts he treated were afflicted with other serious conditions (e.g., syphilis and tuberculous), Butler believed that addiction was related to physical illness and pain.

The view of addiction espoused by these physicians stemmed from observing the many types of patients from different social circumstances (e.g., white middle and upper class women, wounded Civil War veterans, physicians, etc.) who became addicted by taking opiates prescribed by doctors for varying acute and chronic medical conditions. Narcotic maintenance was steadfastly advocated by these physicians since there appeared to be no cure for chronic addiction. They rejected personality theories of addiction that in effect stigmatized addicts with unsavory character traits.

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11. Heroin was used in medical practice prior to 1924. The legislation banning the importation of opium for the purpose of manufacturing heroin resulted in heroin being banned for use in medical practice to alleviate pain.

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To replace theories of inebriety, neurasthenia and degeneration, advocates (e.g., Bishop) of the physiological theory of addiction misapplied contemporary theories of disease based on bacterial infection and the immune response of the body to produce antibodies to fight infection. These theories successfully transformed medical science and practice in the late nineteenth and early twentieth centuries. Simply stated, an analogous condition to bacterial infection was hypothesized when a narcotic, considered a toxin, was administered. In response, the immune system produced antitoxins analogous to the antibodies produced by pathogens and the immune response produced by vaccination. Addiction was considered to be an accumulation of antitoxins produced by the body as a reaction to opiates. Tolerance and physical dependence were readily explainable within the context of this theory: a sufficient amount of antitoxins would theoretically produce sufficient tolerance to protect addicts from overdose. Antitoxins, according to this theory, became toxins if continued intake of opiates were stopped. Thus, the conversion of internal antitoxins to toxins resulted in a decrease of tolerance and physical dependence and the emergence of the opiate withdrawal syndrome.

Opiate addiction was thus incorrectly explained within the context of contemporary medical theory, research and practice. However, the antitoxins to narcotics were never found.[12] The technology and knowledge were not available during the first half of the twentieth century to test hypotheses confirming or negating the premise that opiate addiction was a physical disease or had a physical basis. The failure of science to prove that addiction was a physical disease was in a sense the death knell of the physiological theory of addiction in the 1920s.[13]

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12. Unsuccessful experiments injecting mice with sera from human addicts and then injecting the mice with large amounts of opiates produced overdose deaths at equal rates and at the same dosage levels in subject and control groups.
13. In the early 1920s a visiting physician at the Riverside Hospital, Dr. Arthur Braunlich, anticipated ideas of neuroscientific discoveries of the post World War II era. He hypothesized that morphine affected

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The second major theory to challenge the theory of inebriation was promulgated by Dr. Lawrence Kolb of the United States Public Health Service and was based on psychological theory of mental illness to explain addictive behavior. The psychological explanations of addiction filled the vacuum created by the demise of the physiological theory of addiction.

The psychological theories of addiction were profoundly influenced by the transformation of American addicts that began in the last decade of the 19th century and proceeded into the first decades of the twentieth. The iatrogenically addicted population of southern elderly women and Civil War veterans was decreasing and being replaced by poor white young males and criminal elements from the poor ghettos of the northern cities and Chinese workers. Within two decades they became the majority of opiate addicted persons in the United States.

The theoretical stance of physicians evolved from their experiences treating patients in their medical practices and noting the social class of addicts coming to the attention of public health authorities. Dr. Kolb and other physicians[14] were influenced by the social behavior of nonmedical addicts in the 1910s and 1920s. Therefore, a circular reasoning became manifest in the development of theories of addiction. These theories, primarily psychological, reflected observed behavior of the low socioeconomic class and immigrant

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the brain cells. A "memory of narcotics" was permanently embedded in cells after compulsive use by the addict. He indicated that based on this thesis, anybody could become addicted to narcotics and that narcotic addiction was not curable unless opiates were removed from the environment.

14. Physicians in various cities in the United States were coming into contact with nonmedical addicts, such as Harry Drysdale in Cleveland, Sylvester Leahy in Brooklyn and John H.W. Rhein of Philadelphia. These physicians described nonmedical addicts as psychopathic and inferred that the psychopathology existed prior to the addiction. These ideas were systematically crystallized by Kolb into a psychological theory of addiction based on the interpretations of behavior of the new class of nonmedical addicts.

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group origins nonmedical street addicts. They differed in psychological and social class from the iatrogenically addicted females and males who received opiates from physicians, particularly those in the southern areas of the country and who entered and reentered sanatoria for "cures."

Addiction, according to Kolb, was primarily a manifestation of psychopathology. The character disorders or psychopathic manifestations of behavior were symptomatic of an underlying mental disease. Kolb advocated treatment over a punitive approach and became an effective spokesman having wide influence in the medical profession for his theoretical and clinical positions.[15]

Kolb categorized addicts into five basic subgroups: 1) iatrogenic addicts or psychologically normal persons who received opiates to relieve pain, a small and constantly diminishing group; 2) pleasure seeking individuals or those afflicted with "psychopathic diathesis;" 3) persons with neuroses; 4) psychopathic criminals; and 5) inebriates, usually persons with an alcohol problem who became narcotic addicts. The majority of nonmedical addicts came from the second and fourth categories. Throughout his career Kolb advocated that all addicts receive treatment rather than punishment and incarceration. The psychological theories of addiction promulgated by Kolb in the 1920s and 1930s greatly influenced medical thinking and were adopted, including his classification, at the United States Public Health Hospital in Lexington Kentucky. He was a voice of sanity, compassion and enlightenment in contrast to the demand that addicts be punished and or in extreme cases, executed.

In summation, two basic theories emerged. The physical theory that persons became addicted because of exposure to morphine espoused by the likes of Charles Terry and Ernest Bishop. This group advocated maintenance for the iatrogenic addicts. However, in their thinking a socioeconomic and cultural class line of distinction was clearly drawn between iatrogenic cases predominately southern female addicts and the

15. Persons who retain their reason but are unable to behave within moral or social standards. Serious crimes are committed by these individuals who appear to be normal except for their deviant and dangerous behavior.

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newly emerging street nonmedical addicts in the northern cities. Nonmedical addicts, it was argued by Terry and others who advocated maintenance, should be treated in circumstances that take into account their deviant behavior and they should be placed under proper legal constraints. They were not to be confused with those who became iatrogenically addicted and were essentially complying medical patients.

The psychological theories promulgated by Kolb and eventually adopted by the medical profession emphasized mental illness and psychopathology. There was little room in this theory for a "normal" addict who needs maintenance because of exposure to morphine. There was no connection in the psychological theories between the common physical elements of addiction that cross class lines –dependence, tolerance, craving and relapse after withdrawal. The recognition of differences in class and personality would have vitiated or lessened the underlying concept of mental illness which was basic to Kolb's conceptualization.

The theory that addiction was a physical illness was discredited in the 1920s by the failure to prove or demonstrate empirically through laboratory studies the basis of a physical addiction, thus making the cleavage between the two schools complete. The psychological theories therefore were adopted to explain addictive behavior among the addicts especially the nonmedical addicts who were the majority of users by the 1920s. Incorporated in the psychological theories were class fears especially of the under class who became addicted and as Helmer has indicated, reflected ongoing class conflicts especially in times of economic crisis.

Treatment for Opiate Addiction 1900 to 1923

Within the first two decades of the twentieth century, three basic approaches were developed to treat opiate addiction:

1. Physicians' prescriptions and over the counter remedies.
2. Sanatoria treatments.
3. Clinics for maintenance and detoxification.

However, philosophically, the treatment of addiction was profoundly influenced by the failure to prove that addiction was a disease. The ethical role of physicians in prescribing medications, in this case

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narcotics, became questionable especially when the legitimacy of the illness itself is undefined. The problem was compounded by the transformation of the addicted population from iatrogenic addicts to street or nonmedical addicts. The understanding of addiction was transformed to one involving of serious social deviance. Therefore, morality and ethics entered into medical decisions in the first part of the twentieth century that continue to the present day regarding the prescription of narcotics. The attitude of the American Medical Association Committee of Narcotic Drugs was expressed in a pamphlet issued in 1921.[16] In the pamphlet, the condition of addiction in relation to treatment within the medical profession is stated as follows:

> "The shallow pretense that drug addiction is a disease which the specialist must be allowed to treat, which pretended treatment consists in supplying its victims with the drug which has caused their physical and moral debauchery ... has been asserted and urged in volumes of literature by the self-styled specialists."

A truly effective medication for addiction did not exist in the 1920s. Long acting narcotics such as methadone were not even conceptualized. Therefore, inefficient medications such as morphine and opium that were available to physicians had to suffice but were rejected. In the book, Addicts Who Survived,[17] Dole remarked about the lack of viable effective treatment for narcotics addiction prior to World War II. Nevertheless, similar objections targeted to the treatment of addicts in the early decades of this century were used against the methadone program a half century later.

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16. Dr. Alfred C. Prentice who was a member of the Committee of Narcotic Drugs was the probable author of excerpt from the pamphlet.
17. Material in this chapter concerning government policy and the law is based on the book, Addicts Who Survived: An Oral History of Narcotic Use in America 1923-1965 by David Courtwright, Herman Joseph and Don Des Jarlais.

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1. Physicians' Prescriptions and Over the Counter Remedies

Prior to the passage of the Harrison Act in 1914, opiate dependent persons were able to obtain opiates through prescriptions and over the counter drug preparations containing opiates. Physicians prescribed narcotics for pain, medical conditions and for opiate dependent patients, narcotic maintenance. Addiction was in many cases iatrogenic and maintenance was considered a legitimate treatment. Physicians such as Terry and Bishop considered addiction a physical condition with parallel inferences to the germ theory of disease. Nevertheless, there were a few physicians who prescribed for profit without concern for the patient or the spread of addiction. With the enactment of the Harrison Act in 1914, narcotic maintenance by private physicians and over the counter narcotics was eventually prohibited through harassment and prosecution by the Bureau of Narcotics.

2. The Creation of Sanatoria

For the middle and upper class addicts, sanatoria offering bogus cures were opened. The most famous was the Towns Hospital located in New York City offering a bogus treatment developed by a Mr. Charles Towns.[18] The charlatan soon became known as Dr. Charles Towns although he never earned a medical degree and was regarded for two decades as probably the most "knowledgeable professional" in the United States concerning the treatment of drug addiction. He offered a "cure" which he claimed could rid Asia of the scourge of opiate addiction as well as cure the upper class patrons of his hospital. Mr. Towns falsified outcome statistics. However, after a decade the medical profession realized the false nature of his claims and eventually Towns Hospital was closed. There were a number of sanatoria that were opened to treat iatrogenic addicts with ineffective treatment regimens. However, with false cures being revealed, the majority of the sanatoria were closed by the third decade of the twentieth century.

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18. Towns through force of personality, was able to convince well respected government officials and medical authorities including the august, respected and socially conscious Dr. Alexander Lambert of Cornell University Medical School about the validity of his fraudulent ideas and treatment.

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3. Clinics for Maintenance and Detoxification

Dr. Charles Terry conceived of, and opened in 1912, the first opiate maintenance clinic in the United States in Jacksonville, Florida. In Terry's view, addiction was not a curable condition and addicts had to be maintained. It is to be noted however that Terry's patients were primarily iatrogenically addicted females. The opening of the Jacksonville clinic was an augur of the opiate or narcotic clinics established after the passage of the Harrison Act in 1914 and the methadone clinics opened in the 1960s. Terry did not treat the newly emerging nonmedical street addicts from immigrant groups in the northern cities. As previously indicated he made a distinction between the iatrogenically addicted as legitimate patients and the criminally inclined nonmedical street addicts of the northern cities. He advocated that iatrogenic addicts were legitimate patients and that nonmedical addicts should be brought under legal authority for criminal acts committed in the course of addiction.

However, after the passage of the Harrison Act, about 44 maintenance clinics were opened in 14 cities throughout the country. Heroin, morphine and cocaine were dispensed in these clinics. Perhaps the most famous were the New York City clinic in lower Manhattan and the clinic operated in Shreveport, Louisiana by Dr. Charles Butler. The New York clinic was essentially an opiate withdrawal clinic giving addicts a choice of heroin or morphine. Patients were prescribed a decreasing dose until they were completely withdrawn. However, drug dealers loitered about the clinics selling supplementary drugs to patients. The New York clinic serviced a socially and economically mixed group of patients from the poor, immigrant and working classes. Most of the patients were white males and were nonmedical addicts.

The Shreveport clinic treated addicts with morphine and offered maintenance to the local addicted citizenry as well as withdrawal services to transients. The Shreveport clinic drew its patients from all classes of society including the mother of the local sheriff who was also a wealthy businessman. Dr. Butler kept scrupulous records and was successfully audited several times by the Bureau of Narcotics. The Shreveport clinic was eventually closed after the Bureau of Narcotics used entrapment, questionable witnesses and false information to discredit Dr. Butler.

Armed with a moral mission to save the country from perceived degeneracy of opiate addiction, the Bureau of Narcotics successfully closed all maintenance clinics by 1923. The clinics were of varying quality.

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Some were genuine public health programs, others were operated for profit and still others were poorly administered political sinecures. However, some clinics like the Shreveport clinic were well administered, with detailed record keeping. Irrespective of the quality or purpose of clinic (e.g., withdrawal, maintenance or both), the Bureau managed to find excuses to close the clinics either through legitimate criticisms or as in the case of the well run Shreveport clinic, using deception.

Addiction was regarded as behavior capable of unraveling stability and social values. Furthermore, prohibition of alcohol was in force through the passage of the eighteenth amendment in 1918, and it was inconsistent for the government to support maintenance of narcotic addicts in clinics. Another important factor that strengthened the Bureau's opposition to maintenance was the inability of physicians to prove that addiction was a physical disease. The failure of physicians to validate the toxin-antitoxin theory of addiction gave credence to the belief that addiction was a condition reflecting mental illness and psychopathic behavior. Addicts, therefore, were transformed into an unwanted stigmatized group perceived as a potential danger to the values of country especially within cities where industry was expanding.

One of the major criticisms of the clinics was that addicts were not being cured. It should be noted that no programs or institutions servicing addicts during this period were effectively treating addicts. Long acting narcotics were not yet conceptualized and efficient medications for maintenance and withdrawal did not exist. However, within the limited medical pharmacopeia that was available, the only bonafide medical treatments in the second and third decades were inefficient withdrawal and maintenance procedures using short acting narcotics. In 1920 the American Medical Association adopted a resolution that opposed the operation of ambulatory maintenance clinics. This resolution gave the Treasury Department's Bureau of Narcotics the medical rationale to close all existing clinics.

After 1923, nonmedical addicts were essentially barred from receiving any medical treatment from physicians. Physicians, however, were permitted to prescribe narcotics to frail elderly iatrogenic, mostly female, addicts. Because of the prevailing philosophies and political climate of the country, the Bureau began to harass and prosecute physicians who prescribed narcotics to nonmedical addicts. The result was an almost immediate increase in drug-related street crime and the establishment of criminal networks for the distribution of drugs.

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The 1924 to 1963 Era

This era is characterized by a punitive enforcement attitude towards the use of drugs, dramatic changes in the drug using population, increased legislation to control drug use, the emergence of competing major criminal organizations to control drug distribution, the establishment of an independent Bureau of Narcotics under the direction of Harry J. Anslinger who pursued a vigorous anti-maintenance policy and finally, advances and modifications in theories of addiction with the establishment of programs that reflected these theories. Throughout this era the stigmatization of drug addicts was consciously fostered by the Bureau of Narcotics to preserve power under the guise of preserving social values.

Narcotic Drugs of Abuse From 1924 to 1963

During this period there were major transformations of narcotic drugs that were used by street addicts. By the 1920s, organized criminal groups controlled the distribution of drugs listed as narcotics in the Harrison Act of 1914. The drugs covered in this legislation included opiates, cocaine and their derivatives, although cocaine is not technically a narcotic. Heroin, initially snorted because of its purity, was by the late 1920s injected intravenously.

In New York City, the price and purity of street narcotics was determined by competitive tactics between Jewish mobsters and Italian multitiered crime families in the 1920s. In the 1920s the drug traffic was dominated by Jewish crime groups. The price of narcotics was low, and the purity was high. However, in the 1920s and 1930s, multitiered Italian crime organizations wrested control of the drug distribution from the Jewish groups. This change of distribution coincided with a rising international price of opium, making this bulky narcotic unprofitable to import. The two factors – an increase in international prices of opium and control of distribution by a multitiered criminal organization – resulted in higher street prices and the dilution of the heroin at each level of the distribution network. While snorting heroin was previously sufficient to obtain euphoric effects, by the 1930s, heroin was sufficiently diluted and expensive that heavily addicted users eventually resorted to intravenous injection. Because of its more potent euphoric qualities, heroin eventually superseded morphine as a street drug of abuse, especially in New York City. The ascendancy of heroin is reflected in the admission statistics of the U.S. Public Health Hospitals

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in Fort Worth and Lexington in the 1930s, when morphine intramuscular injection predominated, to the 1960s when heroin intravenous injection predominated. The rapid shift in drug use and route of administration occurred in the late 1930s, reflecting the change in criminal distribution networks and international market prices.

Transformation of the Addict Population 1924-1963

Two transformations of the addicted population occurred during this particular period. The first major transformation in the addicted population reflects the changes in the general population and social transformations in the country. The second concerned the fate of a small group of opium smokers.

1. Major Transformation

By 1923, the iatrogenic addicts, namely white southern middle and upper class women and wounded Civil War veterans addicted in the 19th century were either dead or dying. With advances in medicine, physicians were more cautious in their prescribing of narcotics. The iatrogenic opiate addicts of the late 19th century were not replaced in great numbers during the 20th century. As the prevalence and incidence of iatrogenic addiction decreased, the incidence and prevalence of nonmedical addicts from poor white ethnic and immigrant groups in the inner cities increased. By 1923 they constituted the majority of addicts in the United States and remained so until the end of World War II. Although blacks had established themselves in New York City from the colonial period, addiction to heroin was a marginal but known problem in Harlem by the 1930s.[19]

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19. In the Gershwin opera Porgy and Bess, Sporting Life is the black counterpart of the white 19th and 20th century "sporting men" who were gamblers, speculators, pimps and sellers of narcotics. Bess is addicted to the narcotics given to her by Sporting Life, and at the end of the opera leaves the rural Catfish Row with him for New York City.

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After World War II, the addict population was again transformed by two major population shifts. Encouraged by favorable tax advantages, the building of roads, the increased manufacture of automobiles and the creation of suburbia by developers, the middle class, including the successful offspring of previous white immigrant groups and middle class blacks, moved from the inner cities which were foci of crime and drug abuse. They were replaced by poor Latinos, immigrating primarily from Puerto Rico, and blacks immigrating from southern rural communities. By the 1960s poor black and Latino ghettos in the inner cities were epicenters of heroin addiction which was reflected in public health and crime statistics. In the late 1950s and 1960s, chronic narcotism associated with the injection of heroin, became the major cause of death in New York City for young adults between the ages of 15 and 35. Hepatitis caused by injection of heroin with contaminated needles became a serious public health concern and addict-related crime among non-white minorities and poor white ethnics became a major political issue.

2. Transformation Involving Opium Smokers

Opium, in the early decades of the 20th century, was usually smoked in groups rather than by isolated persons. The complicated preparation and smoking techniques were originally taught to the white marginal and criminal classes by Chinese smokers in the late 19th century. By the early 20th century, opium smoking groups were usually segregated and composed of smokers from a particular class, ethnic group or field of employment.

Opium smokers were an elite minority of the opiate addicts during this particular era. They did not consider themselves addicts and expressed disdain for those who injected heroin. Many were in entertainment, politics or music and were careful with whom they smoked. When opium was no longer available in cheap supplies after World War II, they had to resort to the use of injectable heroin. In general, they retained their fastidious habits by using clean needles in contrast to the street addicts who may have shared needles. Nevertheless, their lives began to unravel with the use of heroin, and some were forced into street activities including theft and prostitution to obtain money to support their addictions.

Transformations within the addicted population were also noted in jails and the Public Health Hospital in Lexington Kentucky. Prior to World War II the addicts in the Public Health Hospital in Lexington were

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primarily white. However, after World War II, the majority (56%) were black, Mexican American, and Puerto Rican (Ball and Chambers, 1973).[20] Within one century, groups at risk for addiction had moved across different major socioeconomic groupings, each with a unique method of obtaining and administering opiates but with the same condition –the majority who used narcotics daily irrespective of social origin and type of narcotic drug were chronic relapsing addicts. The circumstances under which the different groups at risk become addicts, namely their exposure to narcotics, varied but once addicted, the biological condition of addiction was the same.

Anti-Narcotic Legislation From 1924 to 1963

With the passage of the Harrison Act and the subsequent "physician cases" heard before the Supreme Court, Congress passed about 55 federal laws concerning the illegality of interstate possession and the transporting of narcotics. The Boggs Act was passed in 1951 and the Narcotic Control Act in 1956. These acts increased mandatory sentencing for possession and sale of narcotics. By the late 1960s hundreds of state and local laws ("little Boggs Acts") were passed nationwide concerning possession of controlled substances (e.g., heroin, cocaine, marijuana). These laws were passed as the nonmedical street addict became the overwhelming majority within the addicted population. The small proportion of iatrogenic, mostly female, addicts were allowed to be maintained by physicians. With the creation of the Bureau of Narcotics as an independent agency under Anslinger in the 1930s, physicians were harassed and indicted if they prescribed narcotics for "maintenance of addiction."

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20. Material on the epidemiology of drug addiction in the United States the 19th century is based on material in the book, The Epidemiology of Opiate Addiction in the United States, edited by John C. Ball and Carl D. Chambers.

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Theories of Addiction From 1924 to 1950

The psychological and sociological codification of "immoral behavior and vices" imputed to addicts in the 19th and early 20th centuries was completed during this era. The moral failures, moral insanity and character weaknesses ascribed to addicts were transformed into terms such as the addictive personality, the character disorder, the psychopathic personality. With addiction extending itself into poor immigrant groups, social instabilities and poverty related crime were translated into sociopathic behavior.

Dr. Kolb, the preeminent American physician, espoused an almost contradictory view of the addict. Convinced of an underlying mental illness, Kolb argued for abstinence, hospitalization and therapeutic (e.g., psychological and psychoanalytic) treatment. Although against punishment for addictive behavior, Kolb was unable to develop an effective form of treatment. He incorporated and applied concepts from psychology and the emerging field of psychoanalysis into a conception of addictive disorders. However, conceptualization without a successful treatment or resolution played into Anslinger's moral crusade. Anslinger substituted for underlying mental illness, the conception of moral degeneracy that would unravel the social fabric of the country if addicts were maintained. Abstinence as a goal of treatment served two philosophies -the need to "cure an underlying mental condition" (Kolb) and the need "to eliminate a potential social scourge" (Anslinger).

Treatment of Narcotics Addicts From 1923 to 1963

During this era, theories of addiction as well as political considerations played a prominent role in the development of different approaches to the treatment for addiction. Foremost were psychological and social theories tailored to meet political considerations.

In 1930, Harry Anslinger, a respected civil servant involved with prohibition activities, was appointed director of the newly independent Bureau of Narcotics. He was a staunch anticommunist and in line with his thinking concerning communist influence in the United States, he regarded drug maintenance as a menace to American society. His anti-maintenance philosophy reflected the attitudes of the United States Government. Abstinence was the goal of treatment during the Anslinger reign. Anslinger's influence on drug treatment extended from 1930 to 1964, the year methadone maintenance was introduced.

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Socio-psychological theories of addiction with a pathological base of mental illness fit into Anslinger's philosophical ideas. They were transformed into concerns about China destroying the United States as part of a world wide distribution of narcotics. However, his fear and hatred of communism was greater than his fear and hatred of maintenance. Senator Joseph McCarthy was a narcotic addict. Anslinger in the 1950s regarded McCarthy as an ally in Congress, respected his anticommunist investigations, supported the hearings and secretly supplied him with maintenance doses of morphine.

United States Public Health Hospitals

In 1929 Congress appropriated money for the U.S. Public Health Hospital in Lexington, Kentucky and Fort Worth, Texas. The hospitals were needed since addict-related crime had increased, and the jails were rapidly filling to capacity with addicts. Physicians were being harassed and prosecuted if they were found guilty of prescribing narcotics to maintain an addiction. The U.S. Public Health Hospital in Lexington opened in 1936, treating convicted addicts as well as those who entered voluntarily for treatment. The hospital had a capacity to treat about 1,000 addicts and a staff of 500. However, from the beginning, the hospital evinced serious and predictable shortcomings that reflected the contradiction inherent in the psychosocial theories: the lack of any effective provable treatment to cure or control addiction.

Lexington was essentially a prison hospital. Dr. Lawrence Kolb was philosophically opposed to the prison atmosphere, but his theories concerning underlying mental disturbance and psychopathic personality supported the punitive attitudes and approaches of Anslinger. Shortly thereafter, a second public health hospital to treat addicts was established in Fort Worth, Texas that catered to Latino addicts from the southwest.

Addicts entering these hospitals were medically withdrawn from opiates. Therapists were available for individual therapy. However, follow up studies from Lexington Hospital showed relapse rates of over 90%. The U.S. Public Health Hospitals were essentially expensive revolving doors. In the 1970s they were closed and turned over to the Federal Bureau of Prisons.

Riverside Hospital

Riverside Hospital on North Brothers Island in New York City was used to treat and withdraw addicts since

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the 1920s. However, after World War II, it was used to treat adolescent addicts. Patients remained in the hospital for six months receiving therapy and social services. The hospital was closed in the 1960s when a major follow-up study showed that practically all addicts treated there had relapsed upon discharge. The small percentage who did not relapse were not addicts but dealers who chose to enter the hospital as an alternative to jail (Alksne, 1980).

Therapeutic Communities

Therapeutic communities for the treatment of narcotics addiction began with the creation of Synanon in 1956 by Chuck Dederich, a former alcoholic. The therapeutic community was an amalgam of sociology, psychology and the 12 step program. In fact, it could be considered a modified institutionalization of Alcoholics Anonymous. Instead of the 12 steps therapeutic communities generally had built into them a hierarchical structure that was extremely authoritarian. Synanon became a model for development of other communities in the 1960s (e.g., Daytop, Odyssey House, Phoenix House and Project Return). However, Chuck Dederich soon realized that he was unable to cure addicts since many left only to relapse. The philosophy in Synanon was to encourage people to remain in the program for the duration of their lives. By the 1960s, it appeared that only a small proportion of those who entered therapeutic communities (perhaps less than 15%) appeared able to remain abstinent from narcotics after leaving the program.

Civil Commitment

With the increase of minority addicts and rising social and racial tensions, heroin addiction among poor nonwhite males was regarded as a major social problem. To reduce the addicted jail population, civil commitment programs were initiated in the 1960s in California and New York. Both proved to be prohibitively costly with minimal results. The programs were based on the Lexington model with therapeutic and vocational services in what addicts called "candy-coated jails." To improve on the results of Lexington Hospital, an aftercare was organized and committed addicts were placed under supervision of an aftercare or parole officer. However, this scheme has ambiguous results. The majority of the addicts placed on aftercare either relapsed, were rearrested or absconded, essentially duplicating the experience of the U.S. Public Health Hospital in Lexington and the Riverside Hospital in New York.

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The Use of Methadone as a Medication to Withdraw Addicts

Synthetic narcotics that were developed by the Germans as substitutes for morphine when supplies of Turkish opium were interrupted during World War II, were investigated at the Addiction Research Center of the United States Public Health Hospital in Lexington, Kentucky. Methadone, a long acting synthetic narcotic, was found to be similar in morphine in its effect but longer acting. Although having a half life of between 24 and 36 hours, its analgesic effect lasts for only about six hours. Its euphoric effect is duller and its withdrawal syndrome although milder than morphine's is more protracted. It was also found to be effective orally and if substituted at adequate doses to an addicted patient, could be used as an efficient medication for withdrawal with only one oral ingestion per day. By gradually reducing the oral daily dose of methadone, narcotic withdrawal became a relatively uneventful and painless process. It was, in summation, a better way of withdrawing narcotics from an opiate dependent patient than by the injection of short acting drugs every four hours. The withdrawal technique was soon adopted in hospitals throughout the country.

Other Treatments

Other treatments initiated during the post World War II period included the formation of Narcotics Anonymous, a 12 step self help group analogous to Alcoholics Anonymous. The Narcotic Anonymous groups, by their very nature, are not conducive to follow-up studies since confidentiality is a major concern. However, while relapses have been anecdotally reported, the groups appear to have helped some addicts.

Special programs were developed in the 1950s and early 1960s to treat addicted parolees and probationers. Using the conditions of probation and parole as a leverage, both divisions in New York City developed Narcotics Units that employed urine testing and in the case of probation, arrangements for therapeutic treatment through a social agency. The authority of the criminal justice system which mandated treatment and the insights of psychotherapy, social work skills and nursing were supposed to produce insights and behavior changes leading to abstinence. However, when the outcomes of the probation and parole programs were examined, their success was not easily documented. The overwhelming majority of probationers and parolees probably relapsed to the use of narcotics, notwithstanding threats concerning revocation of their probation or parole status and a return to jail.

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Call for Research and New Policies

With the failure of abstinence oriented programs advocated by the Federal government, the medical profession in the 1950s evinced a new interest in challenging federal policies. This change was prompted by the increase in nonmedical addiction within the inner cities, the increase in drug related crime, the diseases that were transmitted by contaminated needles (e.g., malaria and hepatitis) and the increase in heroin related deaths, which by the end of the 1950s was the leading cause of death among young adults between the ages of 15 and 35 in New York City.

In the 1940s, drug dealers began to mix heroin with quinine to prevent the transmission of malaria through contaminated needles. This measure effectively eliminated the transmission of malaria. However, the transmission of hepatitis remained a major public health problem. In the midst of this public health crisis, physicians were unable to prescribe narcotics to maintain confirmed addicts. The New York Academy of Medicine in 1955 issued a report critical of federal regulations that prohibited physicians from prescribing maintenance doses of narcotics to confirmed addicts. This report was followed by a position paper issued in 1959 by the Joint Committee of the American Bar Association and the American Medical Association advocating research for prescribing narcotics to confirmed addicts in a controlled clinical setting. In 1962, the Medical Society of New York County supported the establishment of research on narcotic maintenance and took the position that physicians engaged in systematic research on narcotic maintenance with proper controls were practicing ethical medicine. In 1963 the New York Academy of Medicine and President Kennedy's Advisory Task Force on Narcotic and Drug Abuse recommended that clinics affiliated with hospitals be established to treat addicts by prescribing narcotics.

However, within the medical profession itself there was ambivalence towards the treatment of addicts and the concept of narcotic maintenance. The narcotic clinics that were closed by 1923 were presented by the federal government as a failure although some, like the Shreveport Clinic in Louisiana, appeared to be responsibly managed and administered. Nevertheless, the American Medical Association officially took a position that maintenance or treatment of addiction with a narcotic posed an ethical problem. The following statement was issued jointly in 1963 concerning the concept of maintenance by the Council on Mental Health of the American Medical Association and the National Research Council on Narcotics and Medical

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Practice of the National Academy of Sciences:

> "Continued administration of narcotic drugs solely for the maintenance of dependence is not a bona fide attempt at cure nor is it ethical treatment except in ...unusual circumstances..."

This statement was used by the Bureau of Narcotics to bolster its position that narcotic maintenance is medically unethical and illegal.

Emergence of Modern Neuroscience Research

Two major breakthroughs occurred in neuroscience research in the 1950s and 1960s. The first at McGill University in the 1950s was the discovery by Olds and Milner (1954) of the brain reward system. This discovery changed the direction of neuroscience research in addiction. Psychological theories were challenged because of their circularity. For example, a drug addict uses drugs because of an "addictive personality." The discovery of the behavior reward system made possible the investigation of the neuropharmacologic properties of the drugs themselves and the common effects these drugs produce with humans and animals. Psychological reinforcement did not take into account the underlying complicated neurobiological mechanisms in the brain and the underlying biology of repetitive behavior of laboratory animals self administering certain classes of drugs and only those drugs (e.g., opiates, cocaine, stimulants). With the establishment of the United States Public Health Hospital in Lexington, Kentucky, a second major breakthrough occurred. Studies into the theoretical framework of addiction were implemented through the creation of the Addiction Research Center at the hospital. This important research center set the stage for major conceptualizations and neuroscience breakthroughs that were impossible during the earlier decades of this century. Talented scientists such as Himmelsbach, Martin and Jasinski investigated in the early 1960s the physical aspects of addiction: tolerance, dependence and abstinence in man and laboratory animals (Himmelsbach, 1968; Martin and Jasinski, 1962; Martin, Wilker, Eades et al, 1963). For the first time, detailed records and measurements of the physiological changes that occurred during the different phases of

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addiction, withdrawal and post addiction were investigated.

While tolerance and dependence were previously observed, the research team added to the scientific understanding and knowledge base by their detailed description of these phenomena. However, the withdrawal or abstinence syndrome, although described previously, was for the first time systematically investigated with metabolic measurements. In two seminal papers, one dealing with abstinence in laboratory animals and the other in man, Martin and Jasinski (1962; Martin, Wilker, Eades et al, 1963) established two important phases of withdrawal: 1) the primary abstinence syndrome, and 2) the protracted secondary abstinence syndrome of indefinite length. This was the first instance where an identifiable measurable physical phenomena, namely a derangement in physiological functioning, was causally associated with relapse.

Conclusion

The period from 1870 to 1963 witnessed profound transformations in the risk groups that were addicted to opiates. Within the course of ninety years, opiate dependency shifted from iatrogenically addicted middle and upper class women and Civil War veterans to risk groups within every sector of American society. Theoretical conceptualizations about addiction were continuously evolving and reflected the socio-economic class and racial composition of risk groups and the science of a particular era. These conceptualizations reflecting class and racial tensions within American society became more pronounced during periods of economic crisis.

Transformations were also apparent in the source and causality of addiction. For example, physicians were the source of opiates for iatrogenic female addicts and wounded Civil War veterans, while dealers were the source of opium for opium smokers from the marginal white underclass and Chinese laborers in the 19th century, elite opium smokers from the field of entertainment and finally street heroin users from various poor urban groups (white, African American and Latino) in the 20th century. The source of opiates and the conditions under which they were obtained –either through medical prescriptions or criminal networks– also entered into the social perceptions of behavior and theoretical conceptualizations.

The cleavage between psychosocial and physical theories of addiction was already evident in the 19th century. Prescient scientists in every era postulated a physical basis of addiction which could not be vali-

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dated because of limitations in scientific knowledge. Social biases about addictive behavior ensconced in religious moral values became transformed into concepts such as moral insanity and finally into psychology as psychopathic personality or character disorder to explain addictive behavior. The stigmatizing effects of psychological explanations of addictive behavior were challenged by physicians who backed physiological explanations for continued addictions among their patients especially those who were iatrogenically addicted.

The era was also marked by repressive legislative activity at all levels of government, stemming from the Harrison Act of 1914. The repressive measures and anti-maintenance attitudes emanating from the actions of the Bureau of Narcotics under the leadership of Anslinger resulted in serious social and public health problems. The interpretation of the Harrison Act and the Supreme Court decisions by the Bureau of Narcotics created a class of criminal addicts unable to obtain the medical help to treat their addictions. Diseases transmitted through the use of contaminated needles (e.g., malaria, hepatitis and endocarditis) were transformed into epidemics. Street crime related to addiction became a major political and social issue. Physicians were harassed and many were arrested prior to World War II for prescribing opiates to addicts.

Programs to treat heroin addicts reflected contradictory philosophies that were based in psychology (underlying mental problems) but also reflected political attitudes (criminal behavior that had to be controlled). These programs targeted abstinence as a goal of treatment. However, follow-up studies indicated that the majority of addicts relapsed after a course of treatment. By the 1960s there were calls from medical and legal groups to consider clinical research into maintenance for addicts. Most important, however, was the emergence of neuroscience in the 1950s and 1960s that began an inquiry into the physical basis of addiction.

What essentially started as a condition that evoked compassion in risk groups such as the iatrogenically addicted in the 19th century, became a highly stigmatized criminalized condition in the 20th century. The stigmatization directed to addicts drawn from immigrant and minority groups was essentially transferred over the course of the century to addicted persons in general. Federal and local legislation that essentially criminalized addiction and anti-maintenance attitudes by the Bureau of Narcotics that essentially closed off medical treatment, reinforced and increased the stigmatization of addicted people irrespective of class or ethnicity. By 1963, the accretion of stigma over the past

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century was complete. It had become codified in law, psychological theories and treatment:

1. Addiction was caused by an underlying character disorders and psychopathic personality thus creating a menace to the values of country.

2. Treatment was directed towards abstinence in lockup prison-like programs or sheltered abstinence oriented residences known as therapeutic communities.

The more hopeful development during this the 1950s and 1960s era were calls by various medical and legal committees for experimental programs to prescribe narcotics to addicts despite the resistance of the American Medical Association evinced in statements that maintenance was not considered ethical treatment.

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III

The History of Methadone Maintenance

Methadone maintenance treatment has been thoroughly researched and carefully evaluated for almost three decades. It has received more scientific scrutiny and evaluation than any other medical treatment or human service program (Ball and Ross, 1991; Brecher, 1972; Caplehorn and Bell, 1991; Des Jarlais, Joseph, Dole and Schmeidler, 1983; Dole and Joseph, 1978; Dole and Nyswander, 1976; GAO, 1990; Gearing and Schweitzer, 1974; Inciardi, 1988; Joseph and Dole, 1970; Simpson, 1981; Stimmel, Goldberg, Cohen and Rotkopfe, 1978). Most evaluations have shown that, when correctly implemented, the treatment is capable of producing remarkable improvements in patients who were previously dysfunctional heroin addicts. Methadone maintenance patients throughout the world have been restored to productive lives, relations with families and children have been reestablished, many have furthered their educations, obtained employment and improved their physical and mental health. Nevertheless, contrary to scientific evidence, methadone maintenance treatment remains a controversial issue among substance abuse treatment providers, public officials and policy makers, the public at large and the medical profession itself.

Methadone was synthesized in Germany during World War II as a substitute for morphine when supplies of opium from Turkey were cut off by the United States and their allies. The drug was brought to this country after the war and studied in 1946 at the United States Public Health Hospital in Lexington, Kentucky. It was found to be similar in its effects to morphine but possibly longer acting. Clinical research showed that the drug could be used effectively in the treatment of the opiate abstinence syndrome by substituting it for morphine and slowly tapering down the dose over a period of about one week to ten days (Brecher, 1972). Until the development of methadone as a maintenance medication in 1964, the primary use of methadone in the treatment of addiction was to withdraw addicts from heroin, a procedure that differs from maintenance and exploits only a few of the potentially useful properties of the medication.

By the late 1960s in New York City, heroin related mortality was the leading cause of death for young

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adults between the ages of 15 and 35 (Joseph and Dole, 1970). Serum hepatitis cases related to injection of narcotics with contaminated needles were increasing. A record number of addicts were being arrested for drug-related crimes, including possession, sales, robbery and burglary, and overcrowded jail facilities with no medical care to ease withdrawal were creating havoc (Inciardi, 1988; Joseph and Dole, 1970). By 1968, the Manhattan County Jail for Men (known as the Tombs) was wracked by riots because of the severe overcrowding and lack of medical care for arrested addicts. With the medical and legal professions calling for a reevaluation of American narcotic policies in respect to treating addicts, the climate was more favorable to challenge the Bureau of Narcotics' anti-maintenance position.

In 1962, Dr. Vincent P. Dole, a specialist in metabolism at the Rockefeller University was appointed to look into the situation by Dr. Lewis Thomas, chair of the Narcotics Committee of the Health Research Council of New York City. After studying the scientific, public health and social ramifications of the addiction problem in the city, Dr. Dole received a grant from the Health Research Council to establish a research unit at the Rockefeller University to investigate the feasibility of opiate maintenance.

In preparing for his research he read the book, The Drug Addict As A Patient by Dr. Marie E. Nyswander (1956), a psychiatrist who had extensive experience treating addicts. She had served as a physician at the U.S. Public Health Service Hospital in Lexington, Kentucky, treated addicts in private psychiatric practice, established a store front for treating addicts in East Harlem and was the psychiatrist for the Musicians Clinic, a program which treated addicted musicians (Hentoff, 1969). Nyswander was convinced addicts could be treated as patients within general medical practice. However, she believed that many would have to be maintained on narcotics in order to function, since the majority relapsed despite many hospitalizations, withdrawal and therapy (Brecher, 1972; Courtwright, Joseph and Des Jarlais, 1989). Nyswander joined Dr. Dole's research staff in 1964. At the same time, a young clinical investigator, Dr. Mary Jeanne Kreek, completing her training in internal medicine and neuroendocrinology at the New York Hospital-Cornell Medical Center, was also recruited to join the research team.

Maintenance with low doses of morphine was administered to the first two patients who had used narcotics for at least eight years and had extensive criminal histories related to their additions (Brecher, 1972; Dole and Nyswander, 1967). Both had previously attempted therapy and had withdrawn from heroin several

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times, only to relapse. Since morphine has a half life of four to six hours, the patients required injections at least four times per day. As tolerance developed to the morphine, they required increasing amounts administered at more frequent intervals to remain comfortable. And they remained preoccupied with drugs, apathetic and sedated from the narcotizing effects of the morphine.

The researchers knew that morphine's effects are similar to heroin. It was not a good choice as a maintenance drug. While criminal behavior might be reduced because the drug would be obtained legally, the patient would remain dysfunctional. Impairment would result from morphine's narcotizing qualities and the short half life of the drug requiring several injections per day. With the development of tolerance increasing amounts would be needed to remain comfortable over a short period of time. Similar results were obtained for other short-acting narcotics such as hydromorphone, codeine, oxycodone and meriperidine (Dole, 1988 and 1980; Dole, Nyswander and Kreek, 1966). A distinct disadvantage of most of the short-acting narcotics was that to be maximally effective they had to be injected. As Dole (1995) remarked:

> "... I could see why Butler had a problem with morphine maintenance, he was using the wrong drug. His intentions were right but you cannot proceed with morphine or heroin. These drugs have too short an action to provide stability of function."

With the failure of short-acting narcotics to properly maintain patients, they were to be withdrawn from morphine using methadone. The same tests that were administered to patients while maintained on morphine were given while the patients were administered methadone. Initially, methadone was injected but because of skin irritation at the site of injection, the mode of administration was changed to the oral route. It was in the course of undergoing metabolic tests of the effects of methadone that the serendipitous discovery of methadone's ideal properties as a maintenance medication occurred. "A fortunate accident" as Dole described the discovery in a lecture at the Beth Israel Medical Center on February 3, 1995. Methadone was already being widely used clinically to withdraw addicts from heroin and research had begun into its use as an analgesic in the experimental treatment of pain (Dole, 1988; Joseph and Dole, 1970; Kreek, 1973). In 1964, the technology

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was not yet available to measure the blood levels of heroin, morphine and methadone (Borg, Ho and Kreek, 1992). The results concerning the outcome of methadone as a maintenance medication depended on the observations and insights of the researchers. The research team deducted from the consistent successful outcomes of the first methadone patients that continued addiction was a metabolic disease (e.g., the relief of drug craving, the blockade effect created by the development of tolerance, the stability of medication levels, the changes of behavior from preoccupation with drugs to more productive activities such as the desire for work or further schooling, the clarity of affect, the absence of narcotization).

The Eight Important Findings That Distinguish
Methadone as a Preferred Maintenance Drug

Once methadone was established as a proper maintenance medication at doses of 80 to 120 mg/day, eight important findings were noted from clinical research. These findings would constitute the basis of a maintenance program capable of permitting otherwise intractable addicts to function normally within society (Dole, 1988 and 1980; Dole, Nyswander and Kreek, 1966; Kreek, 1978 and 1973; Payte and Khuri, 1992).

1. The narcotic craving described by addicts as a major factor in relapse and the continued illegal use of heroin was relieved. This is perhaps the most important property of methadone, thus allowing addicts to live a stable life (Kreek, 1988).

2. Tolerance to the narcotic effects of all opiate class drugs is blocked. At doses beginning at 80 mgs/day, tolerance is held at a high enough level to block the euphoric and tranquilizing effects of all opiate class drugs. Should the patient administer any opiate, including methadone, either orally, through injection or by smoking the effect will be blocked. Also, beginning at 80 mg/day, the patient is protected from overdose and respiratory depression if large amounts of narcotics should be administered. This protection is strengthened at higher doses of 100 mg/day or more (Dole, Nyswander and Kreek, 1965; Payte and Khuri, 1992).

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3. Stabilized patients do not experience any euphoric, tranquilizing or analgesic effects. Their affect is clear and enables them to socialize and work normally without the incapacitating properties of short-acting narcotics such as morphine or heroin. Methadone patients experience normal emotions. Their feelings are not blocked.

4. There is no change in tolerance levels. Therefore, the same dose of methadone can be prescribed to a patient for an indefinite period of time (e.g., 20 years). This effect contrasts with other opiates such as morphine and heroin whose dose must be increased.

5. Methadone can be taken orally by patients once per day. This eliminates the use of needles for injection and immediately reduces the risk of HIV infection and other serious conditions caused by using unsterile needles (Ball, Lange, Myers and Friedman, 1988).

6. Studies undertaken over the past two decades, primarily by Dr. Mary Jeanne Kreek of The Rockefeller University, and corroborated by other scientists throughout the world have established the long-term medical safety of methadone maintenance treatment (Kreek, 1992, 1987, 1986, 1978 and 1973; Kreek, Dodes, Kane et al, 1972; Novick, Ochshorn, Ghali et al, 1989; Novick, Richman, Friedman et al, 1993). There are no toxic effects, somatic damage or functional deficits associated with or attributable to methadone for patients who are stabilized at appropriate doses including those receiving over 100 mgs/day, who are not heavily abusing other drugs (e.g., alcohol and cocaine), and who have remained in continuous treatment for up to 18 years. There are minimal nontoxic side effects, such as constipation that can be treated; excessive sweating that in most cases subsides over time; and decreased libido and, in some males, delayed orgasm that normalizes within the first few months of treatment or with dose adjustment (Kreek, 1978 and 1973). Methadone is safe for persons who have been properly stabilized, since methadone can be lethal for non-tolerant persons who will require emergency treatment with narcan for about 24 to 36 hours if they should accidently ingest a dose prescribed

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for a tolerant patient. Methadone maintenance is the preferred treatment for heroin addicted pregnant women (Finnegan, 1993; Kaltenbach and Finnegan, 1992; Kandel, 1993). It is medically safe for the mother and allows the fetus to develop normally. Neonatal withdrawal symptoms are a minor problem and can be treated with paregoric. Methadone treatment is also recommended for opiate dependent HIV infected persons. Methadone treatment does not impair immune functioning, needle using behavior is reduced and AIDS related services can be delivered (Kreek, 1988; Weber, Ledergerber, Opravil and Luthy, 1990).

7. Motor coordination, reaction time and intelligence tests to determine if patients can function normally have been administered to patients maintained on high doses of methadone (over 80 mg/day). No significant differences have been found between maintained patients and the non-maintained controls. On some tests the patients even exceeded the performance of the controls. Patients' intelligence scores also improve over time. The conclusion was that patients are able to function within normal parameters at the full range of jobs when prescribed the high doses of methadone necessary for maintenance (Gordon, 1970). Patients have been able to function in all types of jobs -blue collar, construction, clerical, administrative and professional (Joseph and Des Jarlais, 1980).

8. Tolerance to the analgesic effects of methadone are quickly achieved so methadone patients feel normal pain and can be treated for severe acute and chronic pain by administration of morphine (Dole, Nyswander and Kreek, 1966; Payte, Khuri, Joseph and Woods, 1994).

In conclusion, methadone when prescribed as a maintenance medication functions as a normalizer for a deranged physiology and not as a mood altering narcotic substitute. It is a corrective but not curative procedure (Dole, Nyswander and Kreek, 1966; Joseph and Dole, 1970).

Admissions Protocols

Initially the criteria for admission to methadone conformed to the needs of a strict research protocol

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(Brecher, 1972; Gearing and Schweitzer, 1974; Joseph and Dole, 1970). Only addicts between the ages of 21 and 40 were admitted. The upper age limit was based on the theory that addicts begin to mature out of addiction over the age of 40. The applicants had to be addicted to heroin for at least four years and have relapsed after previous attempts at withdrawal from heroin and treatment. Addicts who were polysubstance users, including alcoholics and those afflicted with major psychiatric and medical problems such as tuberculosis, were not considered eligible. Initially women of child bearing age and pregnant addicts were not permitted because the effects of methadone on the reproductive system were not known and the researchers were investigating a new medical procedure (Joseph and Dole, 1970). As methadone treatment proved to be successful and medically safe, the admission criteria were gradually modified.

Today, the regulations of the Food and Drug Administration (FDA) allow heroin addicts to be admitted with a one year addiction history including current use (Office of the Federal Register, 1993). The lower age limit has been reduced to 16, however applicants between the ages of 16 and 18 must have two prior episodes of either withdrawal from heroin or drug free treatment and parental consent or be declared emancipated before being admitted. The upper age limit has been eliminated since it is now believed that while a group of addicts do mature out, the majority do not. It has subsequently been learned that untreated addicts may have high death rates at young ages, may be incarcerated or become seriously alcoholic (Dole and Joseph, 1978; Joseph and Appel, 1985). Women of child bearing age and pregnant women are now accepted and, with special medical justification, a pregnant woman can be admitted with an addiction history of slightly less than one year. Applicants with major medical conditions and polysubstance abuse problems including alcoholism are now eligible for treatment (FDA, 1989).

Methadone Maintenance Expands:
The Gearing Study and Subsequent Evaluations

In 1965, under the guidance of Dr. Ray Trussell, the New York City Commissioner of Hospitals, the initial research project was expanded and transferred to the Manhattan General Hospital in New York City where a heroin withdrawal program had previously been established. An impartial unit to evaluate the expansion and progress of methadone treatment was created at the Columbia University School of Public

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Health and Administrative Medicine with Dr. Frances Rowe Gearing as the chief of evaluation. The unit's work was reviewed by an independent committee composed of physicians and scientists with Dr. Henry Brill as its chairman. The committee made recommendations for further evaluation, research and expansion of the program (Joseph and Dole, 1970). Thus, methadone maintenance received rigorous scrutiny and evaluations with follow-up studies that continue to this day.

No matter what country, ethnicity, sex, education or economic background of the patients, studies evaluating methadone have been consistent. The following summarizes the findings from major studies conducted over the past approximate three decades.

1. When placed on an adequate dose of methadone (e.g., 80 to 120 mgs/day), heroin use by patients is significantly reduced within the first two months of treatment and eventually either eliminated or significantly curtailed with time in treatment. An adequate dose of methadone is important if methadone maintenance is to be an effective procedure (A.T.F. dosage survey, 1993; Ball and Ross, 1991; Dole, Nyswander and Kreek, 1966; GAO, 1990; Schuster, 1989).

2. Crime related to drug use is reduced significantly within the first year of treatment and the reductions continue with time in treatment (Dole, Nyswander and Warner, 1968). These trends persist irrespective of cities, culture or era. A study of 1,870 methadone patients admitted to treatment in New York City in the 1960s showed that arrest rates decreased 95 percent when compared to arrest rates three years prior to entering and three years after entering treatment (120 vs 5.5 arrests per 100 man years) (Gearing, 1970a and b; Gearing and Schweitzer, 1974). The city of Hong Kong introduced methadone treatment for its addicts in 1976 and subsequently there was an 85 percent reduction in the number of heroin addicts admitted to prisons in the city from 1976 to 1980 (Newman and Cates, 1977). In 1985, a study of methadone programs in Baltimore, Philadelphia and New York City found a 79 percent decrease in the number crimes committed by patients during their first six months of treatment as compared to their last episode of addiction. Criminal behavior declined the longer patients were in treatment (Ball and Ross, 1991).

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3. Productive behavior as measured by employment, school attendance or homemaker status increases with time in treatment. When the program was first implemented in 1964, the patients were able to obtain jobs. Within the first year of treatment, about 60 percent were socially productive (Dole and Joseph, 1978). These trends continued into the 1970s. However, with the change in the employment market from manufacturing to service jobs, the lower levels of education among new admissions, the periodic economic downturns, increased homelessness, cocaine/crack use and HIV infection among the patients, productivity and employment levels for patients declined from a high of about 60 percent in the late 1970s to about 28 percent in 1994 (Randall, 1994).

4. Polydrug abuse and alcoholism affect a significant minority of the patients. Generally speaking, those patients that are dually addicted when entering methadone treatment continue polydrug abuse and alcoholism, unless they are treated for these conditions. Prior to the AIDS epidemic, the physical effects of alcoholism were the major causes of death for patients in treatment and the second major cause of death after heroin overdose in the posttreatment period (Joseph and Appel, 1985). However, with the high prevalence of HIV infection among methadone patients in treatment, HIV infection has become the major cause of death (Joseph and Springer, 1990).

5. Studies by Ball and Ross (1991) and McLellan and colleagues (1993) demonstrates the need for psychosocial services in methadone programs to ensure their maximum potential in helping patients. In the 1980s and 1990s, new admissions presented serious social, psychological and medical problems to clinics. Among the problems are homelessness, cocaine/crack addiction, alcoholism, HIV infection, drug resistant tuberculosis, mental illness, chronic unemployment, poor education and a host of social problems (Joseph, 1992; Joseph and Appel, 1993).

6. In an important study, McLellan and colleagues (1993) have shown that while methadone alone is effective for some patients, the addition of services results in better treatment outcomes for a greater number of patients. All patients in the study were maintained at 60 mgs/day or more of

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methadone and dose was increased as needed if use of opiates persisted. Patients were assigned to one of three service components: (1) Minimal care included an adequate dose of methadone but no other services. (2) Standard care included an adequate dose of methadone plus counselling. (3) Enhanced services included an adequate dose of methadone plus counseling, on-site medical/psychiatric/employment services and family therapy.

The study found that patients involved in enhanced program services showed significant improvements in social adjustment and employment status, with significant decreases in alcohol and cocaine use and illegal activity. McLellan also reported that when dysfunctional patients receiving minimal care were given standard care, the improvements in reduction of illicit opiate and cocaine use were significant and occurred rapidly within a period of four weeks. Patients receiving enhanced care in the McLellan study made significantly greater improvements than those receiving standard or minimal care.

7. A study of socially productive methadone patients (employed, in school or homemakers) by shows that patients are able to hold positions across the spectrum of the job market (Joseph and Des Jarlais, 1980). To qualify for an interview in this study, patients had to be in treatment for at least four years, not involved with illicit drugs or criminality for at least three years, and be employed outside the field of drug treatment, drug-related research or drug-related social services. Furthermore, they had to have addiction histories of four or more years.

It was found that among the 47 who met these criteria and volunteered for taped interviews at three programs, the daily methadone doses ranged from 5 to 100 mg/day with patients at the low dose level withdrawing from the program. About 54 percent of the patients interviewed were receiving between 60 and 100 mg/day. There were no particular relationships between dosage and salary levels. The patients were primarily employed in jobs and professions in private industry. Some examples of jobs at different dose levels included an attorney who was

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withdrawing (5 mgs/day), an architect (30 mgs/day), a rock musician (30 mgs/day), two truck drivers (40 and 100 mgs/day), an auto mechanic (40 mgs/day), a window cleaner on skyscrapers (60 mgs/day), a producer of documentary films (70 mgs/day), two housewives (20 mgs/day and 90 mgs/day), a computer programmer (90 mgs/day), a chef in a gourmet restaurant (100 mgs/day) and a road construction laborer (100 mgs/day).

At the time of the interviews 72 percent of the patients had one continuous episode of treatment, 21 percent were in their second episode of treatment and 6 percent in their third episode of treatment. Patients with two or more episodes of treatment relapsed to use of heroin during their posttreatment periods in spite of their good adjustments, including gainful employment, and had to reenter treatment.

All of the patients were acutely aware of the stigmatization of being maintained on methadone. Concealment of methadone treatment was a primary consideration. Members of their immediate family and employers were not told their enrollment in treatment. Their families were under the impression that the patients were cured and had "kicked their habits." The exceptions were spouses who were aware of the patients' histories and enrollment in treatment.

A Review of Methadone Treatment: Outcome and Follow-up Studies

Some major follow-up studies of discharged methadone patients in the United States and Europe have found that a large majority are unable to maintain abstinence and eventually relapse to daily heroin use. Despite the fact that many of these studies were conducted prior to the homelessness, AIDS and crack/cocaine epidemics, they are remarkably consistent across ethnic, racial and cultural differences. These studies are important since they show that the majority of discharged patients were unable to make sustained good posttreatment adjustments in a less threatening era. The studies include those by Ball and Ross, 1991; Caplehorn, 1994; Cushman, 1980; Des Jarlais, Joseph, Dole and Schmeidler, 1983; Dole and Joseph, 1978; Dole and Nyswander, 1976; Gearing and Schweitzer, 1974; Gunne, Gronbladh and Ohlund, 1993; Joseph and

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Dole, 1970; Simpson, 1981; and Stimmel, Goldberg, Cohen et al, 1978.

The overwhelming evidence is that the majority of patients who leave methadone maintenance, irrespective of their type of discharge (favorable vs. unfavorable) and their individual prospects for successful abstinence, eventually relapse to daily use of narcotics (Caplehorn, McNeil and Kleinbaum, 1993). Today, persons who are HIV negative and leave methadone treatment are at high risk of contracting the virus after leaving treatment because of the high rate of relapse to drug use.

1. Death rates for patients who leave treatment are more than twice the rate of patients who remain in treatment. Excessive posttreatment deaths are usually associated with factors involving the injection of heroin (e.g., overdose and transmission of infectious diseases) and violence. Death rates are excessive irrespective of the type of discharge, but former patients with favorable terminations have lower death rates than those discharged for other reasons. Within the past six years AIDS has become the major cause of death in many methadone programs. In some areas it is estimated that about 50 percent of new admissions to methadone maintenance treatment are infected with HIV.

2. In most studies about 80 percent of the former patients relapse to use of heroin and/or other narcotics within approximately two years after leaving treatment. Excessive, life threatening use of alcohol and other drugs (e.g., cocaine) effects a substantial number of former patients who may not relapse to heroin. In one study, only eight percent of the former patients were abstinent from daily use of narcotics, non-opiate drugs and life threatening alcoholism after one episode of methadone treatment.

3. Gender, ethnicity and level of education did not predict post-treatment daily narcotic use. While these factors may influence decisions to enter treatment, they appear to have little or no influence in preventing relapse to daily heroin use after leaving treatment.

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4. Years of heroin use, time in treatment, abuse of drugs while in treatment, employment status and type of discharge were the factors that contributed most to predicting posttreatment heroin use. Patients who were able to remain abstinent after leaving usually used heroin for shorter periods prior to entering treatment than those who relapsed. They also remained in treatment longer, did not abuse other drugs, were fully employed and received a favorable termination from treatment.

5. Although social rehabilitation is important for a positive posttreatment adjustment, the duration of a heroin addiction may also be a crucial factor for patients to remain abstinent after terminating treatment. Patients in good standing with longer histories of heroin addiction have higher probabilities for relapse than patients in good standing with shorter periods of addiction. Also, longer durations of methadone treatment contribute to posttreatment abstention, implying that pharmacological and biological factors may also influence post treatment outcomes. These include the type of narcotic (heroin-short acting vs. methadone-long acting), the route of administration (oral vs. injection), and the circumstances under which a narcotic is administered. Even under the most optimistic conditions, patients in good standing still have a high probability of posttreatment relapse. Therefore, there should be no moral judgement on the part of treatment staff, family, friends or employers if patients in good standing relapse after leaving treatment. Patients who relapse after leaving treatment should be allowed to reenter the program without feeling guilty or a failure.

Neuroscience Developments During the Post World War II Era

The development of methadone maintenance occurred during a period of revolutionary research in the field of neurobiology. This research helped to reconceptualize theories of addiction involving biological factors as a predominant factor for protracted addictive behavior. Prior to World War II, the physical basis of an addiction was hypothesized and alluded to by researchers and clinicians. However, as previously described in this study, the knowledge base was lacking to give credence to this line of thought. The seminal breakthroughs that would ultimately transform thinking about the action of drugs in the post World War II period

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could be briefly summarized as follows:

1. The discovery of the pleasure reward system in the brain by Olds and Milner (1954) at McGill University (Gardner, 1992).

2) The measurement of tolerance, physical dependence and the discovery of the acute and secondary abstinence syndromes by Martin, Himmelsbach and Jasinski at the Addiction Research Center of the United States Public Health Hospital in Lexington, Kentucky (Himmelsbach, 1968; Martin, Wilker, Eades et al, 1963).

3) The development of methadone maintenance treatment and the conceptualization of receptor cells, their density, their location within the brain and the description of a laboratory technique to locate these receptors when the technology becomes available by Dole and the research team at The Rockefeller University (Dole, 1988; Ingolia and Dole, 1970).

4) The discovery of these receptors following Dole's predictions and the subsequent discovery and mapping of the internal opiate receptor ligand system by Pert, Snyder, Goldstein, Hughes, Kosterlitz, Simon, Terenius and others in various laboratories in Europe and the United States. This system has been traced through the evolutionary scale into primitive vertebrate and invertebrate animal life (Goldstein, 1994).

5) The continuing ongoing research in laboratories worldwide to further unravel this system including the very specific and elusive drug craving that appears to generate a prolonged opiate addiction.

Conclusion

The work of Dole and Nyswander has had a great impact on the treatment of heroin addicts in the United States today. First, they brought the treatment and care of addicts into the medical profession, albeit a

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controlled isolated and highly regulated clinical system. Nevertheless, this was an incredible accomplishment in itself, considering the lack of understanding and resistance to the concept that a continuing opiate addiction had a strong underlying metabolic component. However, it must be emphasized that methadone maintenance did not expand because society wanted to provide treatment for heroin addicts. To the contrary, the main concern was reducing the number of crimes committed by addicts.

Their second accomplishment, although they did not realize it at the time, was the launching of the first and most effective harm reduction program. Harm reduction takes a public health approach toward the problem of drug use with pragmatic strategies to reduce the harm that drugs do to the individual and society. The emphasis on drug enforcement and punishment as the primary strategies to control drug use is replaced with education, prevention and treatment. Today the program has been expanded and is the major public health program for the treatment of heroin addiction in the United States. Presently, there are about 115,000 persons known to be enrolled in approximately 750 methadone maintenance treatment programs in 40 states.

The third impact is in the field of neurobiology. Dole's conceptualization of opioid receptor cells, their density, location within the brain and laboratory techniques necessary to discover them has opened up a vast field of research which is ongoing to the present day. Dole was presented with the Lasker Award for Medical Clinical Research in 1988 because of these two accomplishments: the development of methadone maintenance and the conceptualization of opioid receptor sites.

Commentary

As a comment to this chapter, methadone in the form of dolophine tablets was prescribed informally by private physicians as a possible withdrawal procedure or short term maintenance therapy for opiate addiction. However, the procedures were never researched, conceptualized or developed into a coherent theoretical framework. The physicians were usually harassed by the Bureau of Narcotics and threatened with a revocation of their medical licenses. "Jerry," one of the narrators in the book, Addicts Who Survived, used dolophine prescribed by a physician when he was unable to obtain opium. He entered methadone treatment in 1973. Dolophine in the 1950s and 1960s was called "dollies" by street addicts and was used for self medication. They were obtained from physicians or through the forging of prescriptions (Courtwright, Joseph and Des Jarlais, 1989).

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An informal methadone maintenance program using dolophine was organized by the New York State Department of Mental Health in 1959 under the direction of Dr. Harold Meiselas.[1] Meiselas acknowledged that coherent research protocols and evaluations were never organized (Meiselas, 1995). Furthermore there were no conceptualizations of dose leading to the establishment of narcotic blockade. Formal records are now lost nor are there records of patient outcomes and papers about the experience were never written. However, Meiselas did recall that addicts were initially given methadone in a hospital on Ward's Island in a building owned by the state but which was subsequently turned over to a therapeutic community.

After an unknown period of hospitalization the patients received methadone in the community in outpatient clinics that were operated by the Department of Mental Hygiene. Administrative arrangements and permission to proceed with this pilot were made by Dr. Henry Brill.[2] There were about 30 patients enrolled in the program. Meiselas advised that there are to his knowledge no existing records of how this project began or ended. However, he believes that some of the patients may have entered the Dole-Nyswander program that was established in the 1960s. He does recall having meetings about the program and that methadone was chosen for the program since it was a long acting drug.

The above shows the importance of conceptualization in research and the importance of evaluation. Prior to Dole's work, physicians who may have used methadone did not appreciate the pharmacology of it nor did they develop concepts to further their work. Their basic understanding of addiction was that of a behavioral problem and methadone was merely a long acting substitute for heroin. In contrast, Dole approached addiction as a metabolic disorder and believed that addicts could be treated in the physician's office like any other patient with a chronic disease. In addition to bringing the addict back under the care of physicians, Dole imparted the importance of research, conceptualization and evaluation. Dole's work resulted in a system that generated knowledge and ongoing study but most importantly, the knowledge produced a sound medical protocol that can be implemented worldwide.

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1. Meiselas was contacted on January 25, 1995 by telephone. However, he was unable to recall the details of the program. He acknowledged that coherent research protocols and evaluations were never organized.
2. Dr. Henry Brill was a former state commissioner who is now deceased.

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IV

From Heroin Addict to Methadone Patient

This chapter will describe the steps that transform a street heroin addict into a methadone patient. This is a major transformation that involves the efforts of staff counselors, nurses and physicians cooperating with suspicious and apprehensive newly admitted patients. To assume the patient role, the patient must first relinquish control over the administration of narcotics from him or herself to a professional medical staff. The second consideration is that the patient must be compliant with the rules of the clinic by reporting as directed, taking his or her dose as directed and accepting the rules of the program. This includes compliance with physical examinations, the periodic collection of urine samples and cooperating with social service and medical personnel in the treatment of addiction as opposed to participating in the networks of the streets when the patient was addicted to illegal narcotics.

Thus, there should also be a transformation in the acceptance of networks – the medical, social service network that will provide methadone, other medical regimens, counselling, vocational and educational guidance and referrals for additional services to community agencies when appropriate. However, this transformation implies that patients modify or relinquish networks developed in the streets including old friendships. Transformations in relation to street networks may happen immediately or take years. The transformations could be complete – no contact with former associates – or modified. The modification of relationships to street networks and the consequences of modifying relationships may reflect the role that patients assumed in the street while using heroin. For example, when this writer administered a clinic, a patient tried to remove herself from the control of a pimp and was subsequently found murdered.

Also, transformations may reflect the patient's perception of the program's philosophy towards patients (trust vs. mistrust, concern vs. indifference, excessive control vs. flexibility), the patient's understanding of the methadone, the patient's own agenda for treatment. Does the program trust or mistrust patients? The major component in becoming a compliant patient is the confidence in the medication and the understanding of the properties of methadone (D'Annuno and Vaughn, 1992).

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Phases of Methadone Maintenance Treatment[1]

The methadone maintenance treatment program is subdivided into three basic phases:

Phase 1 This is the initial intake and stabilization period which lasts for about three months. The patients are built up to an appropriate doses of methadone, receive various physical and psychological examinations, are introduced to the regulations of the program and are assigned a counselor. Patients also adjust to the medication, becoming tolerant or resistant to its narcotic, analgesic (pain killing) and tranquilizing effects. Patients during this period make a transition from street addict to patient. They begin to relinquish the use of illegal drugs, primarily heroin and entrust the administration of methadone which they might have used illegally in the streets to the medical administration within the clinic. During this period patients may report six or seven days per week drinking their dose of methadone in the presence of a nurse at a specially designed dispensing station. At most, they receive one take home dose of medication for Sunday. Urine tests are taken two or three times per week during Phase 1. In some clinics the patient is observed while urinating to ensure that the specimen is correct.

Phase 2 This phase can last indefinitely and is the basic period of methadone maintenance. Patients begin to plan for their futures. Those with job skills seek employment while others without needed skills can apply for vocational assessment, counseling, job training and placement if such services are available either within the clinic or the community. Through counselling, families can reunite. The patient's life begins to normalize during this phase of treatment.

1. When the program began, the concept of moving through phases was more pronounced. Today the program is less structured and although the phases still exist, most professionals do not refer to them and patients are unaware of them.

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However, clinics are highly regulated. Some programs serve substantial populations of sick and highly dysfunctional patients with AIDS, tuberculosis, homelessness, chronic unemployment, excessive use of cocaine/crack, alcoholism and a variety of other problems. Methadone is dispensed in bottles each containing one daily dose. Employed and stable patients who report one day a week are given six bottles of medication, which for compliant patients may be difficult to conceal. This clinic system while effective for many patients, especially those with serious problems may work against the continued social adjustment of compliant, stable, and employed patients.

Phase 3 This phase is called aftercare. Patients in good standing report to a clinic once every two weeks, give a urine specimen, drink a dose of methadone in front of the nurse and receive a two week supply of methadone (13 bottles). However, these patients are still in the clinic system, report to an identified methadone program and are subject to the same regulations if they must go on extended business trips or vacations for more than two weeks. The patients are still medically segregated in a special methadone clinic.

Phase 4 This phase is medical maintenance and is considered an investigational status. The federal government is currently deciding whether medical maintenance should be continued. Stable and employed patients are assigned to a physician with a hospital-based medical practice and thereby placed in general medical practice. The reporting schedule is determined by the physician and patient. At the beginning of medical maintenance, patients report once every two weeks. When patients are comfortable with a two weeks supply of medication, their schedules are changed to once per month. They are treated in a private doctor's office, submit a urine sample and drink a dose of methadone before the physician to show that tolerance to methadone has been maintained. They pay for the medication, and the services of the physician who may treat other problems that the patient may present (e.g., arthritis, diabetes, cardiac, and in rare cases, AIDS). Methadone maintenance treatment is therefore

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just one aspect of the patient's health status. The methadone patient is integrated into general medical practice away from the segregated clinic system.

Procedures With Patients in Methadone Maintenance Clinics

About 115,000 patients are currently enrolled in methadone maintenance treatment in the United States. Of this number, about 40,000 (25%) are enrolled in programs in New York State (COMPA, 1993). Patients from different socioeconomic classes and with varying social and psychological problems are serviced in public and private clinics. The administration of the medication is quite formal and regulated (Watters and Price, 1985). Patients begin by standing in line to await their turn at the clinic's medication counter. Methadone is dispensed at a counter by a nurse. Patients are required to drink a daily dose of methadone in front of the nurse to demonstrate a continued tolerance to the medication. Some programs dictate that patients must talk to the nurse after taking their medication so that medication is not secretly spit out into a container and diverted for black market sales in the streets. Urine screening is random and patients must be ready to produce a urine sample if selected to do so. Urine samples are used to determine whether patients have taken their medication on the days they do not report to the clinic and to determine if they are using other drugs. In some clinics, patients may be required to urinate observed by a member of staff. Toilets used by patients to produce urine samples are sometimes difficult to keep clean and sanitary because of the constant use. This results in complaints from the patients because the conditions compromise their dignity.

Patients report from one to seven days per week to a clinic depending on the amount of time they were in treatment and their productively (e.g., employed, student, homemaker). Patients are assigned counselors to assist them to overcome problems and to make relevant referrals. However, in most clinics the counselling is not adequate, considering the many social and medical problems that patients present.

If patients do well they report less frequently within a given week and are allowed to take home up to six doses of their daily medication. This take home process is highly regulated by federal, state and local regulations. If patients have to go on distant business or personal trips, they must ask permission sometimes several weeks in advance to receive additional medication which must be approved at the proper level of governmental authority. An alternative plan is to assign patients on vacation or business trips to local clinics

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that may be more restrictive than the clinic of origin. Patients are therefore in a highly controlled process that can intrude on their business and personal lives. The primary function of the governmental regulations is to control diversion of methadone – the selling of methadone by non-compliant patients to street addicts who are not in treatment. These patients are in the minority, but, unfortunately, their noncompliance impacts on all patients.

The Origin of Medical Maintenance

In the 1980s, Dr. Nyswander realized that the imposed regularity of the reporting schedules hindered the progress of patients who were employed and appeared to be socially and medically stable. Also, from the inception of methadone maintenance, Nyswander and Dole felt that a group of socially stable patients could be treated in medical practice. With the help of this writer, a medical maintenance protocol and criteria were established that allowed selected patients to receive their methadone as a prescribed drug within private medical practice.[2] It was planned that patients would report at least once per month and therefore be able to go on needed personal and business trips and take extended vacations without the interference of rigid controls, denigrating regulations and weekly reporting schedules. Furthermore, patients would pay the physician a monthly fee (about $75.00) for the visit, annual physical exam, monthly urinalysis test and a month's supply of medication. Permission was obtained from the federal government to implement the program as a study or investigation of a new drug. Patients would be removed from a rigid clinical reporting system that compromised their confidentiality. Most importantly, their status as methadone patients would be more concealed since they were removed from identifiable clinics, and the treatment process itself would be concealed within private medical practice (Novick and Joseph, 1991). Another alternative would be to

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2. Criteria stipulate that to be eligible for medical maintenance, patients must be in treatment at least five years, have verifiable employment, be emotionally stable with no drug abuse or arrests within the past three years. They must not be involved in street activities nor present behavior problems to the referring methadone program. Also, medical maintenance is indicated to improve the patients' overall adjustment and functioning.

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withdraw successful patients from methadone. Several studies over the past two decades show high rates of relapse to heroin after patients leave the program irrespective of their adjustments while in treatment. However, patients who leave in good standing appear to relapse at slower rates than those who leave against medical advice (Ball and Ross, 1991; Dole and Joseph, 1978). Neuroscience research has shown that there may be a physical explanation for relapse, namely a dysfunction within the opiate receptor system which methadone normalizes as long as the patient takes the medication (Dole, 1988; Kreek, 1988). Many successful patients, therefore, prefer to remain in treatment since they are cognizant of the reality of relapse to heroin not only from the results of studies but, more importantly, from their own experiences and those of their friends. Patients in good standing have withdrawn but there have been high rates of relapse among this group. Nevertheless, there are patients who have succeeded in leaving methadone treatment and have lived comfortably without medication or relapse to heroin. The reason that some patients can live in comfort after withdrawing from methadone and others are unable to, is a research question that is now undergoing study and has yet not been answered.

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V

The Transformation of Stigma from Heroin Addiction to Methadone Treatment

While Dole and Nyswander were implementing their research, sharp and acidic criticism was directed at them from various professional and governmental interests. This early criticism has not abated, extends the prejudice associated with heroin addiction and is the foundation for the stigma that now encompasses methadone treatment. Extensive clinic regulations enacted during the 1970s by the Drug Enforcement Agency, the Food and Drug Administration, state and local authorities to control methadone treatment are in essence extensions of federal, state and local laws and drug policy enacted since 1914 (Harrison Act) to control heroin addicts and the process of addiction. This section describes examples of governmental action and the portrayal of methadone treatment in the media that has helped to create and then enhance the stigma associated with it. However, the stigma associated with methadone maintenance is derived from the perceived transfer of deviance associated with heroin addiction. The theoretical underpinnings of labelling and the concept of tertiary deviance as conceptualized by Miller (1974) will be discussed in the initial section of this chapter followed by examples of stigma in the media.

The Labels and the Concept of Tertiary Deviance

Drug addicts as a deviant group have always been defined with denigrating labels. Foster, Dinitz and Reckless (1972) state the following about labels and makes the connection between labeling and the Goffman concept of stigma as a 'spoiled identity' in the following excerpt:

> "The labelling hypothesis maintains that being publicly identified as deviant results in a "spoiled" public identity. It contends that being labelled "deviant" results in a degree of social liability ... which would not

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> occur if the deviance were not made a matter of public knowledge. It further suggests that the social liability incurred by being labelled "deviant" has the ultimate effects of reinforcing the deviance."

Lindesmith (1940) commented that heroin addicts appeared to be grouped into a label known as "Dope Fiends." The picture is of a totally depraved individual entrapped by a drive that is the generator of cruel single minded behavior without conscience. He also indicated that heroin addicts are labelled with an assortment of terms many of which are contradictory but all of which add to their stigmatization (e.g., passive psychopath, aggressive psychopath, narcissistic, dependent, childlike, sociopath, constitutionally immoral, hysterical, neurasthenic, weak character and will, self-indulgent, introspective, extroverted, pseudo-psychopathic delinquent, essentially normal).

The connection between labeling and deviance was made by Becker (1963) in the following statement:

> "..that social groups create deviance by making rules whose infraction constitutes deviance... The deviant is one to whom the label has been successfully applied; deviant behavior is behavior that people so label."

Social labeling is then a prime phenomenon in the conceptualization and definition of primary and secondary deviance. Miller (1974) extends this concept to create a third category of deviance known as tertiary deviance to explain the stigma associated with methadone maintenance in relation to heroin addiction which is defined as secondary deviance. Prior to the passage of the Harrison Act of 1914:

> "...there were apparently hundreds of thousands of primary deviants, individuals addicted to a drug that was morally acceptable in society. But they functioned as individuals addicted to opiates, not as a special subgroup of addicts (Miller, 1974)."

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With the passage of the Harrison Act, Miller asserts that

> "...its interpretation by the Narcotics Bureau, the societal reaction which effectively criminalized the deviant behavior resulted in secondary deviance. Since narcotics were no longer freely and legally available one type of pre-1914 addict developed ... a secondary deviance pattern which shifted their self-image and their behavior patterns to a criminal subgroup identity."

The secondary deviance of narcotics addiction in the United States was contained within the criminal subculture that addicts were forced into to obtain money for heroin. Miller (1974) indicates that methadone maintenance, a response to the secondary deviation syndrome, was found to be a pragmatic solution to the criminal activities and transmission of infection but in itself did not resolve the initial philosophical debate over the use of narcotics in maintenance treatment or the behavior involved in the primary deviance of opiate use. As Miller (1974) indicates a dichotomy exists with tertiary deviance since:

> "The solution to secondary deviation abuses is made both legitimate and illegitimate simultaneously. Moreover, the stigmatization of tertiary deviance solutions (such as methadone maintenance) indicates that the original ideological debate over the primary deviation has not been resolved."

Miller cites Nelkin (1973: 150) about the stigmatization of the methadone patient:

> "... as a marginal man, isolated from his/her own community and stigmatized by the larger society as a threat to the social order."

Miller further states that the stigmatization in tertiary deviance will be continued:

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> "Tertiary solutions almost automatically guarantee that ideological debate will continue and that the tertiary solution will remain under assault by interested moral entrepreneurs."

The stigma of the primary deviance (heroin addiction) is continued but in a lesser state. With methadone as a treatment medication, an ambivalence is created in the public's attitude towards patients. As Miller (1974) states:

> "Are they cured or are they still patients? Community opposition to methadone maintenance programs (especially in transition neighborhoods) must be understood in the light of this societal ambivalence."

Addicts themselves have adopted labels for and social concepts about their behavior. These concepts were usually developed in the larger society observing behavior that was deviant and perceived as endangering social values. The labelling is related to the observation by Helmer (1975) that perceptions of drug addicts are embedded in class and racial stereotypes and mythologies that promote minority oppression within a given society. The perceived characteristics of the drug abuser reflect the attitudes towards stigmatized racial and socioeconomic groups and constitute class conflicts especially in times of economic crisis. The two most common terms to describe drug addicts are dope fiend and junkie. Both dehumanize addicts and define a deviant stigmatized subgroup.

In nineteenth century United States, opium was associated with orientals and in particular the Chinese. Heroin, during the first part of the 20th century, was usually associated with the poor white ethnic and immigrant groups while cocaine in the late nineteenth century was associated with poor blacks. Exaggerated accusations of cocaine-induced black crime in the late and early 20th century prevailed among whites.

In the United States, therefore, the terms dope or drug fiend and junkie evolved from a confluence of class and racial stereotypes (e.g., indentured Chinese laborers, poor white ethnic and immigrant groups and poor blacks). These groups were perceived as potentially threatening to the socioeconomic status quo

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especially in times of economic crisis (Helmer, 1975). For example an upper class female opiate addict would not be considered a "drug fiend" or "junkie" but her drug using counterpart in the urban slums conjured up subhuman class and racial fantasies.

One theory about the evolution of the term "dope fiend" is reportedly rooted in behavior caused by cocaine. Cocaine is a stimulant but heroin and opium narcotize the user. Technically, cocaine is not a narcotic but is so classified under the Harrison Act. The possible paranoid ideations of the compulsive and heavy cocaine user evolved into the term dope fiend around the turn of the century (Kleber, 1988). The criminal behavior of a heroin addict to obtain money for drugs after withdrawal merged in the public perception with the cocaine induced behavior. Subsequently, the label of the dope fiend which originally applied to a cocaine addict was also applied to the heroin addict.

Furthermore, the opium den of the 19th century was seen as a den of inequity, and its patrons regarded as moral degenerates. The association of these dens with Chinese traffickers and poor smokers who were indentured laborers imported to work in mines and on the building of railroads further intensified racial and class fears. The Chinese laborers were paid less than white workers and this economic exploitation exacerbated tensions between the two groups. Also, as opium smoking entered the white marginal world of con men, gamblers and prostitutes, the opium dens and smokers became stigmatized and were targeted with restrictive local legislation (Courtwright, 1982).

Brecher (1972) describes nineteenth century America as a "dope fiend's paradise."

> "Opium was on legal sale conveniently and at low prices throughout the century, morphine came into common use during and after the Civil War, and heroin was marketed toward the end of the century."

In describing opiate addicts in a 1916 survey of the New York City Jail known as the Tombs, addicts were referred to as "hypodermic fiends" or "sniffers." In 1919, in the case of United States vs Doremus, Dr. Doremus was convicted of prescribing narcotics to a "known dope fiend," Myers alias Ameris. The ethnic surname and the term "dope fiend" used in describing Myers reveals that the social prejudices targeted to

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immigrant, white ethnics and opiate users were even reflected in the language of the Supreme Court (Courtwright, Joseph and Des Jarlais, 1989).

In Victorian and turn of the century British literature (e.g., the Fu Manchu stories) the Chinese drug users were described in subhuman terms and as oppressing and seducing white women. Opium dens become palaces of evil where upper class men become enslaved to opium. The patrons of opium dens were described in dissolute terms reflecting the concept of degeneracy (Parssinen, 1983). An example is the role of opium and the opium den in the Oscar Wilde novel, The Picture of Dorian Gray. Dorian Gray is an upper class Englishman who is an habitue of the opium den and is driven by his insatiable craving for the drug. The den and the use of opium are symbolic of the dark, hidden and perverse side of his nature. While Dorian Grey retains his youth, his portrait ages reflecting his degeneracy and the use of opium (Wilde, 1977). Dickens also uses the opium den as a symbol of degeneracy in the upper classes in his novel, The Mystery of Edwin Drood (Parssinen, 1983).

In 19th century Victorian literature, upper class opium users were described as alien to the human race with an emotional coldness reserved for the monster and vampire literature of the period (e.g., Mary Shelley's novel Frankenstein). In this context, the dope fiend evolves from the degeneracy of the upper classes, the loss of human attributes and the overpowering craving for opium that leads to the descent of the upper class addict (Parssinen, 1983).

In 1922, the British novelist Aleister Crowley wrote, Diary of a Drug Fiend, which describes the addictions to cocaine and heroin acquired by a young naive couple travelling through Europe on their honeymoon. The novel, contrary to the title, does not describe "depraved," oriental or poor ethnic addicts. The plot deals with addiction within the British upper classes. Although the book describes the effects of cocaine and heroin sniffing in lush overblown prose, the novel is essentially a moral warning against the use of narcotics.

The term dope fiend therefore evolved from the experiences of two drug using cultures:

1. The British Victorian upper class opium smoker patronizes the barbaric Chinese operated opium dens (palaces of evil). The Chinese opium smokers are described in subhuman terms such as in the Fu Manchu stories while the upper class opium

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smokers are described as degenerating into less than a human state.

2. In the United States the term "dope fiend" evolved from the racial and class stereotypes of poor blacks using cocaine and poor whites from the lower and immigrant classes using opiates.

The class and racial contexts of the term dope fiend reflects the country of origin, the use of drugs by different class and racial groups, the type of drug that is used, and the perceived effects of the drug and environment in which the drug is used.

The term, "junkie" evolved within the first two decades of the century and its origin is not completely understood. Courtwright (1982) indicates that word is derived from the junk that addicts sold to obtain money to buy drugs. Stimpson (1973) states that the word is derived from the type of ships known as junkers that the Chinese drug traders used to transport opium.

Within the addict community, however, the terms have evolved to describe a definite addict class hierarchy. The narrator, "Sam," an upper class methadone patient in the book, Addicts Who Survived, relates the following, intertwining the two terms junkie and dope fiend:

> "I was not yet a "junkie" - the commonly accepted convention of the dope fiend, the man lurking in the street with a dirty hypodermic in his pocket, who shoots up in a doorway, Mine was a private problem. I wasn't a "junkie." I was a "narcotic addict," if you please, or some other pretty, polite term. All the while not realizing -- or perhaps realizing, and not even admitting -- that I was a "junkie," as I realize today and admit (Courtwright, Joseph and Des Jarlais, 1989: 76)."

In Sam's mind the drug fiend or junkie is at the low end of the status scale beneath the concept of the more sanitized term narcotic addict. Howe (1957) indicates that the term dope fiend probably evolved from

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pulp fiction and the combining in the public's perception the effects of excessive alcohol consumption with those of narcotics. Waldorf, however, states that the dope fiend identifies with the "culture of the streets." The definition is narrowed to a particular urban subculture.

> "What are dope fiends? They are for the most part urban addicts who are overwhelmed by their addiction and must hustle on a sustained and continual basis to support their drug needs. The combination of uncontrolled drug use and regular hustling – in juxtaposition with the larger culture's mores, laws and values about drug use – causes the development of a social identity distinct from addiction which in a larger social context is seen as the addict subculture. Those addicts who somehow do not identify with the subculture are not, according to addicts, dope fiends; those who do, are dope fiends (1973)."

According to Waldorf, the addict subculture has therefore taken a concept developed to describe what is perceived as compulsive, degenerate behavior by the greater society and transformed it into a concept that encompasses a set of values and mores accepted on the urban streets.

Burroughs (1953) titles his autobiographical book, Junkie, a term used by addicts themselves to differentiate the behavior on the streets of heroin users.

Opium smokers in the 1920s and 1930s looked with disdain on heroin addicts - needle injectors. Several had to make the painful transition from opium smoking which was associated with atmosphere and class to heroin injection when opium was not longer available in the United States after World War II. As one opium smoker remarked in Addicts Who Survived, "When I became a junkie I lost my life" (Courtwright, Joseph and Des Jarlais, 1989). Heroin addicts especially those labelled as junkies were stigmatized as the lowest stratum of opiate user.

Labelling has shifted from the heroin addict to the methadone patient. A specific set of labels has developed to distinguish the methadone patient and the medication. For this study the term "methadonian"

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coined in the 1970s will be used to denote labelling. There are other terms such as "legal junkie" which is obviously denigrating. Methadonian is more subtle. It connotes an alien that uses methadone and, in a sense, removes the patient from the human race. The term methadonian not only demonizes the patient but also denigrates the medication. The stigma therefore enters the molecular makeup of methadone.

The origin of the term is not known. According to NAMA, the term methadonian appeared first on the streets in the 1970s and then in the media. It may have been used initially by working methadone patients to describe dysfunctional methadone patients. Thus a hierarchy of patients may have evolved early in treatment - those who were compliant, were employed and had normalized their lives in contrast to patients who were unemployed, still engaged in street activities, loitering and using a variety of drugs. This labelling may parallel Sam's narrative related above that the pejorative terms junkie and dope fiend are used in a special context to describe poor dishevelled street addicts in contrast to the heroin addict who was "more responsible."

Functional methadone patients in medical maintenance consider themselves medical patients. However, according to NAMA, there are patients who prefer to use the word methadone client instead of patient (National Alliance of Methadone Advocates, May 1994).[1] This "demedicalizes" methadone maintenance. The position of NAMA is that the word client denigrates methadone patients by removing the biological component of addiction: the patient is no longer a legitimate medical patient treated for a legitimate medical condition. The term methadonian, however, has been broadened to include all patients, derides the biological component of addiction and the patient's need for methadone to function normally. Patients irrespective of their adjustment are placed within a stigmatized subgrouping with the distinct label of methadonian.

Two health care workers who are patients in the medical maintenance program reported that the term is used in hospitals where they work and the classes they attend by nursing staff and physicians in private

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1. NAMA's executive vice president related the following regarding the use of client. She was talking with a group of patients from California where the use of client is quite common. After relating all the reasons not to use client the patients responded with, "We don't like to be called patient because we aren't treated like patients!"

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conversations to describe methadone patients. They indicated that the term is another manifestation of stigma. As one indicated:

> "I hear it all the time where I work in classes-in the hospital. It is very stigmatizing."

A patient who owns a business in a suburban community near Manhattan had the following reaction to the term, its sociological implications and its effect on him as a hard working productive person:

> "I saw a program where Geraldo Rivera stated that someone would succeed like a methadonian on methadone. I've seen the word methadonian on signs and walls in my community and heard it in conversation. Someone in the community writes signs about methadonians. They want to put us in a subculture. In this day and age, it bothers me that I've got to hide myself. I'm being put down for this (being a methadone patient), for trying to help myself, I don't stick needles in my arm – it just isn't fair."

Bruce Stepherson (1994), a former methadone patient who is open about his treatment, acquired a master's degree and is now the Director of AIDS Outreach and Prevention at National Development and Research, Inc. (NDRI) sums up the connection and meaning of labeling for heroin addicts and methadone patients as follows:

> "The forces mentioned above (intellectual, academic, political, religious, social, moral, cultural) have been effective in convincing communities, as well as users, and former users that they have "no value." This is evidenced by the fact that drug users are "demonized" and presented as

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> being "nonhuman" by the media and the non-drug using community at large. One only needs to look at the language used to refer to drug users, words like 'dope fiend' and 'methadonians' as proof of this fact. This conscious demonization serves to further isolate and marginalize users."

The Role of the Bureau of Narcotics

From the first clinical research procedures with methadone maintenance in 1964 at The Rockefeller University, the Bureau of Narcotics perceived the theoretical and clinical work as a threat to its anti-maintenance position. In 1966 the Bureau published a pamphlet for the treatment of narcotics addicts by physicians. The following excerpt summarizes the Bureau's attitudes and philosophy:

> "It is well established that the ordinary case of addiction yields to proper treatment, and that addicts can remain permanently cured when drug-taking is stopped and they are other wise physically restored to health and strengthened in willpower."

This quote conveys the belief that willpower is sufficient to prevent relapse and effect a permanent cure after medical withdrawal. Yet at the time this pamphlet was published, all available studies showed that the majority of addicts relapsed after withdrawal in hospitals and extensive therapeutic interventions.

The belief in "cure by willpower" implies the absence of metabolic dysfunction, the persistence of a weak will and the need to control behavior until the will is strengthened. Thus, addicts who continue to relapse or continuously use narcotics are weak willed. This rationale constituted for the Bureau a theoretical basis to continuously control an addicted "irresponsible" population through criminal sanctions, legal statutes and commitment. The proof of their irresponsibility was of course their drug use. In contrast, the metabolic theory of addiction and the idea of methadone maintenance, the medicalization of an addictive disorder, challenged the concepts and philosophy promulgated by the Bureau to maintain power: methadone maintenance threatened to replace the primary deviance and stigmatization of heroin addiction. In a

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letter to the Yale Law Journal dated January 6, 1969, Donald Miller, Chief Counsel to the Bureau of Narcotics and Dangerous Drugs wrote about methadone maintenance:

> "The Bureau does have a vital role ... to alert society as to the possible pitfalls and to caution against mass acceptance of a theory which could adversely affect our society by increased addiction.
> ...Will there be any deterrence when potential users are assured that there will be no ill consequences from drug experimentation; indeed that addicts may even receive preferential treatment?
> What will be the result of having no social stigma against addict proselytizers in our communities?"

The Bureau therefore perceived methadone maintenance as a medical sanction for continued narcotics addiction, hence a deviancy to be stopped. The concept that continued addiction can be treated successfully as a medical condition was discerned not only as lessening the social stigma of addiction but as a threat to the Bureau's philosophical approach and power. Their approach to solving the heroin addiction problem adopted since the passage of the Harrison Act included as a goal "enforced abstinence" which was impossible for most addicts to achieve. Other strategies the Bureau employed were the supporting of legal statutes and criminal procedures, harassment of physicians who prescribed narcotics, institutionalization of addicts including imprisonment and prolonged confinement to specially created prison-like hospitals. These goals and tactics essentially maintained and increased the social stigma and deviancy associated with addiction.

The next strategy was to stop the clinical research on methadone maintenance. The Bureau adopted a policy of intimidation and harassment. However, Dole had obtained not only the backing of the administration of The Rockefeller University but recruited the counsel at the university to study the legality of research on maintenance. It was found that there were no substantive legal issues or laws to prevent the establishment of research on narcotic maintenance, including methadone.

An agent from the Bureau of Narcotics appeared at his laboratory peremptorily threatening legal

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action and arrest if the research continued. After learning that the legalities had been researched and it was possible to lose in court, the Bureau discontinued its open threats of legal action and announced instead that Dole was "conducting a very limited set of research studies with their authorization and under their control." However, the Bureau continued its harassment, but covertly. Agents infiltrated the clinics where the research was being conducted. Records were stolen and false rumors were spread. Attempts were made to discredit Dole and Nyswander, even intimating they were liars. Nyswander was followed. Her activities including vacation plans were reported to the Bureau by an unknown surveillant. Many years later under the Freedom of Information Act, Nyswander obtained a censored record of these activities. The file was the size of the Manhattan telephone book.

In 1970, a representative from the Bureau of Narcotics visited the editor of the journal Federal Probation[2] and demanded that an article that was being considered for publication by this writer and Dr. Dole, not be published. The demand was made when the article was not yet completed or titled. However, the Bureau appeared to know the contents. The editor of Federal Probation who informed this writer of the incident refused to surrender to the Bureau's demands, and the article was eventually published.[3] It was a social, neuroscience and statistical clinical review of the program. Included were the methadone programs's philosophy, history and outcome statistics which detailed the successes and failures for first five years of its implementation. The article stated that the narcotic craving or drug hunger experienced by heroin addicts was symptomatic of a metabolic alteration in the central nervous system and may persist for long periods; perhaps even for the duration of a person's life. This concept was threatening to the Bureau. The metabolic theory of addiction would diminish the psychopathic or character disorder theory upon which the stigmatizing punitive approach of the government was based.

2. Federal Probation is printed by the Department of Justice with a world wide distribution.

3. The article was published in the June, 1970 edition of Federal Probation entitled, Methadone Patients on Probation and Parole.

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Clearly, the thousands of addicts whose lives have been restored through methadone maintenance may have never been given the opportunity were it not for the stature of Dr. Dole and his tenacity to continue with the work. Very few scientists would even consider standing up to the Bureau of Narcotics and risk their career or even possible imprisonment

The Drug Enforcement Administration (DEA) is the successor of the Bureau of Narcotics. The philosophy of the Bureau has been continued through the DEA which concerns itself with the diversion of methadone. The responsibilities of the DEA include storage of medication and the architecture of the clinic to minimize diversion. However, DEA agents have testified before Congress as recently as 1994 intimating that methadone was responsible for countless deaths. This viewpoint is contrary to scientific evidence and will be discussed later in this chapter. Other harassment tactics of the DEA include entrapment of patients (e.g., undercover agents pretend to be an addict in withdrawal and beg patients for their methadone). These strategies result in oppressive clinic regulations which all patients must adhere to. Programs fear their licenses to dispense methadone will be revoked if they are cited for violations. These oppressive tactics of control also create an atmosphere that stigmatizes the program and the patient. Miller's concept of tertiary deviance - that stigmatization is continued since the primary deviancy of heroin addiction has not been resolved - applies to the perception of patients by the DEA.

The Role of the Media in the Development of Stigma

In this section selected examples of articles in magazines, journals, books, newspapers and television programs that promoted a sensationalized negative view of methadone treatment and contributed to stigma will be reviewed. There are many more examples but the following exemplify the type of attacks that have appeared over the past three decades. The vitriolic attacks from various sources reflected Miller's (1974) contention that methadone maintenance is viewed as an "ideologically deviant rehabilitative therapy." Irrespective of the intentions of the critics, the ultimate effect of the criticisms stigmatizes patients: the "deviant rehabilitative therapy" has become a "rehabilitation without honor."

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Magazines, Journals, Books, Newspapers, Television

Bayer (1978) reviews the incessant attack on methadone treatment in the popular literature. He reports that by the 1970s the majority of the articles published about methadone were unfavorable attacks upon methadone, the patients and the work of Dole and Nyswander. Included in his analysis are attacks on methadone during the 1970s by the author, William Burroughs, who by 1981 became readdicted to heroin, entered methadone maintenance and has remained a patient in good standing to the present. He was interviewed as a methadone patient in the book, Addicts Who Survived (Courtwright, Joseph and Des Jarlais, 1989). Although Burroughs may be considered a successful methadone patient who has produced books and acted in the film, Drug Store Cowboy while being maintained on methadone, he has never published a disclaimer to the article published in the New York Times on November 11, 1977 entitled, Heroin Maintenance: Methadone Kills You Faster than Junk.

Bayer (1978) analyzes a complaint lodged against New York Magazine with the National News Council concerning the publication of an article written by a free lance writer, Blake Fleetwood, entitled Psst, Kid ... Wanna be a Junkie? Try Methadone. This article grossly misrepresented the methadone program and the medication. It was a supposed exposé of a privately run methadone clinic in lower Manhattan. The article was inaccurate about methadone as a medication and highly stigmatizing to patients. The opinion of the National News Council favored the magazine since the magazine was not considered a scholarly journal, was presenting advocacy journalism and printed several letters in rebuttal to the article in subsequent issues. However, one of the members of the National News Council, Sylvia Roberts, who dissented from the majority opinion wrote following:

> "The article moved from the writer's personal experiences to a general indictment of all methadone programs. The argument was totally one sided; no arguments in favor of methadone were included.
>
> ....
>
> The article leaves the impression that methadone patients are "junkies" who are so continually "stoned" that they cannot hold jobs. Metha-

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> done alone may not be the answer to the nation's addiction problem, but there is substantial evidence that methadone therapy has helped many patients function productively. By labeling methadone patients as unreliable "junkies," the article contributes to a stereotyped image that makes it difficult for even the most motivated patient to obtain a job.
>
> ...
>
> In our judgement, the damaging impact of so one-sided an article cannot be undone by subsequent publication of letters to the editor."

One of the earliest magazine articles to attack methadone treatment appeared in the New Republic (August 13, 1966) entitled, Stoned on Methadone by Louis Yablonsky. Yablonsky (1965) was the author of a book Synanon, The Tunnel Back promoting an abstinence oriented treatment. The New Republic article described a methadone patient interviewed for it as a "mummy man." In the September 16, 1966 edition of The New Republic, the patient wrote a letter to the editor refuting Yablonsky's description, indicating that he was normal and working. This was the first known attack in print in which proponents of abstinence oriented therapeutic communities portrayed a negative, biased image of patients on methadone.

A major attack was launched by Edward Jay Epstein in the 1970s in his book, Agency of Fear, and in an article written for the magazine, The Public Interest (Epstein, 1975). Epstein attacked the central metabolic hypothesis of Dole and Nyswander's work, their initial reports and the effectiveness of methadone maintenance treatment. Epstein never contacted Dole for information in preparing either his book or article. For the rejection of the metabolic basis of addiction and effective methadone dose, Epstein relied on the opinions of a Stanford University professor, Avram Goldstein, who subsequently entered neurological research in the addictions after Dole predicted the existence of opiate receptors. Goldstein organized methadone programs in California, was the codiscoverer of a group of opioid peptides known as the dynorphins and subsequently shared a Lasker Medical Award. Today, Goldstein does not reject the idea of a metabolic basis of an opiate addiction and has indicated that considering the advances in neurological research there is a strong basis for the Dole-Nyswander hypothesis (Goldstein, 1994). While Goldstein initially felt that

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methadone dose was "irrelevant," he has subsequently changed his mind and believes in higher rather than lower doses and that patients should receive adequate doses of methadone.

Epstein also relied on the work of Drs. Irving Lukoff and Paula Kleinman of the Columbia University School of Social Work for the evaluation of methadone treatment. Lukoff and Kleinman evaluated a program that was created by administrators of the VERA Institute of Justice and funded through the National Institute on Drug Abuse (NIDA). The program, the Addiction Research and Treatment Corporation (ARTC) services the black community in central Brooklyn and conducts clinical research. The VERA Institute of Justice developed a poor and dangerous research design concerning dose. Initially, low inadequate doses of methadone were prescribed to a poor addicted black population. At the time the ARTC program was designed by the VERA Institute of Justice, high doses (e.g., over 80 mg/day) were already known to be more effective than lower doses in the treatment of heroin addiction. Despite the protests by Dr. Dole and others to the head of the proposed board of ARTC, former Attorney General Katzenback, the program was implemented with this questionable design. The initial low dosing schedule with a cap of 40 to 50 mgs/day did what was predicted - high rates of heroin use among patients and high drop out rates. Over the years, ARTC was cited by the New York State Drug Abuse Control Commission because of the number of patients using heroin who were prescribed low doses of methadone. It was during this period of low and ineffective doses that Lukoff and Kleinman did their evaluation, found minimum effectiveness, and dubbed methadone treatment a modest hope (Kleinman and Lukoff, 1975; Kleinman, Lukoff and Kail, 1975). Unfortunately, this publication has been used throughout the years to demonstrate that methadone is ineffective (See Appendix, United We Win).

After the initial evaluation which showed poor results, ARTC was audited regarding its dose policy by the New York State Drug Addiction Control Commission (DACC). When confronted, ARTC modified its policies and began to prescribe adequate doses of methadone and has openly admitted the error of prescribing low inadequate doses as recommended by the misguided research protocols of the VERA Institute of Justice (Primm, 1995; Scro, 1994). Scro advised this researcher that OASAS then known as DACC (the Drug Abuse Control Commission) examined the urine results and the doses that were prescribed to patients at ARTC. When it was found that the doses were inadequate, a meeting was held with the administration of

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ARTC and a change of policy was subsequently enacted. Dr. B. Primm (1995) of ARTC was also interviewed and admits that the policy when ARTC was opened was wrong and that patients now receive adequate doses of methadone. However he indicated that in 1995 patients come into treatment with major medical problems such as AIDS, alcoholism and cocaine/crack addiction. In addition there are serious social problems related to unemployment and homelessness.

Unfortunately Epstein (1975) regarded the expansion of methadone treatment simply as a means for controlling crime. During the time of expansion of methadone treatment, the jails of the inner cities were filled with heroin addicted men and women. Also, there were serious public health issues related to heroin addiction such as:

1. The leading cause of death in New York City among young persons 15 to 35 was related to the use of heroin.

2. A drug related hepatitis epidemic was in progress; the virus was transmitted by heroin addicts through the sharing of contaminated needles.

The issues of a serious public health crisis and criminal activity related to heroin addiction, and the potential for methadone to address them were totally omitted by Epstein in his attacks. Also, Epstein believed the reports about excessive "methadone related deaths" from medical examiners without questioning the validity of their conclusions or the contexts of the reports. Methadone findings on autopsy were considered as the cause of death irrespective of factors such as trauma, accidents and the presence of other toxic drugs.

The validity of "methadone deaths" is similar to the report from Harris County that was used on the February 21, 1993 "60 Minutes" television program. Methadone when used correctly within a clinical situation is nontoxic. Untreated street addicts may die from the various combinations of drugs they either ingest or inject but methadone mentions on autopsy may not be relevant as a cause of death. Contrary to what Epstein reported in his book about methadone, the following was reported in New York City during

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the years 1971 through 1973 when approximately 19,900 patients were enrolled in treatment:

1. Drug arrests decreased by about 24,900 arrests or a decrease of 1251 arrests per 1,000 admissions to methadone maintenance treatment (Joseph, 1988).

2. Property crime complaints decreased by 77,000 or a decrease of 3,869 complaints per 1,000 admissions to methadone maintenance treatment (Joseph, 1988).

3. Serum hepatitis cases transmitted by contaminated needles decreased by about 1,500 cases or a decrease of 75 cases per 1,000 admissions to methadone maintenance treatment (Joseph, 1988).

4. Drug dependent deaths decreased by 324 deaths or a decrease of 16 deaths per 1,000 admissions to methadone maintenance treatment (Community Treatment Foundation and The Rockefeller University, 1974; New York City Department of Health, 1974).

By four important measurements, methadone maintenance was effective in New York City when about 19,9000 patients were admitted over a three year period. There were pronounced reductions in drug arrests, civilian complaints about property crimes, decreases in serum hepatitis cases and drug dependent deaths. The major impact of methadone maintenance on public health and crime in the period 1971-1973 may be criticized as an anomaly unique to New York City at the particular point in time and unrelated to methadone. However, the same phenomenon related to reduction in crime was noted in the city of Hong Kong at a different point in time. In 1976 about 8,000 addicts were treated with methadone and an 85% decrease in drug related incarcerations were reported over a four year period – a decrease of 287 incarcerations per 1,000 admissions to methadone treatment. Methadone maintenance was the only treatment for heroin addiction that could produce such dramatic results in public health and crime reduction. Dr. Jerome

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Jaffe, a former White House official (1971) was interviewed by this writer. Jaffe recognized that methadone maintenance was the only treatment that could be expanded to achieve massive reductions in addict related crime, the transmission of addict related disease and the reduction in addict related deaths. He therefore recommended the expansion of methadone treatment. Epstein ascribed Machiavellian motivations to Jaffe's recommendations. Epstein's contribution was to create a climate of confusion and misinformation about methadone, thereby adding to the stigma of both the program and the patients and a subsequent reduction in support for the only addiction treatment program capable of producing meaningful results on a public health scale.

The attacks on the integrity of Dole and Nyswander remain to this day in spite of the advances in neuroscience thereby casting a shroud of doubt on their theoretical conceptualizations as well as the effectiveness of the program. An example of this may be found in a current college textbook entitled Drug Abuse, An Introduction by Howard Abadinsky (1989). Although Dr. Abadinsky supports the concept of methadone maintenance, his descriptions of Dole and Nyswander's concepts trivialize their initial careful research. For example, he writes that:

> "Dole and Nyswander (1966) intimated that they had discovered the "magic bullet:" methadone blocked the effects of heroin."

Dole and Nyswander never stated or intimated that they had discovered a magic bullet for addiction and both knew that antagonist drugs also blocked the effects of heroin. On a more serious level their integrity as researchers is questioned:

> "The figures given out by Dole and Nyswander were deceptive: the rate of "cure" attributed to methadone was better explained by the screening mechanism used - older and more motivated addicts were preferred - and the fact that unsuccessful cases were simply dropped from the program and the final tabulations."

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The initial criteria for the program in its first phase of research targeted a group of heroin addicts without complicating conditions. The reason for this was that methadone maintenance as a treatment for heroin addiction was in the development stage and other serious conditions (e.g., alcoholism, barbiturate abuse and mental illness) would complicate the outcomes. A clear demonstration concerning the effectiveness of methadone maintenance for heroin addiction was needed before admitting patients with serious co-morbidity. The premature admittance to a research protocol of subjects with complicating co-morbidity would vitiate the results and cloud the findings about either the effectiveness or ineffectiveness of methadone treatment.

The first group of patients was restricted to heroin addicts without serous co-morbidity, between the ages of 20 and 40. Heroin addicts comprising this group entered methadone treatment with an average of 12.5 year histories of addiction; multiple arrests, convictions and incarcerations; several attempts at withdrawal including admissions to the U.S. Public Health Hospital in Lexington. Once methadone maintenance proved its efficacy in reducing heroin use with this initial group of heroin addicts, applicants with histories of polydrug abuse and alcoholism were admitted as well as pregnant addicts and addicts with serious mental problems. Also, the upper age limit was removed and the lower age limit was reduced to 18. However, programs were not funded to treat all of the patient's social, medical and personal problems. For example, addicts with the dual problems of alcoholism and heroin addiction were admitted. The methadone program attempted to treat both conditions but an effective medication for the long term treatment of alcoholism has as yet to be developed. Furthermore, 12 step programs such as Alcoholics Anonymous refused to accept methadone patients as full participants in their meetings. Therefore, many of the health problems that methadone patients evinced and the subsequent deaths in methadone treatment were caused by chronic alcoholism developed prior to admission to the program (Joseph and Appel, 1985).

Abadinsky questions the use of the term narcotic blockade to describe the effect of methadone in blocking the euphoria of heroin and other opiates. He indicates that there is no blockade effect but only cross tolerance. This is reported in the text as follows, again implying that Dole and Nyswander are deceptive:

"Eventually, the bad news came out. Methadone was not the "magic

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> bullet." Indeed there was no blockade but simply cross tolerance. .... In fact it was discovered that methadone patients, even those taking high daily doses, were often abusing heroin as well as other drugs. And, while methadone maintenance was designed for heroin addicts, the problem was often one of polydrug use."

Dole described the creation of the blockade effect by the induction of tolerance in major articles including the seminal, "Narcotic Blockade" in 1966. At high doses of methadone, the euphoric effects of heroin are blocked if the patient self administers heroin. The term, narcotic blockade, describes perfectly the effect that the patient experiences. Cross tolerance is implicit in the elementary definition of any narcotic drug, namely cross tolerance to morphine. Dole who is one of the foremost narcotic pharmacologists in the world is fully aware of this phenomenon. In this instance Abadinsky has unknowingly overstepped his expertise. Also, from the beginning of the program, polydrug abuse, especially alcoholism, was recognized as a major problem and was noted as such. More recently in the late 1980s and early 1990s the problem of cocaine/crack addiction has created many serious problems for patients and the program. With the emergence of the cocaine/crack epidemic, patients who injected cocaine would combine the cocaine with heroin. This combination known as "speedballing" was reported for patients at all doses. However, for patients receiving high maintenance doses (e.g., over 70 mg/day) the practice of "speedballing" and use of heroin was significantly less when compared to patients maintained on lower doses (Hartel, 1994). Recent advances in the technology of measuring blood levels of methadone have shown that there is a group of patients who metabolize methadone rapidly and may need extremely high doses to feel correctly stabilized without the occurrence of withdrawal symptoms. Also, as of 1994 there were no long term successful chemotherapeutic interventions for alcohol, cocaine/crack or nicotine addiction that are comparable to the efficacy of methadone for opiate addiction. Talk therapies for polydrug use have had limited success but nevertheless have been employed in some methadone programs with very modest gains.

Alcohol treatment programs and Narcotics Anonymous (NA) discriminate against methadone patients. Methadone patients are either refused treatment in alcohol treatment facilities or told they must

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detox before they can be considered. For example, in 1994 the homeless shelter for men on East 3rd Street in Manhattan refused to medically withdraw alcoholic methadone patients from alcohol. NA considers methadone a "drug" and methadone patients are not allowed to participate (share) in 12 step groups.

Newspaper Articles

Newspaper articles attacking methadone appear periodically in daily newspapers and neighborhood publications. There are many examples of newspaper articles and in actuality the majority present only the negative side of methadone treatment, or in order to appear "fairminded" present a basically negative article with comments that some persons are helped by the program.

The Village Voice has published two major articles that attacked the concept of methadone maintenance. Although purporting to attack unscrupulous physicians, the articles presented a stand against the concept of maintenance and again equated primary deviance (heroin addiction) with methadone treatment. The first of these articles published on November 24, 1975 by Douglas Garr entitled, "How MD's Gross Methadone Millions." Although rightfully exposing unscrupulous physicians, the article distorts methadone as "synthetic junk." Methadone is therefore presented as another drug of abuse akin to heroin but even worse as a synthetic as opposed to a "natural opiate." Here Garr demonstrates his ignorance of pharmacology because heroin is a semisynthetic opiate which in the opinion of the reporter is probably better than methadone. Again, this concept further stigmatizes patients by vitiating the qualities of methadone that make it such an effective medication. The second article was published on April 5, 1988 by The Village Voice as a cover article entitled, "Hooked: The Madness in Methadone Maintenance" by Jim Landless. The article described methadone patients as methadonians, a demeaning term for compliant and productive patients. The article includes isolated statistical information with questionable interpretations. Methadone is described as giving patients a "buzz." This is refuted by scientific evidence and probably refers to patients who are abusing alcohol, cocaine or benzodiazepines since correctly stabilized patients report feeling normal on their stabilized doses. The article not only tries to debunk the program medically and politically but adds by its negative posture and sensationalism to the stigma and shame that compliant functioning patients experience as methadone patients.

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Our Town, a Manhattan weekly, in the September 23, 1993 edition highlighted the loitering problems created by unemployed methadone patients with serious mental disturbances and polydrug use problems. The story entitled "The Methadonians," by Justin Brown, featured a homeless, physically and mentally ill, unemployed, Vietnam veteran who was alleged to be a patient. While highlighting serious problems among patients, the news media wrongly blames the methadone programs for the lack of extensive community social services to help this visible and dysfunctional population. Employed patients feel stigmatized by the visibility of the loitering, unemployed, mentally ill, homeless patients. Working patients usually report early in the morning or late in the afternoon for their medication on their way to or from jobs. However, the picture on the front page of Our Town showing a dysfunctional mentally unstable patient (primary deviancy is accentuated) creates an illusion that surrounds the programs and adds to the stigmatization and marginalization of functional patients. The publicity and stories lessens the distance between primary and tertiary deviance. Hence both groups (the primary and tertiary deviants) are highly stigmatized.

On January 4,1995, Newsday published a "Profile of Patrick Perri," a policeman on the beat in the South Bronx (McKenna, 1995). The policeman described methadone patients in the most negative terms - methadonians, unemployed, dishevelled, loiterers, urinators on the streets, drug users and dealers. The newspaper did not temper its story with images of methadone patients who were employed, supported their families and were responsible with their medications. Furthermore, the policeman did not describe how he was able to identify untreated addicts from methadone patients.

Documentaries and Television

The documentary, Methadone: An American Way of Dealing, was produced in the early 1970s by the socially conscious film producers, Julia Reichert and James Klein. The film was shown in art film series at the Whitney Museum and the Museum of Modern Art, in movie theaters and on public television across the country. It was photographed at a program called BUDA in Dayton, Ohio in a style called cinema verité. The film discredited methadone treatment placing the treatment within locus of the primary deviancy of heroin addiction and substance abuse. The picture, therefore, became a source of great stigma for patients who were doing well in treatment. The following is a summary of this writer's contacts and

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correspondence with officials in the state of Ohio, the newly appointed director of the program, one of the patients who participated in the film and groups of patients who protested.[4]

The state hired an individual from New York City who made false claims about his experiences with methadone treatment. The program was clinically and financially mismanaged and this person was fired. During his tenure he invited the producers into the clinic to shoot this documentary without the permission of state authorities. However, there were many problems with the program because of poor management. Nevertheless, several patients did benefit from the medication and unfortunately cooperated with the producers of the documentary. The result was a distorted picture of methadone maintenance. As an example of the tactics employed, one successful patient invited the producer into his home. He was told to lie down on his living room couch and was interviewed in a reclining position. This position gave the audience the impression that the patient was sedated from the methadone. Furthermore, in a verbal agreement with the producers, according to the patients, the film was not to be shown in Dayton to preserve their confidentiality. The film was shown in Dayton, thus breaking the agreements and promises of confidentiality, which caused serious problems for patients who participated in it. When the producers were confronted with this breach of confidentiality, they did nothing and the distribution of the film was continued. In New York City, methadone patients attended the showings at the Higher Ground Cinema (a movie theater), the Whitney and Modern Museums to present their side of the methadone story. Authorities at the museum were contacted by the Chief of the Ohio Bureau of Drug Abuse requesting that they discontinue showings because of the distortions that were presented (Zwissler, 1975) (See Appendix for letter). A group in New York City called the Committee of Concerned Methadone Patients and Friends (CCMP) mounted protests at the Whitney Museum and the Higher Ground Cinema where the film was shown (Carlo, 1975). Success-

4. The following three individuals were contacted in 1975 about this documentary: Dr. Mel Zwissler, Chief, Bureau of Drug Abuse, Dayton Ohio; Mr. Edward Lampton, Director of BUDA Methadone Program; Mr. Fred Stroud, a former patient at BUDA who was in the film, Methadone: An American Way of Dealing. (See Appendix for letters and articles).

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ful patients distributed literature about the background of the film and talked with movie goers to demonstrate that the film portrayed a false and prejudicial image of methadone treatment and especially harmed patients (See Appendix). The film was shown and distributed nationwide despite the protest from patients, officials and programs.

The following is an excerpt from a letter by a former patient in the BUDA clinic to the State of New Jersey Division of Narcotic and Drug Abuse Control requesting that the film not be shown in New Jersey. The patient was medically withdrawn from methadone and appeared to be doing well (Stroud, 1975):

> "I can testify that methadone was a successful factor in my rehabilitation from the drug culture. Prior to my admission to the Dayton clinic, all other attempts to become drug-free had failed. An agreement was made with the film makers that the film would never be shown in the Dayton, Ohio area. I personally have witnessed the screening of the film in this area on two different occasions. This film reflects a negative image of methadone clinics in general, and the Dayton Ohio clinic in particular, and it should not be used to demonstrate the quality and effectiveness of these programs. This film has proven to be extremely detrimental to my image in the community and to my progress and survival and has caused me a great deal of mental anguish" (See Appendix).

The nationally televised news program, "60 Minutes," aired a program on February 21, 1993 about unregulated and privatized methadone clinics in Harris County, Texas. Physicians were operating programs without proper services, patients were selling the medication and a woman claimed that her two sons died as a result of methadone overdoses. A transcript of the television show (60 Minutes, 1993) and an internal unpublished report (Barrett, Luk, Parrish and Jones, 1993) concerning drug related deaths in Harris County, Texas prepared for the Center for Disease Control (CDC) in Atlanta were obtained for this study.

A review of 91 deaths by the CDC where methadone was located upon autopsy in Harris County,

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Texas showed that 85% of the deaths were due to polydrug use and other substances in addition to the methadone. Furthermore, about 80% of the decedents were not even enrolled in methadone treatment in Harris County, the enrollment status of the remaining decedents could not be verified with certainty and low amounts of methadone were found upon autopsy in many of the cases. In other words, the overwhelming majority of deaths occurred within a population of addicts with serious polydrug problems, including valium, cocaine and alcohol and who were not enrolled in treatment programs in Harris County. Other causes of death among this group of untreated addicts included trauma, AIDS and natural causes. "Methadone mentions" at autopsy as determined by the medical examiner's office have remained constant from 1987 to 1992. However, polydrug toxicity increased in 1990 and 1991. On the national scene, "methadone mentions" in autopsy reports did not increase during the period 1980 through 1991, but "heroin mentions" in the same period increased by 193%. This report was completed by the CDC (Barrett, Luk, Parrish and Jones, 1993). However, "60 Minutes" did not mention the CDC report on the examination of deaths in Harris County or the substantial increases nationwide for "heroin mentions" or "polydrug mentions" in autopsy reports.

A former patient claimed that methadone "left him with nerve damage and nervous tics." In the "60 Minutes" report he displayed a special hatred for the clinics, which he claims "enslaved him." There is no medical evidence that methadone causes nerve damage or nervous tics. However, studies showing that patients maintained on methadone for up to 30 years show no toxic effects from the medication were not mentioned on the programs. "60 Minutes" neglected to inform audiences of the results of long range medical studies that show methadone maintenance is a safe procedure. The former patient also allowed the producers of the show to hide a camera in a fake arm cast in order to film in the clinic without the knowledge of staff or patients. The former patient was attempting to show that "anyone" could enroll in the program, but the effect was unfortunately to breach the confidentiality of the patients shown. Patients shown on the program without their permission have initiated a class action lawsuit against the producers of the segment, "60 Minutes" and CBS.

The "60 Minutes" program was poorly researched and inferred the most injurious stereotypes about methadone patients, programs and the medication itself, emphasizing that it was "developed by Nazi Germany." Methadone was described as "more addictive than heroin" and doses were referred to as a "daily fix."

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The history and philosophy of methadone programs were distorted. The problems presented on the television show, however, reflected indifference by the state to properly regulate programs and discipline physicians who inappropriately prescribe methadone and mismanage programs. Texas has privatized all methadone treatment, and unscrupulous physicians have opened programs without adequate regulation. The methadone program shown on television was mismanaged, subsequently closed and the patients were transferred to other more reputable programs. Although employed patients who had benefited from the program were interviewed indicating that methadone helped them stabilize their lives. The general attitude towards methadone treatment portrayed by the producers added to the stigma and could be summed up in the following final statement of the telecast:

> "The one thing methadone does achieve? It hides the unsightly problem of addiction from public view. They made it (addiction) legal and declared victory."

The statement incorporates a basic premise of the concept of tertiary deviance as defined by Miller (1974):

> "Tertiary deviance implies that societal legitimization of the new behavior patterns is incomplete. ... Moreover, the stigmatization of tertiary deviance solutions (such as methadone maintenance) indicates that the original ideological debate over the primary deviation (heroin addiction) has not been resolved. ...the ideological debate will continue and ... the tertiary solution will remain under assault by interested moral entrepreneurs."

Methadone patients, therefore are portrayed nationwide as "hidden addicts" and thus the stigmatization of the tertiary deviancy is transformed into the stigmatization reserved for the primary deviant. Moreover, in this program, the distance between primary and tertiary deviance was reduced. Methadone patients were portrayed as unreliable and devious, akin to heroin addicts rather than productive and responsible methadone patients.

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NAMA protested to the producers of the show and many individual patients called the station. One of the patients who called and was interviewed for this study stated that she was treated coldly and with indifference. She could not discuss the issues with one of the assistant producers and the producers refused to return her calls for further discussion. Another of the patients interviewed for this study, a professional musician, saw the show; his reaction was one of anger indicating, "I wanted to smash the television set." And to this date NAMA still receives letters from methadone patients across the country commenting with disdain about the segment.

Therapeutic Communities

No stronger criticisms of methadone maintenance have been voiced than those by adherents to a drug-free, abstinent oriented philosophy. Directors of abstinent oriented programs attacked methadone for two reasons 1) competition for funding, and 2) a series of ideological concerns most of which were based on a simplistic understanding of the pharmacology of methadone and ignorance on the biological aspects of addiction. Leaders of therapeutic communities may be considered in Miller's conception of tertiary deviance as moral absolutists or moral entrepreneurs. More than any other group, they have transferred the stigma from heroin addiction to methadone maintenance. While methadone is seen in Miller's conception as a tertiary deviance, the adherents of drug-free programs regard methadone as problematic as the use of heroin. Therefore it has become aligned with the primary deviance of heroin use not the tertiary deviance of Miller's conceptualization. Howe (1973) expresses this relationship based on a fundamental misunderstanding of the pharmacokinetics of methadone maintenance as follows: "Since methadone is a substitute for the pleasure of indulgence in heroin, its use must be equally wrong ..." The concept of "pleasure of indulgence" implies that in the United States there is a boundary of acceptable pleasure and that the euphoriant effects of opiates are considered a vice, not a legitimate pleasure, to be condemned and considered outside of acceptable bounds. Simrell (1970) sums up this attitude which existed in the 19th century:

> "The problem (narcotic abuse) had elements of ordinary vice; that is socially disapproved form of pleasure. ... As a vice, narcotic abuse was

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> largely identified with opium smoking and opium dens alien to American concepts of legitimate pleasure."

Therefore, the support for the drug free approach and therapeutic communities from the moral entrepreneurs is rooted in American social and cultural history. Nelkin (1973: 150) also expresses this phenomenon concerning American attitudes towards drug abuse within the 20th century:

> "...rooted in a tradition that placed great value on abstinence, will power, postponement of gratification, and self control, as well as a strong moral taboo against any drugs that alter moods or weaken individual self-mastery."

Methadone as prescribed in maintenance therapy does not alter mood or weaken self mastery. On the contrary, the patients in this study were able to achieve impressive goals while maintained on methadone. The refusal of moral absolutists to recognize this or to take the effort to understand the pharmacokinetics of methadone maintenance raises doubts about their sincerity for rehabilitation of large numbers of heroin addicts. A more realistic concern would be competition for funds and a diminution of their power if methadone should prove to be successful. Therapeutic communities were never able to demonstrate a large percentage of "cures." However, a few graduates, estimated at less than 10 percent of the admissions, were able to live without relapsing to opiates. Many graduates became staff members of the therapeutic communities thus reinforcing their abstinence. DeLeon (1984) in a study of 7 therapeutic communities showed annual retention rates of 9 to 15% for all admissions.

Some of the criticisms of methadone treatment included statements by directors of therapeutic communities such as Dr. Judianne Densen-Gerber, founder of Odyssey House who indicated that "Methadone is a Lie" (Markam, 1973) and a statement published by Lennard, Epstein and Rosenthal (1972), "Methadone permits the illusion of a solution."[4] These statements add to the stigmatization of the program, the providers and ultimately to the patients themselves. Again the tertiary deviance that Miller (1974) ascribes to methadone treatment actually becomes with these statements closer to the primary deviance of heroin

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addiction in the minds of the drug free moral entrepreneurs. Miller (1974) sums up the drug free criticisms of methadone maintenance treatment as follows. Answers to these criticisms will be given after each criticism is stated:

1. "Maintenance treats the symptoms of addiction, not the underlying social-psychological disturbances involved."

   Answer: Methadone maintenance is medical replacement therapy for a deranged physiology created by use of heroin. The current neuroscience investigations have uncovered a complicated endogenous opioid system that is currently being investigated for its role in a continued opiate addiction. Methadone maintenance does not preclude the identification and resolution of underlying social-psychological disturbances that contribute to an addiction. Both the medical and social aspects of addiction can be addressed while patients are maintained on methadone.

2. "A legal addiction is an unacceptable substitute for a illegal addiction."

   Answer: Methadone as prescribed in maintenance therapy acts as a normalizer rather than a narcotic. It is orally effective and does not produce mood swings, tranquilization or narcotic effects. The patient is able to function in every physical, emotional and intellectual capacity without impairment. Methadone patients can obtain college educations, perform all types of intellectual and

4. Dr. Mitchell Rosenthal is the director of Phoenix House, one the largest therapeutic communities in the United States.

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physical skills, marry and raise families. Methadone does produce dependency as do other medications prescribed in medicine. For many addicts the alternative to methadone maintenance is continued illicit use of heroin, criminal behavior, jail and premature deaths.

3. "The methadone illusion encourages the nation to presume that human problems can be solved by chemical means."

Answer: Methadone maintenance addresses only the physical derangement that is produced within a newly discovered endogenous opioid receptor ligand system. Methadone is not a curative procedure, it is corrective for the time that the patient is prescribed the medication. The human problems that lead to addiction in society must be solved by human means (e.g., prevention programs, solution of poverty, racism and availability of drugs). Methadone maintenance does not preclude addressing the social and human problems that lead to addiction. Methadone maintenance addresses only the medical condition caused by abuse of heroin.

4. "Methadone diversion will create a series of street addicts whose primary addiction is to methadone."

Answer: Studies over the past 30 years have shown that diverted methadone is primarily used for self medication by untreated addicts. A large group of primary methadone street addicts has not emerged (Galea, 1994).

5. "Premature methadone will transform individuals on the margins of addiction career into a permanent addictive dependence."

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> Answer: The program has set up criteria for admission to prevent persons without demonstrated evidence of physical dependence on opiates from entering. Also, there is evidence that a small number of patients - perhaps 10% -- can live comfortably without relapse after withdrawing from methadone. Ability to live without relapse after an episode of methadone treatment may be related to the duration of heroin addiction.

The type of brainwashing and anti-methadone propaganda that is encouraged by the therapeutic communities reveals a fear of losing the competition for funding and political support. Three patients in this study spent at least one year in different therapeutic communities. Two of the three were graduates. They related that they were consistently brainwashed against methadone. One medical maintenance patient, employed by a state government agency, has been on methadone for about 15 years. He is considered an effective, trusted employee who has worked in ethnographic street research and currently is responsible for overseeing budgets. He is prescribed 100 mg/day of methadone, states that he feels normal and does not experience sedation or mood altering effects from the medication. He related the following about his experiences in a therapeutic community:

> "Before entering methadone, I was twice in a therapeutic community, once for two months and the other time I graduated after 18 months of treatment. While in the therapeutic community I was a model resident and soon became a leader and spokesman. We were told that methadone did not work and referred to patients as methadone mummies. When visitors came - politicians, people from Washington, the county - we told them how great our program was. But we always worked methadone into the conversation and told them that methadone did not work. By the time the visit was over they were supporters of our program and against the methadone program. I knew about the relapse

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> rate from the therapeutic community - that it was very high, but we never discussed it. A lot of my friends who were in the therapeutic community are now dead.
>
> I relapsed after leaving and then applied for methadone treatment. At first my parents were against the methadone program. My mother belonged to a parent's group that was affiliated with the therapeutic community. She was told not to let me in the house if I went on methadone. However, she has since seen how the program has helped both me and my wife. Both of my parents are now behind the methadone program. In fact, my father says I should have gotten in sooner. My mother now defends the program and gets upset if anyone says anything against methadone."

Another patient related the following:

> " I don't know what therapeutic communities are like today but when I was a resident it was horrible. They took everything away from you, your family could not visit and they put you on the lowest scale. I must have stayed for about a year. Methadone was considered a no-no – just another drug, the same as shooting dope."

After the patient left the therapeutic community she relapsed to opiate use and entered the methadone program.

Another patient who was a graduate of a famous therapeutic community relapsed within a year of his graduation and then entered methadone treatment. While in the therapeutic community he stated that he was subjected to anti-methadone propaganda.

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> "We were told methadone doesn't work. That it's a crutch another drug. However, after I graduated and relapsed I got on a methadone program and within two weeks I was working. I returned to the therapeutic community for a reunion and when I told them I was in a methadone program they told me they didn't want me in their buildings. To this day they still have the same attitude. I have a friend that works for them. When I see him he always asks me when am I getting off the stuff."

Methadone is not dignified as a medication but rather referred to as "stuff" which in itself stigmatizes the procedure and the patients. In summation, therapeutic communities in the course of their operations launched a covert attack against methadone maintenance treatment by relaying misinformation about methadone to residents and visitors including politicians. Twelve step programs are also ideologically against methadone treatment. NAMA reports that these groups, and especially NA have consistently discriminated against methadone patients since methadone maintenance is incorrectly perceived as a mood altering procedure. To avoid stigmatization and discrimination directed against them if they should want to participate in a NA or 12 step group, methadone patients have in recent years developed their own self help programs.

Within the past decade programs were developed that combine methadone treatment with drug free residential therapy and counseling. An example is the Short Stay Residence that was developed in 1983 by the Lower East Side Service Center. Methadone patients are referred by their respective programs and remain in the residence for 3 to 6 months. Residents are maintained on methadone and returned to their programs of origin after their problems are resolved.

Stigmatization by the Community

Communities at large have rejected methadone maintenance programs as well as other forms of drug treatment. The NIMBY (not in my backyard) syndrome has successfully prevented the expansion of methadone treatment in the last fifteen years notwithstanding the AIDS and tuberculosis epidemics for which methadone treatment has proven to be a highly effective prevention measure. There are countless examples

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of community resistance to the establishment of methadone treatment. The Director of Community Relations of OASAS is of the opinion that the bias against methadone treatment is widespread and it is extremely difficult to open programs because of community resistance (McGill, 1995). The following two examples demonstrate the type of resistance that is mounted by communities when faced with the opening of methadone programs. Again, methadone patients are perceived to be no different than heroin addicts. Although most of the patients treated in local community programs are residents of these communities. Communities themselves deny that the problem of addiction exists. There is no relationship in the communities perception that methadone may reduce overall crime in the neighborhood and lessen the transmission of HIV.

Example 1

In 1992, a methadone clinic operated without incident by Beth Israel Medical Center at 113th Street and Broadway for over 20 years moved three blocks to another location within the community. This is the only methadone clinic on the Upper West Side of Manhattan. The local community board mounted a sizeable attack on the move claiming that the methadone clinic was a failure and not needed. They further alleged that the community was being saturated with social service programs (e.g., programs for unmarried mothers, the mentally ill and the homeless). The methadone clinic did not have to obtain new approval for this move since it was an established, approved and licensed program. At the 113th Street location the program was in fact so well administered so effectively that few in the community were even aware of its existence. At the 110th street location the hospital promised increased security arrangements to placate any fears within the neighborhood. Nevertheless, the community was not satisfied and attempted to stop the move and if possible, close the facility. Demonstrations were organized, meetings were held and a newsletter entitled, United We Win, was printed and distributed within the neighborhood (See Appendix). The headline news story was entitled, "Too Many Methadone Clinics = Genocide?" (Profumo, 1992). The article stressed the need for therapeutic communities in the neighborhood rather than methadone clinics. The article was authored by a white male social worker who claims to have treated dysfunctional methadone patients. The author concludes his article as follows stating that methadone is used "in a way frighteningly similar to the way we used alcohol to repress and control Native People (Native Americans). In fact,

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methadone reminds me of the small pox infected blankets that European colonists distributed to Native People in 1763. In this context as a member of the Upper West Side Jewish community faced with the prospect of yet another methadone clinic, I feel like saying "Never again!" We must speak up loud and clear against the abusive way in which methadone continues to undermine rather than empower communities of color."

In this excerpt the author summarizes a view of methadone that incorporates mythologies of death and colonization. The overblown analogies offer an insight into a conspiratorial political framework that misleads poor sick untreated addicts and at the same time feeds into reactionary forces within the community that reject social service programs in their neighborhoods. NAMA indicates that methadone patients including members of their organization showed up at community meetings, and one of the patients was booed when he tried to speak. NAMA also indicated that newsletters and articles such as the one distributed by this neighborhood were highly stigmatizing to methadone patients and that members of the community did not disguise their contempt for the program or the patients. According to Bayer (1978), the press has so miseducated the community that opening new clinics has proven to be a Herculean task.

The clinic opened, offering the community increased paid security arrangements in the neighborhood. However, the matter became a political issue and the majority of the politicians, with the exception of one brave assemblyman, have backed the community.

Example 2

The second example involves a hospital's attempt to open an additional methadone clinic in a white working class community. The clinic would serve 300 addicts from the community. Already two clinics are operating, serving a total of 770 methadone patients. The hospital operates one 400 unit clinic which is open six days a week from 6:00 AM to 7 PM. However, with the addicted population in this working class community growing, an additional clinic is needed. Heroin addicts who want to enter methadone treatment have to travel to different boroughs. The existing clinic operated by the hospital appears to be well administered and has had little or no negative impact on the community. Nevertheless, in a community meeting covered by the local newspaper, The Staten Island Advance on January 13, 1995, the community refused to believe the hospital administration about the effectiveness of methadone or that the existing

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clinic is well administered (Pagan). The community mounted a strategy of resistance to the clinic. They claimed to be saturated with social services and enlisted the support of elected officials and the local newspapers. Meetings were held, committees were organized and demonstrations planned. In the process the negative reactions to methadone, the program and the patients were expressed by the residents and covered by local newspapers. Despite the reassurances of the hospital and the experience of the hospital operating a well administered program, the community board voted unanimously against the establishment of the clinic. The objections of the community could be summarized as follows: perception of increased loitering by patients, although the hospital indicated that this problem would be monitored and patients who were guilty of this infraction would be discharged. The residents also expressed fear of increased crime, harassment of their children and a decrease in property values. None of these problems transpired with the existing clinic operated by the hospital. In these objections the primary and secondary deviance of heroin addiction are invoked against methadone maintenance. Methadone maintenance is not perceived as treatment capable of changing the lives of heroin addicts but as a legal opiate addiction no different than the illegal addiction of heroin. The local newspaper, The Staten Island Advance on January 13, 1995, reported that the woman who agreed to chair the committee against the establishment of the clinic was herself a diabetic and took offense to the statement that "methadone treats people addicted to opium just as insulin treats diabetics." She indicated that she witnessed fights by patients trying to sell their take home doses. The hospital spokesman indicated that it would dispatch staff to the scene where altercations occur. In this instance, a patient with a relatively unstigmatized metabolic illness (diabetes) distanced herself from patients with a highly stigmatized metabolic illness. The perceived deviant behavior of the methadone patients defined the origin of their illness not the derangement of metabolic processes such as in diabetes. A chiropractor in the community voiced his opposition by stating that he is "against a methadone clinic anywhere especially at my expense." The editorial in the newspaper supported the community with following statements about methadone:

> "Methadone treatment is a controversial and still suspect method of treating addiction, although it has been around for a long time. Clients are

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> still addicted to a drug, methadone. ...they tend to congregate outside methadone clinics as people with a common concern and occasion to meet each other daily will.
>
> Those in the drug treatment field, ... , tend to be a little starry-eyed ... about both the efficacy of methadone treatment and the behavior of methadone clients (Editorial, 1995: A16)."

The editorial omits thirty years of worldwide research and plants doubts about the treatment and its effectiveness in the minds of its readers. Advocates for methadone treatment are considered starry eyed and unrealistic. The editorial mentions that methadone patients congregate as others with a "common concern" are wont to do. This also implies the formation of a methadone subculture - a parallel to the criminal heroin subculture which caters to the worst fears and stereotypes that the community harbors about methadone patients. Another deviant group has thus been suggested by the editorial. This would also correspond to the status of tertiary deviance as described by Miller. Thus in this editorial, traits of primary and secondary deviance of the heroin addict are transferred to methadone patients.

John Fusco, a New York City Council member, suggests that an existing correctional facility in the community would be a better site since it would remind the methadone patients that continued use of illegal drugs would result in a jail sentence (Pagan, 1995). This also is indicative of the transfer of the characteristics of the primary and secondary deviance of heroin addiction to methadone treatment and the patients.

Other major political figures were enlisted in the fight against the methadone clinic including the Republican County Leader, the Congresswoman and the Assemblywoman. The director of Methadone Policy and Planning at OASAS indicates that resistance to methadone programs can be seen in practically every community. Addiction is not regarded as a disease to be treated medically and methadone is looked upon as just another drug. Also, the community may fear some of the patients because they loiter or may sell a part of their take home medication. Loitering and drug sales are major issues with communities as can be seen in the newspaper articles. However, the patients who loiter and sell are in the minority, perhaps

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twenty to thirty patients in comparison to the usual total of 300 patients per clinic. Because of the stigma against the treatment and the perception of loitering issues, it is difficult to open up needed programs.

In the above examples from two communities common themes emerge. Methadone patients are not wanted in the community. They are considered a stigmatized and criminal group. The complexities are such that the community continues the stigmatization even if patients have the potential to change when enrolled in methadone treatment. As Goffman (1963: 5) stated:

> "By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances."

A well run methadone program improves the quality of life for all in the community but the hatred and fear engendered by stigma effectively blocks rational discussion, compromise and equitable resolutions.

Conclusion

Virulent attacks and commentary by the Bureau of Narcotics on the work of Dole and Nyswander began with the initial research at The Rockefeller University in 1964. The attacks continued unabated over the years in the popular literature and media. Documentaries produced for nationwide television and movie theaters have miseducated the public about methadone maintenance and heroin addiction. The program has been trivialized by academics and social critics in serious journals and books.

The attacks appear to be especially vitriolic since the critics do not take into account the very serious medical and social problems that patients present to under funded methadone programs. Methadone clinics are set up to dispense methadone under highly regulated conditions and not solve the massive social inequities of society including chronic poverty, unemployment and homelessness. There are attempts, however, by clinics to meet these social needs, but in reality methadone clinics are regulated medical clinics with staffs that can only provide a level of service commensurate with funding (Corradi, 1994). Therefore many of the problems that the patients present must be solved by social service agencies within the commu-

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nity that unfortunately also discriminate against methadone patients.

The major result of these attacks which originated from the Bureau of Narcotics and its successor the DEA were continued by the media has been a transfer of stigma from heroin addiction to methadone treatment. Patients who chose methadone treatment are therefore subject to harsh alienation and stigmatization which complicate their lives and can, in the words of Goffman, reduce their life chances.

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VI
The Stigma from the Streets

Street addicts developed their own conceptions of stigma against methadone maintenance. However, the history of street stigma is related to the stigma from the media, government and medicine itself. Each source feeds the other. Interestingly, prior to the establishment of methadone maintenance programs in the 1960s, methadone in the form of dolophine tablets had an excellent reputation among street addicts. Dolophine tablets were widely used by active heroin addicts to self medicate withdrawal symptoms and for extended use or short term maintenance when heroin was not available (e.g., street panics). Dolophines were obtained from physicians who would write prescriptions that were filled by local drug stores in the 1950s and 1960s. A frequent crime committed in the years prior to the establishment of methadone maintenance was the forging of dolophine prescriptions by addicts. Forged prescriptions of dolophine were the first examples of "methadone diversion" which persisted when the programs opened – the sale of methadone diverted from their take home medication by unemployed and dysfunctional patients.

Methadone is the generic name for methadone while dolophine is the trade name that was developed by Eli Lilly to market methadone as an analgesic. The word dolophine is derived from two sources: the Latin word dolor for pain and the second syllable of morphine, a term derived from Morpheus, the Greek god of sleep. Addicts did not attribute destructive side effects to dolophine such as is currently believed about methadone (e.g., rot the bones or teeth). It was a benign drug with the street name "dollies." However, in street mythology, methadone and dolophine are not the same drug. The following quote is from the National Methadone Conference held in Washington in 1994. A methadone patient was voicing fears about long term methadone treatment (Town Hall Meeting, 1994):

> "Long term – methadone is a dangerous drug. It tears the body down. I am a methadone patient but I don't believe in long term treatment.

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> There was another method to treat drug addiction – dolophine, but the government took this pill off the market. It is the best pill they ever had for addiction. Why did the government take this pill off the market?"

Unfortunately the patient was not answered precisely by the physician who responded. The patient was told that dolophine tablets were used in methadone clinics to fine tune stabilization doses of methadone. The patient was not told that methadone and dolophine are the same medication.

However, there is a street ambivalence about dolophine. Since methadone was synthesized in Germany in World War II, street addicts assumed that the drug was named for Adolph Hitler – "adolphine." In street mythology the "a" is simply removed. Dolophine, therefore, is looked upon as a "Nazi Drug" but a benign and helpful "Nazi drug." In a study conducted by the Street Studies Unit of the New York State Office of Alcoholism and Substance Abuse Services (OASAS) in 1993, the perception that methadone is a "Nazi drug" was given as a reason by one of the untreated heroin addicts for not applying for methadone treatment.

The fact that methadone was developed in Nazi Germany is used in street publications directed to the poor and minorities. As indicated in the previous chapter, the origin of methadone is presented in books and on television as a narcotic developed by the Germans in World War II.

The Origins of Street Myths

To determine the origins of street mythology, the officers of NAMA were interviewed. The purpose of NAMA is to educate patients, the public, physicians, social service providers and especially professionals working in the field about methadone maintenance; to assure that patients are treated with dignity and respect by physicians in private practice, clinics, hospitals, and jails; to dispel mythologies about methadone and methadone maintenance; to fight the stigma, biases, prejudices and discrimination that methadone maintenance patients face worldwide in employment, education, health insurance, housing, health care and so forth. The organization also keeps records of problems related to mistreatment, stigma and mythologies worldwide that methadone patients and others report.

NAMA was founded in 1988 and currently has about 8,700 members in 18 chapters in 15 states and

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five international affiliates have been organized in Canada, Australia and Sweden. While most of the members are current and former methadone patients, membership also includes interested health care professionals, researchers and others who are sympathetic to the problems faced by methadone patients. For this study the president, Stanley Novick and the vice president, Joycelyn Woods who is also the editor of the organization's newsletter, The Ombudsman, were interviewed in July of 1994. Novick is a former methadone patient having withdrawn from methadone in good standing after more than ten years of treatment. He advises that he is one of the few former patients who are biologically able to live without medication and that he is an exception not the rule. Woods is an active patient in methadone maintenance for over twenty years, has a master's degree in bio-psychology and has worked at The Rockefeller University in the laboratory of Neil Miller and has been the principle author of one of the first papers on the endogenous opiate receptor system.

Both advised that to understand the street myths, the use of methadone as a medication must be understood. Methadone was introduced as a medication to withdraw heroin addicts in 1961 at the now closed Manhattan General Hospital where Mr. Novick had been a patient. He advised that high doses of methadone were prescribed but could not recall if the administration was oral or intramuscular. However, the amount of pure methadone prescribed for withdrawal caused the patients to experience a certain type of "high." He relayed the following:

> "the "methadone high" is different from the euphoria produced by heroin. Heroin produces a real euphoria (for non-tolerant individuals) while the methadone high is sedated or dull (for non-tolerant individuals). Of course, the heroin high is preferable. As is wont in detoxification wards patients signed out before the withdrawal process was completed if they learned that somebody either had money or a good stash of heroin. After a hospital discharge against medical advice, the patients would begin to experience symptoms of methadone withdrawal which could not be relieved with impure unknown quantities of heroin. Since metha-

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> done is a long acting drug, the withdrawal is longer than heroin but less severe. During methadone withdrawal you experience muscular aches and pain which some of the addicts attributed to "methadone in their bones." However, you must remember we signed out of the hospital early. I also was treated with methadone in Lexington[1] but there were no problems because I stayed to complete the treatment."

The myths, according to Novick and Woods, were exacerbated during the early 1970s with the expansion of the methadone program. Prior to the 1970s dolophine, known as "dollies" were used by heroin addicts without any mythology. As Mr. Novick related:

> "You never heard the myth that dolophine rots the bones, that dolophine is white man's genocide. Dollies did not have a repressive connotation. Drug dealers spread rumors that methadone rots the bones to try to prevent addicts from registering for treatment. When the program opened up in Harlem, there were protests by the community and politicians that methadone is 'white man's genocide.' This charge was in the papers - I believe it was in the Times. Also street addicts began to see "dollies" as something they themselves controlled and methadone treatment as adversarial: clinic regulations, nurses, supervisors, standing in line waiting to be medicated, counselors, urine tests. You had, in other words bureaucracy and power that controlled patients. With street dolophine they had control over the drug and in methadone treatment this control was removed and placed in the hands of the staff that was not trusted."

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1. The US Public Health Hospital in Lexington Kentucky.

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Therefore, with methadone treatment formalized into a highly regulated clinic system the medication was seen in a different or repressive context as opposed to unfettered street use. Mr. Novick related that patients began to believe all types of rumors:

> – Japanese kamikaze pilots during World War II were given methadone to control them and ensure they completed their suicide missions.
>
> – The Germans used methadone to kill Jews when they ran out of gas.
>
> – On the Rikers detoxification ward a prisoner told his counselor and other prisoners a variation of the 'rots the bones myth' which the prisoners believed to be true: "...a friend was on methadone for a long time and had brittle bones. One day he fell down the stairs and disintegrated into dust!"
>
> – Methadone maintenance is like substituting whiskey for scotch.

Another important source of the stigma against the program is the overt and covert propaganda generated by the drug free programs including therapeutic communities and 12 step programs such as Narcotics Anonymous. Mr. Novick stated that 12 step programs are allowed to recruit and proselytize on the detoxification wards of Beth Israel Medical Center. They still talk against methadone and perpetuate the myths. Beth Israel houses a drug free program called the Stuyvesant Program. Representatives from this program have spoken out against methadone and have also perpetuated myths. Ms. Woods related the following incident about the role of drug free programs perpetuating destructive myths:

> "In the 1970s there was a great deal of competition for funds and methadone myths and anti-methadone propaganda were used by drug free programs to gain a political advantage for funding and residents. For

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> example, one program, Project Return, issued a leaflet in the 1970s claiming that methadone caused malformed babies. This leaflet was believed by many women, both active users that could be helped with methadone and women patients. I know of one pregnant woman who was a patient. Her husband had never used drugs so it was probably difficult for her because she was worried the baby would be born dependent, and it would be her fault. She some how got hold of one of these leaflets and was so upset and depressed that she was crying herself to sleep at night for several months. Finally she got the courage to ask her counselor and she broke out into tears that her baby was going to be born deformed and it was her fault. The only thing that I can call such an irresponsible idea (to make the pamphlet) is just plan vicious, mean and selfish. And this was done by one of the large international therapeutic communities."

Both NAMA officials indicated that street myths continue to proliferate and that there are no major educational programs targeted to the patients or the community to counteract the destructive street mythology or sensationalized reporting from the media. NAMA also insists that methadone patients be called patients instead of clients. Social workers and psychologists usually refer to people they treat in therapy as clients and that label has been transferred to methadone patients. The term client trivializes or negates the biological determinants and medical basis of addiction. Methadone is prescribed by a physician and administered by a nurse, therefore persons who take the medication should be considered patients. The term client removes the medical procedure as the primary therapy and therefore diminishes the importance of methadone in the treatment of opiate addiction. In a subtle sense it adds to the stigmatization of patients, since it brings to the fore psychological characteristics that do not apply to all patients. Although psychological characteristics in general may not be stigmatizing, those associated with addiction are: character disorder, psychopathic personality, liars, cheaters, etc. Therefore, to avoid further stigmatization and to stress the biological factors of an addictive disorder, NAMA insists that patients in programs be called patients and

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not clients. However, major sociologists while acknowledging methadone usually consign the medication to a secondary consideration contrary to the NAMA position.

An example of the misunderstandings that are perpetuated in the social sciences about methadone treatment has been presented in a previous chapter in the work of Abadinsky. However, Stephens (1991) while acknowledging biological factors in the addiction of street addicts, fails to appreciate the central role of methadone as a medication in the treatment of opiate addiction. In the following excerpt about clinics set up primarily for its dispensing, methadone is referred to as a narcotic not a medication.

> "In many ways, methadone maintenance initially demands less of the clients than do some of the other modalities. This is because the modality does not mandate that addicts give up a central aspect of their lives, namely the use of narcotics. In fact, the narcotic becomes a central aspect of their lives, namely the use of narcotics" (Stephens, 1991: 146, 147).

This above statement reveals a fundamental misunderstanding of the role of methadone in the treatment of opiate addiction. Methadone in maintenance therapy functions as a normalizer of a deranged physiology and allows patients to live normally. Furthermore, methadone patients do not have an easy time transforming their lives, considering the prejudice directed against them. Many methadone patients come into treatment with serious social and medical conditions that cannot be resolved because of the bias and stigmatization that permeate social and medical institutions. Methadone patients are consistently refused services unless they withdraw from methadone. The derangement of metabolic processes caused by a heroin addiction may be permanent for many patients and methadone is necessary as a medication not a drug. Also the term client – as NAMA officials state – to describe methadone patients subtly negates the biological factors of opiate addiction. Stephens also criticizes the centrality of the dispensing of methadone in methadone clinics as follows:

> "The very fact of the centrality of the drug itself in methadone mainte-

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> nance can also be seen as a criticism from the sociocultural viewpoint. It seems to me that the typography of many methadone clinics themselves reinforce what I am talking about. When one enters a clinic, almost invariably within the just a few steps of the front door is the methadone dispensing window. ... Thus, the client is constantly reminded of the central importance of the drug to his or her life. Other aspects of the therapeutic process of leaving the addict role are minimized. Taking of the drug is the only "therapeutic event" that ordinarily occurs every day in the patient's life. Drug is King!"

Stephens obviously has never been in many methadone clinics. Clinics offer a variety of services, but since addiction is a disease the medication is the primary aspect, just as insulin is to a diabetic or cardiac medication to a heart patient.

Counseling in methadone programs may not be funded adequately to address the complicated social and medical issues that confront and overwhelm the staff. Methadone is not just another drug as Stevens insinuates. The medication methadone is necessary to stabilize patients so they can begin to address their problems. The methadone clinic is organized primarily to dispense methadone, in the same manner as a cardiac clinic is organized to dispense cardiac medication. In both clinics, the prescription of medication is central to the control of the medical condition.

Street Propaganda

An example of the type of propaganda that is promulgated is an article entitled "Methadone" in the squatter newspaper Your House is Mine (Morales, 1992). The newspaper was distributed in the East Village of Manhattan in 1992. The article presents a conspiratorial viewpoint of methadone treatment and the system of clinics established to dispense methadone maintenance (See Appendix). Although this article was written recently it has historical precedents back to the 1970s when the programs were first expanding. Charges of genocide against methadone have abounded from minority communities since the inception of the program. How-

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ever, as statistics have shown in this study when methadone programs were expanded in the early 1970s there were corresponding decreases in drug related crime, the transmission of infection and overall drug related deaths. Miller (1974) sums up the black militant critique of methadone as follows:

1. "...methadone is viewed as a pacification of underlying social and economic problems of the under class of society."

2. "... methadone programs are seen as part of the white Establishment's plan to hold potential revolutionaries in submission."

3. "This desire for submission is often viewed as racist in origin."

4. "... methadone maintenance is seen as chemical warfare."

5. "... maintenance is viewed as a police devise to control blacks, Puerto Ricans and Chicanos through addiction to methadone."

Morales' (1992) article is an example of the application of the above critique and conspiratorial beliefs about methadone. Nevertheless, this type of literature impacts on poor untreated addicts who have experienced discrimination. The opening sentences of the article stresses the Nazi connection:

> "Methadone was invented by Nazi scientists at Adolph Hitler's request. It was named "adolphine" after Hitler."

The article then enumerates an exaggerated list of side effects including degenerative brain damage, rotting of the bones, sexual impotency, insomnia, abnormal menstrual periods, slurred speech, drowsiness, heart and lung failure. Methadone is perceived as a major cause of death and genocide spreading HIV

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infection and is ten times more "addicting" than heroin. He lies about the excessive funding. Morales infers that there is a methadone conspiracy to control addicts and the poor.

The article discusses rightfully the existence of exploitative medicaid programs that administer methadone. Unfortunately, he does not disentangle the issues (e.g., medical issues and the delivery of health care services). There are unscrupulous physicians and entrepreneurs in all areas of health care. This practice is common in the delivery of medical services in poor neighborhoods. However, the medicaid medical offices are woven into a broad political conspiratorial context. The shortcomings of medical practice in poor neighborhoods are not only connected to the administration of methadone to control an opiate addicted population but also to the methadone itself. It is potentially a killer drug prescribed by medically exploiting programs that "rots the bones."

The pivotal roles of Dole and Nyswander affiliated with The Rockefeller University and that of Dr. Robert Newman of Beth Israel Medical Center are also cited as proof of an interconnected conspiracy. Since the Rockefeller family is associated with capitalist exploitation, research that emanates from the university is suspect. Beth Israel Medical Center is perceived as part of an establishment to control the lives of the poor through methadone because of individuals associated with the hospital. For example, the head of the trustees at Beth Israel Medical Center is identified as belonging to a family with interests in the oil and pharmaceutical industries. Also, as a member of the New York State Public Health Council this person "actually approves clinics as methadone sites." There is no mention that only two new clinics opened up in the past 20 years in New York City. Eli Lilly is identified as the manufacturer of methadone[2] and former president George Bush is reported as a stock holder in the company. This is considered the proof of a conspiracy to control, exploit and commit genocide against the poor with methadone.

Another source of anti-methadone propaganda filtered into poor drug addicted populations at risk for AIDS is unfortunately within organizations that are fighting the spread of HIV infection. In newsletters

2. Methadone is manufactured by Mallinckrodt Pharmaceuticals. Eli Lilly is a distributor as are several other pharmaceutical companies.

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distributed by the People with AIDS Coalition of New York, methadone is presented as a potentially harmful drug. In their January, 1994 newsletter, the People with AIDS Coalition reprinted an article from a British anti-AIDS publication called Mainliners with the following statement:

> "Methadone is a sugary substance and along with other sugars, helps to accelerate the rapid decline and decay of cavities that may already exist."

In another article the People with AIDS Coalition a column again reprinted from Mainliners:

> "Methadone detox is about the worst. It takes more than twice as long as heroin and can be harder."

This statement summarizes a street mythology about methadone. Addicts perceive methadone as harder to "kick than heroin." However, given comparable amounts of methadone and heroin, methadone, since it is a long acting drug, has a longer onset for appearance of withdrawal symptoms than heroin, the duration of symptoms are more protracted but the symptoms themselves are less severe. In comparison, addicts use adulterated street heroin in uncertain amounts while methadone is obtained in pure and carefully calibrated amounts from clinics. The perception of addicts that methadone is harder to kick comes from unequal comparisons of heroin and methadone: one adulterated and of uncertain purity (heroin) and the other pure and carefully calibrated (methadone).

To understand the prejudices in the AIDS community against methadone, Bruce Stepherson, Director of the AIDS Outreach Unit of the National Development and Research Institute, Inc. (NDRI), a former methadone patient and an advocate for methadone treatment discussed the problem. He indicated that many AIDS activists come from a drug-free orientation, know very little about methadone and therefore adhere to their prejudices. In his unit he has trained workers about methadone and has employed both methadone patients with drug-free advocates as outreach workers. However, he is aware of the deeply held prejudices against methadone that exist across the spectrum of professionals including Ph.D.s and directors of projects.

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Studies of Street Mythology about Methadone

Street mythologies about the perceived destructive effects of methadone became apparent in the 1970s. Three papers from three eras of methadone treatment document the rise of street mythology (Goldsmith, Hunt, Lipton and Strug, 1984; Langrod, Lowinson and Joseph, 1977; Rosenblum, Magura and Joseph, 1991). Street mythologies about perceived effects of methadone were first identified in the early 1970s by Langrod, Lowinson and Joseph (1977). At that time, the rumor that methadone rots the bones and the teeth were becoming a common mythology on the streets. However, medical studies reported that methadone had no effects except for transitory problems at the beginning of stabilization. Sedation, decrease in libido, constipation and sweating were the most common effects with sedation and decreases in libido corrected over time with either changes in dose or the development of tolerance. Sweating appeared to persist but constipation slowly subsided with the development of tolerance and changes in diet (Kreek, 1973). However, as patients entered the program from the streets, symptoms of various illnesses emerged that were masked by heroin (Langrod, Lowinson and Joseph, 1977). The patients attributed erroneously a variety of aches, pains and poor dentition from neglect and poor nutrition to methadone. These misconceptions intertwined with the perceived conspiratorial political agenda of control and genocide and combined into a powerful folk mythology. Perhaps the most persistent myth is that methadone rots the bones and teeth. Interestingly, the number of symptoms in the street folklore attributed to methadone increased with time. By the 1990s a solidified system of beliefs about methadone as a destructive drug (e.g., rots the bones and teeth) was firmly in place (Rosenblum, Magura and Joseph, 1991). Untreated addicts had developed a clear ambivalence about methadone treatment. This ambivalence, shaped by street mythologies, influenced adversely decisions to enter treatment, accept an adequate dose of methadone (preferring low dose which is ineffective) and the time they would remain in treatment to avoid what they perceived as long term detrimental effects.

Ethnographic studies by the Street Studies Unit of OASAS show that mythologies still persist. Untreated addicts primarily value diverted methadone for self medication (i.e., withdrawal and short term maintenance when they are unable to obtain heroin) (Galea, 1994).

The reasons heroin addicts are not in methadone treatment include the usual "rots the bones and

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teeth" myth, methadone is a Nazi drug (genocide), too addicting, harder to kick than heroin and more addicting, long waiting list to get into treatment, no identification for medicaid and too many rules and regulations in the programs (orange hand cuffs). Another term that was used to describe the program on the streets was "deathadone" referring to the large number of HIV-related deaths that were occurring in the program. Methadone therefore has become a program associated with death.

Since these mythologies were strongest in minority communities, African American patients in medical maintenance were questioned about the possible origins of these myths. One patient with a 24 year addiction history who had been enrolled in methadone treatment since 1971 and in medical maintenance for about eight years stated that he believes:

> "The rumor about methadone rotting the bones was started by dealers to prevent addicts from entering treatment. I've been on methadone for 23 years and my bones are just fine."

About the theory that methadone is genocide and social control for the black community, the patient related the following:

> "Methadone saved my life. I would not be here talking to you if it were not for the methadone program. Those addicts that I knew in the streets who did not enter methadone programs are not here. About methadone being used to control black people – what about welfare, that is a form of control they don't talk about that – yet they wait for their checks. When people start talking about methadone in this way I just walk away. They don't know what they are talking about, and they will not change.
>
> I used dolophines, they were small pills and were called 'Dollies.' I knew

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that dolophine is methadone. I used them when there was a heroin panic. The Germans perfected the drug, that's a fact. There were no rumors that 'dollies' rotted bones."

Another African American patient, married and with two children, a good job in management and attending graduate school indicated that the methadone clinics are viewed with suspicion. Methadone is regarded as genocide in the black community and he advised that this was:

"...understandable, but unfortunate considering the history of blacks in this country. I think that the Tuskegee experiment with black men who had syphilis has a lot to do with the suspicions about medical programs that are set up in the community."

A former methadone patient who is African American and with a graduate degree, married and with children attending college offered a different view:

"A lot of poor addicted blacks may not know about the Tuskegee experiment, and this is unfortunate since they should. However, I believe that the negative attitudes towards methadone are just the result of general suspicion about white programs and institutions in the black community. Also, the community sees unemployed patients loitering selling and using drugs – so it (*methadone*) gets a bad reputation."

However, at the 1994 National Methadone Conference in Washington, D.C. a large contingent of African American patients, community leaders, program administrators and politicians including the mayor were very supportive of methadone programs (Town Hall Meeting, 1994). Although sharp differences of opinion were expressed about spirituality, methadone dose and duration of treatment, the tone of the

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meeting was devoid of extreme hostility (e.g., methadone is genocide). People, including patients were trying to reach a consensus about the program. One female patient who appreciated the program and the progress she made indicated that "although it is a form of bondage" she had changed her life on the program. African American patients were proud to be on the program and related their progress and accomplishments. Street myths were not enunciated except for one patient who did not know that dolophine and methadone were the same drug. One black female patient stated that "methadone patients should stop overdosing on anonymity and come out of the closet."

Nevertheless there were confrontations with Marion Barry (Barry was between terms). Barry is an advocate of 12 step programs and came out against long term methadone treatment. However, one of his election workers at the meeting admitted to being a current methadone patient and was on methadone when he directed the campaign in the district in which Barry received his greatest victory. Barry was aware that this man had used drugs at one time but was unaware of his status as a methadone patient when he was hired to direct the campaign in this particular district. Barry made no comment after the public disclosure. It is noteworthy that the patient found it easier to acknowledge his former use of heroin than his current enrollment in methadone treatment.

It should be noted that the initial efforts to lobby for the expansion of methadone treatment in New York State were led by two leaders in the African American community: Dr. Arthur Logan and James Haughton, a labor leader and the founder of Harlem Fightback. The late Dr. Logan was Duke Ellington's personal physician and a social and political force within the African American community. Ellington knew jazz musicians who were addicted to heroin and functioning normally on methadone. He introduced the patients to Logan who knew about their heroin histories and was impressed with their transformations as methadone patients. Haughton became aware of methadone treatment through members of Harlem Fightback who were methadone patients. The two leaders were personal friends and organized a citizen's committee (See Appendix, Cover Page of Proposal for Expanded Methadone Treatment). Led by Hogan, Haughton and Dr. Ray Trussell, the founder of the Columbia University School of Public Health, the group lobbied for funding and the expansion of methadone treatment. As a result of the efforts of this group known as CODA, Governor Rockefeller allotted $15,000,000 for the initial expansion of methadone treatment

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through the New York City Department of Health in the early 1970s.

However, at the same time there were groups within the African American community that perceived of methadone as a means of genocide and control of the poor. These sentiments were also held by Chicanos and radical whites. Many of the criticisms of methadone treatment were based on the social inequities of the country in the 1970s including the Vietnam War. Demands at the Fourth National Methadone Conference by these groups called for greater representation from the community in the control of programs and representation from the community in the planning of conferences.

At present leaders within the African American community are divided in their support of methadone. For example, in New York City, Representative Charles Rangel has not openly supported methadone treatment, while in Baltimore, Mayor Kurt Schmolke is an advocate of methadone treatment. There exists now a group of African American physicians including Dr. Janet Mitchell of Harlem Hospital, Dr. Edward Drew and Dr. Melissa Freeman of Beth Israel Medical Center, Dr. Lawrence Brown and Dr. Beny Primm of Addiction Research and Treatment Center (ARTC) in New York City who are strong advocates of methadone treatment. However, the community planning board of Harlem and other groups within Harlem are against the expansion of methadone programs as are groups in other communities.

Conclusion

The prejudice against methadone found among addicts mirrors the stigma that the media continues to present. The mythologies that abound among the untreated addict population are an example of the prejudice directed towards them being projected onto a medication which has been shown to be medically safe and effective.

The stigma against methadone is so pervasive that it has entered into the "molecules" of the medication itself. No other medication in the history of modern medicine has been so unjustly maligned. It is impossible to expand the program to control the spread of HIV among the addicted and to bring into treatment sufficient new addicts to control the current heroin epidemic.

The origins of stigma are varied but among them are: the control that programs enforce upon patients; the lack of education among methadone professionals, patients and the community; the media portrayals of

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poorly managed programs and sick dysfunctional methadone patients; the confused interweaving of social inequities with common addictive metabolic processes that span the spectrum of social and ethnic groups. Foremost is the reluctance of the community, professionals, untreated addicts and many methadone patients to recognize that compulsive narcotic addiction is a metabolic disease, not a character disorder, and that it can be effectively treated with a medication (methadone).

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VII

Stigma Within the Medical Profession

The effects of stigma and the question of what constitutes a medical condition affects the treatment of methadone patients. These issues involve the value systems which physicians adopt and affect their perceptions and understanding of conditions presented by patients. There is a difference in concept and attitudes towards patients depending on whether methadone is prescribed to control a character disorder or to normalize an aberrant physiology. Is addiction a legitimate illness? How does this question influence the dose of medication prescribed, the duration of treatment recommended for a particular condition and the attitudes towards patients. In this section, interviews with Dr. Dole, the co-developer of methadone maintenance and others, including patients, will deal with the effects of stigma on the treatment of methadone patients within the medical profession. The article about addiction and methadone treatment by Jaffe (1990) in the basic medical and pharmacology text by Goodman and Gilman is a straightforward description of opiate addiction and the role of methadone treatment. Jaffe reports the metabolic basis of addiction as hypothesized by Dole and Nyswander and the role of methadone as a legitimate therapeutic intervention to relieve craving. Notwithstanding Jaffe's article, stigma against methadone treatment and the patients persist.

The Institute of Medicine (1995) recently issued a sober report about methadone maintenance. This report while not directly addressing stigma should resolve many of the biases that are found within the professions. The following is a quote about the report by Yarmolinsky and Rettig (1995):

> "Methadone is a weak opiate that does not induce drug euphoria. When properly used, it reduces or eliminates the craving for opiates and reduces the symptoms of opiate withdrawal.
>
> Because methadone does not produce the high of other opiates the risk of

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> its being diverted for illegal uses is very low. It is generally not an abused drug, and there is no evidence that it has been the object of organized crime drug trafficking. Most of what is diverted from licensed treatment programs appears to go to addicts who are trying on their own to manage temporary withdrawal from heroin."

Stigma, A Limiting Factor

Interview with Dr. Vincent P. Dole

Dole (1994) in an interview discusses the effects of stigma on attitudes towards addiction and methadone treatment within the medical profession.

> Question: When you first began studying addiction were you aware of any stigma that was directed against this population within the medical profession?

> Answer: "Stigma was a limiting factor because I soon found out that nobody among my friends in the medical profession was interested in addiction as a medical topic. They saw it primarily as a behavioral deviation and its management was the responsibility of the enforcement agencies. I grew up in a medical world quite ignorant of anything to do with the physiology of addiction. Of course the medical school curriculum had no courses and the people who taught were uninformed about addiction. The only people who had any contact with this problem were the pharmacologists who studied the pharmacology of addictive drugs. They studied addiction through animal experiments and under rather artificial conditions. They had no clinical contact. The efforts that I made in the early days (1960s) to arouse peoples interest to

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> study narcotic addiction were quite futile. Nobody was willing to give the effort and thought to study addiction as a disease. Marie (Dr. Nyswander) in the 1950s tried in her way as a solo person to set up treatment for addicts. She was harassed by the Bureau of Narcotics who saw her efforts as an invasion on their authority. Generally speaking, it was assumed that addicts were persons with histories of criminal activity and their management was controlled by law enforcement agencies. If there was any medical intervention it would be only in the context of being at the Public Health Hospital in Lexington, Kentucky under lock and key."

Dole and Nyswander (1967) published the article, "Heroin Addiction: A Metabolic Disease," in which they proposed an alternate theory for narcotics addiction: the craving for heroin in an extended addiction may be symptomatic of a metabolic dysfunction within the central nervous system rather than a psychological aberration.

> Question: What was the response to the paper, "Heroin Addiction: A Metabolic Disease?"

> Answer: "Surprisingly negative on the part of the medical profession. It was not regarded seriously, it was regarded as sort of a story and not reality. The medical profession took as an axiom that using drugs was a sign of psychiatric disturbance. ... it was unquestioned by virtue of the medical profession that this was a disturbance of behavior or some sort of character defect or weakness of will and the only cure that could be accepted was total abstinence."

Dole (1992) indicates that: "...for the majority of physicians, teachers and practitioners of the past

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generation, addictions were moral problems, a sign of depraved character, not diseases. This attitude is still prevalent. However, it is not likely to persist in the mainstream of medicine beyond this generation. A judgmental attitude is inconsistent with the current advances in neurobiology."

The attitudes that Dole described as prevalent in the 1960s are still prevalent years after clinical and neuroscience research began. An example of trivialization of Dole and Nyswander's work may be found in journals, prestigious books and in statements by physicians themselves.

The most often quoted criticism of methadone maintenance is that "it just substitutes one addiction for another" or, in another form, "one drug for another." This criticism implies erroneously that patients are in effect receiving a legal high or methadone euphoria. The simplicity of the statement reveals an inability to differentiate clearly between a heroin addict and a stabilized methadone patient. The statement is an example of Miller's (1974) conceptualization that the primary and secondary deviance of heroin addiction has been transferred as tertiary deviance to methadone patients and methadone treatment. Although this criticism was first published in 1966 by Dr. David Ausubel in the Illinois Journal of Medicine, it is still levelled at the program with stigmatizing effects for both the patients and the program. The article was reprinted for widespread distribution in 1968 by the New York State Narcotic Addiction Control Commission. The purpose was to garner support for the New York State Civil Commitment Program, one of the most expensive failures in the history of public health in New York State.

In this article, Ausubel (1968) advocated closed ward commitment of addicts as the most humane and effective treatment for heroin addiction. Ausubel did not understand the stabilization process and the development of tolerance to the narcotic effects of methadone in a maintenance regimen. Therefore, he attributed the reported success of methadone maintenance "to the free methadone euphoria" dispensed by Dole and Nyswander. He trivialized the regimen by putting the word treatment in quotes and went on to attack the publication by Dole and Nyswander (1965), a progress report on the first 22 patients who had been maintained on methadone from about 1 to 15 months. The patients' doses were reported, their duration of treatment and their jobs. The data were clearly and honestly presented but were attacked by Ausubel in almost hysterical and vituperative language. Ausubel inferred that Dole and Nyswander did not know what they were doing and were no more than unscientific publicity seekers.

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In his classic book, The American Disease: Origins of Narcotic Control, Dr. David Musto (1973), the medical historian, devoted little more than perhaps two and a half pages to methadone maintenance. Although he appears to favor methadone maintenance, Musto also trivializes the use of methadone by placing the phrase medical treatment in quotes. He subtly rejects the idea that this is a medicine for heroin addiction in the following statement:

> "... methadone maintenance helped create favor for "medical treatment" of heroin addiction. From the care with which it is dispensed, the public appears to believe that methadone is a medicine like an antibiotic rather than what it is - a synthetic and addictive morphine substitute discovered by German scientists in World War II."

This statement inherently promulgates the stigmas associated with methadone treatment and opioid addiction with all of its connotations: German 'Nazi' research, methadone is not real 'medical treatment' (since the phrase is stated in quotes), and finally methadone is not a real medication but a narcotic. Musto's clear exposition incorporates the basis of the very biases that cause stigma for many successful patients. The view of Musto is refuted by methadone patients and will be dealt with in a later chapter.

The rejection of drug addiction as an illness and the "Nazi" connection to methadone, was alluded to by the psychiatrist, Thomas Szasz (1986: 101) in the following misguided statement:

> "After all, not only the whites, but most of his own black people (referring to Malcolm X) and all of the black leaders, believed – and continue to believe – that drug abuse is an illness. That is why they demand and demonstrate for "free" detoxification programs -- and line up for methadone programs like Jews did for the gas chambers."

In the above statement Szasz distorts the reality in African American communities. Methadone

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treatment as previously discussed is looked upon with ambivalence. It's rejected by many African American leaders and accepted by others. Furthermore, the allusion to Jews lining up for gas chambers and comparing this horrendous genocide to minorities receiving methadone treatment is a distortion that belies comment. Methadone maintenance is not genocide. Overall it has saved thousands of lives, reduced crime, increased productivity, improved health and successfully prevented the transmission of HIV for the majority of patients who entered and remained in treatment.

In another statement Szasz (1986: 102) reveals that he regards methadone simply as an addiction to control dissidents.

> "The Russian tries to narcotize its dissidents with alcohol, tobacco, work and Communism; when these fail ..... it deals with them accordingly by incarcerating them in prisons or insane asylums. Similarly, the American government tries to narcotize its dissidents with alcohol, tobacco, work, money and methadone; when these fail ..... it deals with them accordingly, by incarcerating some in prison, others in mental hospitals, and putting the rest on "methadone maintenance."

Szasz is against all drug laws and rightfully argues against the excesses of certain laws that have created classes of criminals, over crowded prisons because of harsh sentences and serious social problems. He is also an advocate for legalization of heroin. However, his perception of methadone treatment is distorted in his attempt to create a logical argument for his position. Methadone maintenance is not a medical procedure in Szasz's conceptualization but a means of social control by narcotization. Social control is a danger in methadone maintenance that has been resisted by patients. However, patients have accepted methadone because of its valid therapeutic qualities. Szasz does not perceive of addiction as a metabolic disease independent of the social circumstances of drug availability (legal vs. illegal). That a psychiatrist of the caliber of Szasz would make such incredulous statements reveals an ignorance of methadone maintenance, the differences in the pharmacology of opiates (long vs. short acting), the years of research and evaluation on metha-

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done maintenance, and a profound ignorance of heroin addiction itself. That a man with Szasz's acknowledged leadership is unable to assimilate and abstract conceptually the concepts of addiction and maintenance shows how an ideology can distort perception and understanding. There is probably no procedure in all of modern medicine that has been subjected to such scrutiny as methadone maintenance and has aroused such feelings of hostility, revulsion and rejection.

Effects of Stigma on Dose and Delivery of Services

The attitudes prevalent in the medical profession against the concept of addiction as a legitimate disease are seen as impeding the delivery of necessary services to stem the transmission of HIV. Cooper (1992) addresses these issues and reviews doses of methadone prescribed to approximately 100,000 patients nationwide in surveys conducted by the National Institute on Drug Abuse. Approximately half of the patients are receiving inadequate doses of 55 mg/day or less with about 25% receiving doses under 40 mg/day. About 50 percent of the programs encourage patients to withdraw prematurely within six months. Also, several states do not permit long term treatment of nonmalignant pain with opiates. For example, New Hampshire has legislation prohibiting the prescribing of methadone for pain and maintenance. Cooper attributes these counterproductive practices to attitudes within the medical profession itself. Certain conditions are not viewed as legitimate medical disorders. Drug hunger, depression and fear may be associated with "a weak will." "Cures" and legitimate therapy are associated with the "building of a value system" and strengthening the patient's "will power." Patients with symptoms perceived as volitional are regarded with bias, stigmatization and subjected to feelings of shame. The symptoms of their illnesses such as drug craving are dismissed as trivial. Hence patients are under medicated and encouraged to leave treatment prematurely. These practices, based on prejudices, rather than scientific studies and evaluation research are hampering the delivery of adequate methadone treatment to prevent the transmission of HIV.

Cooper's comments have direct applicability within the staffs of methadone treatment programs. In Washington, D.C., Brown, Jansen and Bass (1974) studied attitudes of staffs in methadone programs. One of their conclusions is as follows and reflects Cooper's concern about staff attitudes, biases and moral judgements:

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> "Essentially, staff attitudes appear to reflect a basic ambivalence regarding methadone treatment. Methadone is of positive value in that it helps clients become independent of the drug heroin, but long term maintenance on methadone is not a desired end state. Rather it is seen as suggesting a certain lack of personal integrity on the part of these clients as compared with clients who have become abstinent. It is as if "treatment" or "cure" is incomplete until the client is completely drug free."

There are other reports in the literature that corroborate the findings of Brown, Jansen and Bass. A counselor, Greg Gordon (1994) at a Seattle based methadone program places methadone maintenance in an adversarial relationship to what he considers treatment. Treatment is considered therapy (12 step, group therapy, etc.) that restructures the patient's life to enable withdrawal from methadone. The dose level to achieve blockade is questioned despite research that has shown blockade doses at least at the beginning of treatment are most effective. Withdrawal from methadone over a period of six months to two years is recommended. Long term methadone is seen as a last resort for specific groups of patients – repeated failures, pregnant women and persons with health problems.

A second example of the concerns that Cooper writes about is incorporated in an article by Bratter and Pennacchia (1976). In this article the metabolic theory of addiction is seen as a negative concept for patients who want to be withdrawn. The second author presents himself as an example of a patient who withdrew from the medication and then entered Daytop Village, a therapeutic community for what he considered treatment. Neither Gordon or Bratter and Pennacchia have data to back up their theories or approaches. However, studies by Caplehorn and colleagues (1993) showed results contrary to the expectations and opinions of Gordon, Bratter and Pennacchia. The study involving 227 patients referred by a team of psychiatrists and psychologists to what they considered appropriate treatment – either an abstinence oriented methadone program or an indefinite maintenance program. Both programs were staffed with professional general and psychiatric nurses for counselling and a medical officer. The conclusion of the study is as follows (Caplehorn, 1994):

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> "... investigations have found that heroin addicts assigned to the abstinence-oriented program were progressively more likely to leave during the first 2 years' maintenance and as a result, were more likely to be arrested than those assigned to the indefinite maintenance program. ...addicts assigned to abstinent-oriented treatment were more likely to use heroin and inject drugs while in treatment and more likely to relapse and return to maintenance after discharge. The abstinence-oriented program was also less able than the indefinite maintenance program to attract heroin addicts into treatment. It is recommended that methadone programs abandon abstinent-oriented treatment policies and, instead, offer heroin addicts long-term maintenance."

The ambivalence expressed about the effectiveness of long term treatment by the staffs of the programs investigated by Brown and the articles of Gordon, Bratter and Pennacchia are of concern since data from reliable studies show long term treatment to be more effective than abstinence oriented treatment.

Miller (1974) indicates that the tertiary deviant status of methadone treatment and its "semi-stigmatized" state produce a cognitive and social dissonance among staff and patients. There are patients who have educated themselves about methadone, addiction and theories of addiction to a greater extent than most counselors, nurses and physicians in the clinics. These patients have become frustrated in their dealings with a clinic staff whose philosophies (e.g., short term, abstinent treatment) may be destructive to their best interests. One such patient who is a former student from an Ivy League university indicated the following:

> "...my opinions of methadone and the programs that administer it could not have been farther apart. Methadone itself had been a Godsend, literally saving the lives of myself and my friends, allowing us to reclaim ourselves and rejoin society. I had every reason to believe that given continued access to methadone, I would be able to lead a full and healthy

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

Umbricht-Schneiter and colleagues (1994) compared methadone patients who were treated in a methadone clinic for various medical conditions other than addiction to methadone patients who were referred to mainstream medical clinics for treatment. The site (methadone clinic or mainstream clinic) of treatment was randomly selected. It was found that 92% of the patients treated on site in their methadone programs received medical treatment as opposed to 35% of the referred group. The reasons given for the differences between the two groups are:

1. Patients fear discrimination or hostility in hospitals and clinics if their status as drug users or methadone patients becomes known.

2. Patients may be withdrawn from methadone if they are hospitalized and the

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resulting withdrawal symptoms not adequately treated.

3. Four mainstream off site clinics refused to participate in the study even though they would be paid for all appointments including those that the patients missed. (This refusal to treat the patients may reflect stereotypical beliefs about their behavior.)

In this study, the referred group received adequate instructions about procedures to register, and all financial obstacles were removed. Nevertheless, only a minority received treatment in the referred system.

Dr. Umbricht-Schneiter (1994) was contacted and indicated that there appears to be a great deal of stigma directed against methadone patients within the medical profession. She states that addiction is not taught in medical school and that physicians are not aware that this is a medical condition related to opiate receptor and endorphin dysfunction within the brain. She is aware of the bias towards patients within the medical profession and the fears of patients. Dr. Umbricht-Schneiter indicated that stigma against patients was an undercurrent in her study. She admits that she herself was once abusive to methadone patients by misinterpreting their behavior before she became aware of the biological factors that are involved in an addiction. Dr. Umbricht-Schneiter related that a patient from her clinic was referred for breast surgery, and the hospital did not provide post operative pain medication. This, she indicated, "...is ignorance, and physicians have to be educated." She also advised that patients are aware of the anti-methadone attitudes of physicians. She herself lectures to physicians about addiction and treatment trying to change attitudes and practices since information about methadone may not be available to the average physician.

Patient Interactions and Experiences with Physicians

Methadone patients have had a variety of experiences with physicians. Some have been good but unfortunately the vast majority of the experiences have reflected prejudicial attitudes by the physician and ignorance about medical procedures involving methadone, as noted by Dr. Umbricht-Schneiter. One patient who revealed his methadone status to an examining physician in a hospital was faced with an abrupt change of attitude

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> "I'll never forget this. I went to the local hospital because of pains in my chest. When I told the physician that I was on methadone, his attitude abruptly changed. He told me that "all I wanted was drugs" and "to get the hell out of here and if you don't leave immediately I'll call a cop."

The physician obviously thought of this patient as an untreated drug addict while in reality he was a very successful business man and a model methadone patient.

Another methadone patient and the vice president of NAMA was hospitalized in a Manhattan hospital for gall bladder surgery and was not given adequate post operative pain medication when the physician learned she was a methadone patient. "He thought that my methadone dose would relieve the pain. I was in agony and he did not believe me." That methadone patients do not need pain medication is a commonly held misconception about methadone among physicians.

Methadone patients who are employed in the health care professions in hospitals report that there is widespread prejudice against patients by doctors and nurses. Three health care workers maintained on methadone and employed in different hospitals commented on the widespread stigma against methadone patients. One patient is in a graduate program in health care maintaining an 3.85 average reported the following:

> "In my class methadone is put down as a treatment. I just have to sit and listen. They describe patients in the most derogatory way – referring to methadone patients as "methadonians." I also hear methadone patients referred to as "methadonians" in comments in the hospital where I work. Some of the worst people with the most negative attitudes towards methadone patients are in the medical profession. They treat methadone patients very badly. It is very difficult for me just to listen. I get very angry and do not say anything.
>
> Not all doctors are that way. My old dentist knew that I was a metha-

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> done patient and treated me very well. He was understanding. My new dentist is not very understanding. However, I had a physician for hepatitis C. He thought I contracted it on my job and was very sympathetic. I told him I was a methadone patient since I may not have contracted the virus on my job. I really don't know when I contracted the hepatitis. His attitude changed immediately – It was like Dr. Jekyll and Mr. Hyde. He thought I was dirty - under his foot. I told my medical maintenance doctor and he is referring me to another liver specialist who understands methadone."

Another methadone patient who is a health care professional employed for years in a suburban hospital is applying for medical maintenance. She stated that methadone patients are treated very poorly by staff and sometimes referred to as "animals." She relayed the following about a physician with whom she worked but who did not know that she was a methadone patient:

> "A patient came to the department for an examination for a surgical procedure. He tried to explain to the physician that he was a methadone patient. The doctor stated that he did not want to hear about that since he was here only to treat the patient's hip. When the patient tried to explain to the doctor that he had to know about the methadone, the doctor told him that probably he had the wrong doctor. After the patient left the doctor remarked to me, "Can you imagine these animals getting on methadone?""

A third health care worker was interviewed. She verified that anti-methadone attitudes were prevalent among doctors and nurses. She indicated that most doctors are not trained about methadone and therefore may be ignorant about pain and proper dosing procedures. She has heard the term methadonians fre-

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quently used to refer to methadone patients. She relayed the following:

> "About two years ago in a Manhattan hospital, I noted a patient that was tied in a restraint. It turned out that he was a methadone patient and was not given methadone for three days. I got very angry and when I spoke to the nurses they brushed the matter off stating that he was difficult to treat and they referred to him as an animal and that it was his fault that he was an addict. I told them that he should be medicated and when he was, he turned out to be a very cooperative patient. I then turned to the nurses and said "who is the animal now."

A patient with a chronic thyroid condition stated that one of the ways she "determines a quality doctor is by his attitude towards methadone treatment." If she informs a physician that she is on methadone and the physician attributes all of her medical problems to the methadone, she knows that the physician is either ignorant about methadone or may be biased in his attitudes. Her current physician is aware of her enrollment in methadone treatment and is currently treating her thyroid condition without requiring her to detoxify or change her dose. This patient is also a counselor in a methadone program. One of her patients in the clinic has AIDS. He was told by the physician who is treating him for AIDS to withdraw from methadone since methadone lowers immune functioning. She told her patient that this was not true, and that he should get another opinion before he makes a decision.

Methadone patients are concerned about their confidentiality in medical matters and the way they will be accepted by physicians and dentists. However, their decision to withhold information about their enrollment in methadone treatment can have dire consequences. Physicians in medical maintenance are sensitive to the concerns of the medical maintenance patients and usually work with other physicians if their patients have serious or chronic problems. However, sometimes emergencies arise and the patients may become ill, go to an emergency room and not reveal that they are enrolled in methadone treatment. One of the physicians in medical maintenance relayed that one of her patients complained of pain went to

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a local hospital, did not inform the medical staff about his enrollment in methadone treatment and was administered narcan, a painkiller classified as an antagonist drug. Antagonist drugs precipitate the withdrawal syndrome in opiate dependent people. Therefore, it is contraindicated for methadone patients. After the administration of narcan, the patient went into acute narcotic withdrawal.

Stigma from Advocates of Alternative Medications

Advocates of alternate medications for the treatment of opiate dependency present their viewpoints by denigrating methadone maintenance treatment or the population that chooses to enter methadone treatment. As an example, the drug naltrexone has been introduced over the years as an effective medication for the treatment of narcotic addiction. Naltrexone is a medication that was developed by DuPont. It essentially blocks the effects of heroin if tried but it does not relieve the craving for narcotics. The patient feels the need for opiates but is unable to address this need. Naltrexone has not been accepted by most patients. There are some side effects such as dysphoria and nausea. The drug stimulates the hypothalamus-pituitary-adrenal axis and precipitates withdrawal symptoms in the acute phase of narcotic withdrawal. The drug, in the opinion of this writer, also exacerbates the secondary withdrawal syndrome. Patients have complained that it has exacerbated drug craving. Relapse usually follows cessation of naltrexone treatment (Azatian, Papiasvilli and Joseph, 1994). It is estimated that about 15% of the heroin addicts will respond to this drug. The medication is stated to be effective only for motivated addicts who do not want to get high. Published studies acknowledge a high drop out rate (Azatian, Papiasvilli and Joseph, 1994). However, addicted physicians who are threatened with loss of their medical licenses, middles class suburban addicts and addicted parolees are reported to do well on this medication (Greenstein, Fudula and O'Brien, 1992). The medication, therefore has been marketed for motivated, educated and employed addicts (Resnick, Volavka, Freeman and Thomas, 1974). The inference is that methadone is for addicts who want to get high or who are not motivated. This immediately places a stigma on those patients who choose to enter methadone treatment. Conversely, patients who choose naltrexone are more "motivated." There are no large studies over a period of two or more years in the literature that validate the claims of physicians who advocate naltrexone maintenance for certain groups of "motivated addicts."

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Conclusion

Stigma within the medical profession directed against methadone patients appears to be widespread. Dole indicated that addiction was not taught as a subject in medical school nor is it taught in medical schools today. When it is taught there is the possibility that it may be presented simply as substituting one addiction for another. In the 1960s, addiction was considered a moral or behavioral problem and Dole found that stigma was a limiting factor since he was unable to galvanize interest in the subject as a legitimate study. In 1995 the same situation exists. Physicians are not taught in medical school about addiction or the use of methadone as a therapeutic intervention. However, with the emergence of neuroscience, Dole feels that the stigma will be reduced since a judgemental attitude is incompatible with findings of current brain research and that addiction will be considered a metabolic disease.

Methadone patients currently face widespread ignorance and bias within the medical profession which may result in the denial of methadone or adequate pain medication when they are hospitalized. Also, methadone patients may experience sudden rejecting attitudes when the physician learns that the patient is enrolled in methadone treatment. They are treated like virtual heroin addicts which is a result of the tertiary deviant status of methadone treatment as described by Miller (1974) and the resulting stigmatization.

These attitudes based on moral judgements have impacted negatively on prescribing practices – ineffective low doses of methadone, premature discharge from treatment and inadequate prescribing of pain medication. Educated and knowledgeable patients find program staffs uneducated about methadone. Staff opinions about the effectiveness of short term abstinence-oriented methadone treatment are not born out in a major study evaluating short term abstinence oriented vs indefinite methadone treatment. The moral attitudes about addiction and methadone treatment appear to prevail to the detriment of patients. Public health issues are also involved since adequate methadone treatment can blunt the spread of HIV. However, current practices minimize the potential therapeutic effects of methadone treatment. A vast educational campaign is indicated that would introduce neuroscience and the findings of rigorous evaluation studies to change attitudes within the medical profession and staffs in clinics.

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VIII

Stigma, Public Policy, Regulations and Methadone Treatment

The effect of stigma on policy and regulations will be discussed in this chapter. In essence, methadone regulations are extensions of the narcotic laws passed on federal and local levels prior to the establishment of methadone treatment. These laws were enacted to control a perceived dangerous population that threatened the survival of values within capitalism. During the early post-World War II period the international distribution of narcotics was regarded as a "communist conspiracy" linked to Red China. In the 1960s, civil commitment of addicts was implemented in California and New York to institutionalize addicts legally (Joseph, 1988). The diversion of methadone and questionable prescribing practices by a few unscrupulous physicians in the late 1960s and early 1970s served as an impetus to pass restrictive legislation regulating methadone treatment at every level of government. The over restrictive nature of these regulations has elicited the following response from the Institute of Medicine (1995):

> "Current policy ... puts two much emphasis on protecting society from methadone and not enough on protecting society from the epidemics of addiction, violence and infectious diseases that methadone can help reduce."

Stigma and Social Policy

Dr. Enoch Gordis (1991), the Director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), in an essay about the relationship between science and public policy, cites methadone maintenance as an example of "Good science, but policy obstructed." He states:

> " the widespread provision of methadone-maintenance therapy for narcotic addiction – is a policy that does not lack for scientific justification

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> of its effectiveness. Nonetheless, it is a policy that has been blocked by many obstacles since its introduction as a therapeutic technique for narcotic addiction. ....Part of this battle has to do with a failure to educate the public about methadone, a very complex educational challenge."

He identifies the following four groups of obstacles that impede the acceptance of the expansion of methadone treatment in the face of an expanding AIDS epidemic:

1. Attitudes, biases and preconceptions by the public about heroin addicts and their perception of a character disorder, defect and emotional problem as the driving force of an addiction. Addicts are not liked or accepted by the general public and this antipathy extends to patients who are be doing well in treatment. While some addicts may have a character flaw others do not. Nevertheless, methadone is criticized for not addressing the addicts's perceived personality defects. However, programs that have attempted to address the preconceived character disorders to change the addict have generally not validated their claims with large numbers of addicts over extended periods of time. The public does not understand that they harbor a misconception about the basic nature of addiction.

2. The second problem is one of semantics and is an example of language as the purveyor of stigma. The most frequent criticism of methadone treatment is that it substitutes one drug for another or as a variant, one addiction for another. The word drug has an ambiguous connotation. A drug can be either a legal or an illegal substance. The word substitute implies the preservation of an equality and addiction implies the use of a mood altering or euphoria producing substance. Thus the criticism substituting one addiction for another blurs or lessens the differences between heroin and methadone and also the differences between heroin

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addiction and methadone maintenance treatment. Furthermore, Miller's (1974) concept of tertiary deviance as applied to methadone treatment connotes a connection to the primary deviance of heroin addiction. Thus, the carefully researched medical regimen of methadone maintenance for the treatment of heroin addiction is reduced to a trivialization. The word addiction itself leads to ambiguous connotations. In one sense it is associated with alterations of mood, compulsive use and criminal behavior. In another sense, it is the strict biological phenomenon of physical dependence, tolerance and withdrawal. In the public's mind both intertwine to create a nebulous state defined or labelled as addiction.

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

4. Narcotics which include methadone are perceived as inherently evil. A moral quality is placed within the molecular structure of heroin and methadone. The social stigma is not only transferred to individuals but to the medications they are taking to control their addictions. Methadone, itself becomes stigmatized. Thus the political and social roles of drugs and medications influence the perception of the pharmacology. Therefore methadone is perceived as just a substitute narcotic to continue a legal addiction and not perceived as a researched medication prescribed to control a chronic condition.

According to Gordis, these concepts influence the thought and action of government policy makers and administrators. He cites, as an example the report of the 1988 White House Conference for a Drug Free

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America. With all of the research that has been completed on methadone, an intelligent group of people came to the "incredible recommendation" that the only treatment for narcotics addiction that required a "thorough new evaluation was methadone maintenance!" Gordis emphasizes that, no other treatment in alcohol and drug abuse has been as extensively evaluated or showed such consistent results. The results of evaluations for drug free programs are "far thinner and much less convincing." He sums up his observations with the following statement:

> "Once again we see a group of intelligent, well meaning people being swayed by a combination of the stigma of addiction and the failure to understand the complexities of methadone maintenance."

Funding Allocations

In the 1980s about half the admissions to methadone treatment were infected with the human immune deficiency virus and during the cocaine/crack epidemic it was estimated that about 60 percent of the admissions were dually addicted. New patients also presented serious social problems such as homelessness and chronic unemployment endemic to minority groups within the inner cities (Joseph, 1992). The counselor to patient ratio was funded 50 to 1 (Corradi, 1994). Other drug and alcohol programs were funded at ratios of patients to staff of 30 and 20 to 1. Although AIDS counseling was provided in methadone programs, the counseling ratios and legislative monies allotted to the programs reflects another aspect of stigma since programs were being discriminated against by the lack of funding and services that should have been provided. In summation other social service, drug free programs, therapeutic communities and alcohol treatment programs are more generously funded although they had never been subjected to the rigorous evaluations that methadone programs underwent since its inception. Most importantly, these programs were never able to demonstrate the same type of successful outcomes as methadone treatment with large groups of patients over long durations of time.

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Clinic Regulations

Experiences with a few unscrupulous physicians in the 1970s gave the federal government the rationale to regulate methadone treatment. Also, other abuses came to light on the street level. Methadone was sold by poor unemployed patients on the streets who diverted some of their medication to the "black market." Diverted methadone was sold primarily to untreated addicts (Galea, 1994, Institute of Medicine, 1995). Primary methadone addiction has not emerged as a public health problem since the mood altering quality of methadone for non-tolerant persons is dull as compared to the rush and euphoria of heroin. The DEA regard methadone as a euphoria producing narcotic and a major diversion issue. The Institute of Medicine (1995) has seriously questioned the claims of the DEA and from available data concludes that methadone diversion is a "relatively small part of the drug abuse problem generally." Furthermore, the Institute of Medicine indicates that data to support the allegations of the DEAs concern about widespread methadone diversion "are not available" and "... it is impossible to arrive at a clear assessment of any potnetial public effects of diverted methadone."

Emergency room episodes involving controlled substances show that methadone ranks last of the 20 controlled drugs monitored by the Drug Abuse Warning Network (DAWN). Furthermore, some of the methadone mentions in the DAWN report may include methadone patients who may have used the emergency room for legitimate medical conditions not related to the use of drugs (Institute of Medicine, 1995).

Instead of expanding and improving services, the federal government instituted a multi-tier regulatory process though the following three agencies (Institute of Medicine, 1995):

1. The Federal Drug Administration for establishing medical safety, and consistent quality.

2. The Drug Enforcement Administration to supervise production and distribution including the monitoring of clinics for diversion.

3. The Department of Health and Human Services monitor how methadone is

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used in the treatment of opiate addiction.

Additional tiers of regulations have been created by individual states, counties and municipalities. These multi-levels of regulation have been instituted to control diversion by dysfunctional patients (Molinari, Cooper and Czechowicz, 1994). However, all patients are subject to these regulations irrespective of their adjustments and level of social functioning. These regulations could be seen as the successors to the numerous narcotic laws passed by the federal government, states and localities since the Harrison Narcotic Act of 1914. In effect methadone patients are placed by these regulations under more strict supervision than convicted probationers and parolees.

The Effect of Regulation on Compliant Patients

Regulations govern every aspect of treatment (admissions, staffing, record keeping, treatment plans, reporting requirements for patients, frequency of urine testing, dose ceilings, amount of methadone a patient is allowed to take home, amount of time a patient can travel with methadone, etc.). State and municipal regulations may be more restricting than the federal regulations and even contradict them: patients must report seven days a week, ceilings on maximum dose which are lower than the recommended effective dose and time limits on the duration of treatment are some examples. Methadone treatment cannot be obtained in 10 states (11 if you include upper Michigan) and one state, New Hampshire has made it illegal to prescribe methadone to treat addiction and chronic pain (Lowinson, Marion, Joseph and Dole, 1992).

These regulations affect every aspect of the patient's life: personal and business travel are restricted, the patient must report at least once per week to clinics within set hours that may conflict with work, home responsibilities and education. Furthermore the patient must urinate on demand if randomly picked to do so. The clinic physician is also bound by these rules and must request permission to prescribe methadone above certain amounts if the patient feels uncomfortable, has a medical condition, or taking a medication that accelerates the metabolism of methadone (Lowinson, Marion, Joseph and Dole, 1992).

Dole (1994) has the following to say about the regulations and its relation to stigma:

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"By the time the early 1970s arrived the methadone program was treating thousands of people around the country and several national methadone conferences had been held. It was clear that the fiction of it being an investigational program had passed and one would have to face up to the reality that it was an established program that had been thoroughly evaluated. It was clear medically that it was the best available treatment for narcotic addiction. So we were forced into the position of letting this now be brought into the new drug category as opposed to its previous investigational status. This now opened the way for anti-methadone forces to converge from the Bureau, now transformed into the Drug Enforcement Administration but staffed by the same people, and competitive drug free programs and others, all converged on the fact that methadone should be eliminated. If it couldn't be eliminated then it should be contained in a very rigid package. So without any consultation with us, the primary treatment program, a group from the Food and Drug Administration, the Drug Enforcement Administration and various other agencies set up the most rigid set of protocols that have been experienced in the field of medicine. An unprecedented invasion of medical responsibility. In all respects programs were restrained to a certain format – dosage, objectives – which radically changed the nature of the program and many became punitive.

Now on the stigma side, patients in the early years of the program, from 1964 to 1972 or so, were proud to be in methadone programs. They saw how much they had accomplished and were proud that they had jobs and took care of their families. They were often times proud to discuss their progress with medical people who visited the program. However,

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> the pressure from the federal government early in the 1970s translated into oppressive rules which began to transform the programs. Also, the type of doctors that were willing to work in them were themselves abstinence minded and saw methadone as a crutch that should be thrown away."

Dr. Dole's observations were corroborated by several employed patients in medical maintenance. Programs are now subjected to audits by inspectors from various agencies who never see a patient. Also the inspections have little or nothing to do with quality treatment or program outcomes but with conformity to regulations that can be cited as violations. Therefore, in order to survive, a major objective of programs is to conform to the regulations of various agencies by developing forms and record keeping that are acceptable to inspectors. The regulations made the programs less flexible and the rigidities imposed by the regulations affected counseling by staff. The following statement issued as a petition to the administration of the methadone program at Beth Israel Medical Center by the Committee of Concerned Methadone Patients (CCMP), a organization that preceded the current National Alliance of Methadone Advocates (NAMA), highlights the effects of the newly imposed federal regulations on the adjustment of patients and the counselling that emphasized control rather than rehabilitation.

> "Re: Commentary on Our Program
>
> It is our considered opinion that were we to enter into treatment today, we would most certainly not succeed. In fact, given today's restrictive and repressive conditions, we probably would not even apply for treatment.
>
> In general, we can say with certainty that the program is being operated for the convenience and benefit of staff rather than the patients. Patients are treated disrespectfully. Psychological and health needs are being met minimally, if at all. Common courtesy is more forthcoming

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from strangers than staff members who are ostensibly charged with patient care. This must change or there will be no program in the future (Research Assistants and Patients, 1975)."

In many instances the clinics became centers of control imposing the regulations in rigid ways that further stigmatized and infantilized patients. One of the first women patients admitted to the program in 1967 related that until the early 1970s the programs really helped patients:

"The clinics were pleasant to come to and if a patient had a problem the staff was interested. There was also flexibility. However around the early 1970s this began to change. Before I became a counselor, I used to work two or three jobs. My elderly mother lived in Florida. Before the 1970s I was able to obtain methadone to go to see her. However, during the 1970s the regulations became strict. I remember asking for a two week supply of methadone, but the clinic doctor felt that I was taking too many vacations. I told him that my boss would let me go and that I had the money for the trip but the clinic doctor refused my request even though it did not require too much on his part to get the approval. It is the control and the different levels of supervision. You have the nursing staff with their supervisor, the counseling staff with their supervisor and the doctor who is responsible for dose changes and reporting. There may be conflicts between the nursing and counseling staff on decisions about reporting and dose and who the doctor relies on for decisions."

Another patient who is in the medical maintenance program and works for a large methadone program indicated that the clinics were part of an institution:

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> "I would never want to go back to a clinic. My medical doctor is terrific and I get personal attention. In a clinic, at best, you have to manipulate a few systems. There is the nursing staff and sometimes a nurse would be in a bad mood. So there is also the counseling staff and the counselor might not be in such a great mood. Then there were different supervisors in the clinic and the doctor who was hardly ever there. When everything came together it was okay, but sometimes someone would come in, get up on the wrong side of the bed in the morning and you would have to adjust.
>
> Another thing is the vacation medication and the regulations. I have known patients who did not go on vacations because the clinic would not trust them with medication. They wanted to visit their families in other states. The families did not know about the patient being on methadone. The program wanted to assign the patients to pick up methadone everyday in local programs in cities where they were going - to pick up for a week or so. Now the patients would have to make excuses everyday to pick up methadone at strange clinics – the families might find out. Patients would rather not go on vacation if they couldn't get extra bottles to travel. The most you can get is up to two weeks – beyond that the program has to get permission from the government."

There are patients in medical maintenance who profited from the counseling offered in some of the clinics despite the regulations. One patient remarked:

> "In the clinic I attended, the staff was friendly, I never had any trouble.

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> However, it was a clinic with a set of regulations. I thought that clinic staff did the best they could considering the system. Medical maintenance with a private doctor is much better, its more personal."

Some patients had been in more than one clinic and were able to compare the implementation of regulations under different administrations. One patient who was treated in two clinics gave the following account:

> "In the first clinic the atmosphere was friendly. It was like a waiting room. We sat and waited to be called and the nurse individually medicated us. We were treated as patients. Then when I moved from the city I was transferred to another hospital where everything was strict. The doctor was like a "Nazi." There was drug dealing around the clinic and patients were not trusted. However, I was a model patient in both clinics. I never abused drugs and when other doctors prescribed medications, I told the clinic. My urines were 'clean' from the time I entered treatment.
>
> I will never forget the time I was asked for a urine sample and could not urinate freely. After much effort I did give the nurse a very small sample. She was not satisfied, and my take home privileges were suspended for the week."

This patient was an employed mother. From all criteria she could be considered responsible yet according to the regulations or the interpretation of the regulations, she was to be punished for not being able to urinate freely on demand. In this particular instance a model patient could not be trusted by the staff and therefore, regulations about random urine samples were not modified.

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Another patient stated that in the first clinic she attended:

> "The attitude towards the patients was terrible. I remember I had a urine that was positive for heroin and I denied using. Fortunately, I was in therapy and the therapist was also taking urines. I had a urine specimen which showed that I did not use heroin. When I brought in the results of the test taken by my therapist, the clinic staff accused me of being a trouble maker. I transferred to another clinic connected to a hospital and found that the counseling and the attitudes were better."

Notwithstanding the regulations the quality of the clinics developed unevenly during the past two decades. Regulations have limited the prescribing of methadone within a marginalized clinic system that perpetuated the stigma associated with methadone maintenance treatment. Molinari, Cooper and Czechowicz (1994) indicate that the excessive multi-layers of regulations by federal, state and local jurisdictions have hampered the administration and expansion of methadone treatment that is unique in medicine in the following statement.

> "In addition to the separate federal registration and regulation of narcotic treatment ..., many states require separate registration and compliance with state treatment standards. Multiple federal and state registrations have established a relatively small treatment system, ... with a federal and state oversight bureaucracy. While this closed system has presumably reduced methadone diversion, the correlation between quality of patient care and program registration or compliance to treatment standards has never been established. To the contrary, some evidence suggests that the quality of programs and treatment outcomes may be getting worse. ... Patients are rarely

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> treated in private physicians' offices. Most patients are treated in large numbers in a clinic setting and actually do not consult with a physician. Unlike any other medication, a psychiatrist or internist treating one or several opiate-addicted AIDS patients in their private medical practice must refer such to a government-licensed narcotic addiction program... Keeping methadone treatment isolated from small individual medical practice continues to stigmatize further this particular patient population and the treatment modality."

Molinari, Cooper and Czechowicz (1994) indicate that the regulations have to be changed and that organized medicine "will need to take a leadership role." They conclude by stating, "We believe it is time to initiate the process of making narcotic addiction treatment more consistent with the other medical therapies and to mainstream this treatment (methadone) into the general health care system." In 1995 the Institute of Medicine addressed the oppressive regulatory system. The following statement was issued acknowledging the problem:

> "... the scope of federal regulation of methadone treatment should be reduced in favor of authorizing greater clinical discretion in determining appropriate medical treatment. One means of assuring that clinical discretion is exercised is through clinical guidelines .... Such guidelines are making their appearance in the substance abuse area, most notably in the Treatment Improvement Protocol (TIP) series of the Center for Substance Abuse Treatment ... the committee considered then as a complete alternative to regulations."

Interestingly, the issue of stigma towards patients was not addressed directly as a major problem by the Institute of Medicine.

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Summary

Stigma has been an underlying current in the implementation of regulations of methadone treatment. The Drug Enforcement Administration which is the successor of the Federal Bureau of Narcotics has been most zealous in its controlling attitudes and practices concerning methadone treatment. Philosophically the Drug Enforcement Administration has supported and espoused an anti-maintenance position. This agency therefore has adopted an adversarial relationship to both patients and the programs under the pretext of controlling a major diversion problem . This powerful regulatory agency linked to other federal agencies that promulgate regulations sanctions the current multi-tiered system of regulations. From the perspective of the working and socially rehabilitated patient this multi-tiered system acts as an invisible and perpetual jail with the programs designated as caretakers.

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IX

The Perception of Stigma

Methadone patients feel they are a highly stigmatized group in society. This was conveyed in interviews concerning their social interactions with relatives, friends and employers. However, there are other stigmatized groups prominent in society. The purpose of this section of the study, therefore, is to determine the patients' perceptions of society's stigma against methadone patients compared to other stigmatized groups. Some patients harbor more than one invisible stigma. To ascertain which invisible stigma is considered greater, four methadone patients with lesbian and gay sexual orientations were interviewed as well as patients treated for emotional problems and alcoholism. To determine whether another identifiable group holds similar or differing perceptions of social stigma, twenty-three elementary school teachers were also interviewed.

Methodology

A stigma rating form was created and administered to 58 methadone patients and to a comparison group of 23 elementary school teachers. The teachers were waiting on line for their paychecks when they were approached to volunteer by another teacher who was also the elected union delegate from the school and was regarded as a leader. The teachers evinced considerable enthusiasm for the study and consented to participate.

The purpose of the form was to determine the order of the perception of social stigma directed at the following ten groups which are highlighted in the media:

1. Persons with HIV/AIDS
2. Heroin and/or Cocaine Addicts
3. Physically Disabled People (e.g., Amputees, Users of Wheelchairs, Blind and Deaf Persons)

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4. Persons with Serious Criminal Records
5. Minorities (Persons of Color)
6. Methadone Patients
7. Homeless People
8. Gays and Lesbians
9. Alcoholics
10. People with Histories of Mental Illness or Mental Retardation

Each group was rated on a scale of from 0 to 5 with 0 being no perceived social stigma to 5 the highest rating for a particular perceived social stigma. A mean stigma score was computed for each group. The stigmatized groups were then ordered by the scores into two categories: methadone patients and school teachers. The mean stigma score therefore incorporates in one number the level of social stigma as perceived by the respondents directed to a particular group of people. (See Appendix for Stigma Score Form.)

Results

Table 1 summarizes the scores of socially perceived stigma of the ten groups as reported by the methadone patients and a contrast group of school teachers. They are ranked within the first five stigmatized groups that include active heroin and/or cocaine addicts, persons with serious criminal histories and people with AIDS/HIV. Methadone patients are placed within the first five socially stigmatized groups by both the methadone patients (Rank Order=3) and the teachers (Rank Order=5). For both groups methadone patients are perceived to be more socially stigmatized than alcoholics, the homeless, minorities, the physically disabled and gays and lesbians. These are probably among the most stigmatized groups in society. Furthermore, with the exception of the mentally retarded and mentally ill, the causality of the problems within first five groups are perceived to be the result of the affected individual's behavior. This reflects the belief that the affected persons brought the problems on themselves.

Overall, Table 1 reveals a similar pattern of perceived social stigma among methadone patients and teachers. Active heroin and cocaine addicts are perceived of as having the greatest social stigma, followed by

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Table 1
Order of Perceived Social Stigma of Different Groups by Methadone Patients and School Teachers

	Methadone Patients (n=58)		School Teachers (n=23)	
Rank Order	Group	Stigma Scores	Group	Stigma Scores
1.	Heroin & Cocaine Addicts	4.63	Heroin & Cocaine Addicts	4.48
2.	Persons with Serious Criminal Histories	4.32	Persons with Serious Criminal Histories	4.44
3.	Methadone Patients	4.29	Persons with HIV/AIDS	4.43
4.	Persons with HIV/AIDS	4.25	Mentally Ill and/or Retarded	3.90
5.	Homeless People	3.73	Methadone Patients	3.69
6.	Gays and Lesbians	3.42	Gays and Lesbians	3.52
7.	Minorities (People of Color)	3.37	Homeless People	3.45
8.	Mentally Ill and/or Retarded	3.24	Alcoholics	3.34
9.	Alcoholics	3.00	Minorities (People of Color)	3.23
10.	Physically and Sensorially Disabled	2.33	Physically and Sensorially Disabled	3.04

persons with serious criminal histories. These two groupings probably are the most stigmatized in the United States and methadone patients have histories both of heroin addiction and serious crime.

With methadone the stigma was transferred from heroin addiction to methadone treatment. The public is ignorant and does not know how to treat the methadone patient: Are they still addicts in the sense of heroin addiction? Are they methadone 'addicts,' or are they cured? The confusion has resulted in a transfer of stigma and image from the heroin addict to the methadone patient. The order of Table 1 reflects the attitudes of the public. Methadone treatment is highly stigmatized following the primary deviance of heroin addiction and criminality. Thus, the perceived degree of social stigma is slightly less than that of the

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heroin/cocaine addict and those with criminal histories.

In both groups gays and lesbians rank sixth with the physically disabled ranking tenth. Stigmas perceived as behavioral have greater rankings than stigmas that are perceived as not under the person's control. Teachers on the other hand regard persons with mental illness and retardation as highly stigmatized. This may be a function of their role in their school. Students with serious mental illness and retardation are known in the school setting and referred by teachers to special education which is a stigmatized classification for a student. Methadone patients, on the other hand, may perceive of mental illness and retardation as less stigmatizing since it is not regarded as volitional. Furthermore, mentally ill and retarded persons may not be a part of the methadone patient's social circle while school teachers may have daily contact with mentally disabled or retarded students who are marginalized within the school system.

Persons with physical and sensory disabilities are ranked last or were given the lowest stigma score by the patients and teachers. The acquisition of a physical disability may be perceived as beyond the person's control or responsibility and, subsequently, there is a degree of compassion for persons so affected. However, prior to this century and modern science persons with physical or sensory disabilities were a highly stigmatized group. The disabilities were seen as a visible moral failing and a mark on the affected person's parents and family.

Interrelationship Among the Invisible Stigmas of Homosexuality, Emotional Disorders and Methadone Treatment

The results in Table 1 suggest that methadone patients may be more socially stigmatized than homosexuals. To further investigate this possibility, four methadone patients (1 white gay man, 1 Latino gay man, 1 black lesbian and 1 Latina lesbian), who also harbored the invisible stigma of homosexuality, were interviewed. The Latino gay man advised that he identifies with the gay culture and participated in the Washington March for Gay Rights in 1993. He also attended the final ceremony of the gay games in Yankee Stadium in June of 1994. He advised that he could never see himself marching in a parade for the rights of methadone patients. Also, he never reveals his status as a methadone patient in casual social relationships but does inform a prospective partner in an extended relationship. At work he is accepted as a gay person.

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He works as a medical technician, considers himself to be skilled and creative "like many gays." At work his supervisor illegally searched his locker and found a bottle of methadone. She did not report this finding to the administration, since the search was illegal. As far as he is able to determine, nobody at his job knows that he is a methadone patient except his supervisor. He is of the opinion that the stigma against methadone patients is greater than the stigma directed against gays which is greater than the stigma directed at Latinos.

The two lesbians indicated that when they are employed, they quickly learn who the "girls" are at work. However, they never reveal their status as methadone patients since they feel they will be the first to be blamed in the office if anything is stolen or "disappears." The Latina lesbian is also HIV positive. In order of stigma, the two perceive HIV infection as the greatest social stigma, followed by their status as methadone patients, having a lesbian sexual orientation and lastly their minority status.

A white gay patient with degrees from Ivy League universities advised that methadone is very stigmatized within certain organizations of the gay community and AIDS activist organizations. He is a member of ACT-UP and indicates that there are people within ACT-UP who do not accept methadone treatment as valid. He met another methadone patient in ACT-UP and was told not to reveal his treatment status to anyone because of the stigma that is directed to the program and possibly to patients. Also, at the Gay and Lesbian Center on West 12th street in New York City, the major treatment recommended for drug addiction is a 12 step program. He advised that gay advocates of the 12 step programs reject methadone maintenance as a treatment for addiction. Also, he is involved in mental health volunteer groups and indicated that methadone is also viewed with suspicion since the philosophy of 12 step programs has penetrated these services. He is currently in therapy for a depression disorder and had to educate both the therapist and the psychiatrist at a well known downtown hospital about methadone maintenance. Although he has improved with time in methadone treatment, the psychiatrist still regards him as an addict.

As a member of the gay community he states that he has never felt more stigmatized since entering a methadone program. At the present time, he is living with a companion but has not informed him of his enrollment in methadone treatment because of the stigma and possible personal rejection. However, he has informed his companion about his depression and enrollment in psychotherapy. Both are regarded as "legitimate:" depression and psychotherapy are socially acceptable.

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A female patient in medical maintenance with a diagnosed emotional disorder has similar comments about the interrelationship of stigmas. She has attended 12 step programs as an adjunct to therapy although she does not abuse alcohol or other drugs. She unknowingly informed the participants that she was a methadone patient and was immediately confronted since methadone was incorrectly considered a mood altering drug. She was not permitted to participate in the meeting and left the group. She embraces some of the principles of 12 step programs and found another group to attend without informing the participants that she is a methadone patient. In addition to medical maintenance, this patient is under the care of a therapist for panic attacks and is medicated for severe anxiety.

When questioned about the possible relative stigmas of methadone treatment and psychiatric treatment with anxiety relieving medications, she advised that methadone is the much greater stigma. She has confided to friends that she is in therapy and is prescribed medication. However, she never tells friends that she is a methadone patient since they have no understanding and only know about methadone from the negative media presentations. Her friends regard methadone treatment as a "legal high" and methadone patients as "legal junkies." For this patient, therapy for anxiety with medication is socially acceptable without serious social stigma. She related that:

> "Television and the media present positive images of recovering alcoholics and drug users in drug free programs such as TC'S (therapeutic communities). Methadone is never positively presented on TV. There are TV commercials for therapeutic communities in the media, ...TV commercials about condoms, but where are the methadone commercials? Even AIDS is more acceptable than being a methadone patient. .... There has been a lot of education about AIDS. It does not have the stigma that it used to have, and people appear to be a little more understanding."

Since she attended AA programs and has met alcoholics, she indicated that the current social stigma for alcoholism is low: "There is an acceptance that this is a medical condition. Participation in treatment for

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alcoholism such as the 12 step program or treatment for drug addiction in a therapeutic community is considered admirable."

Overall, elementary school teachers, a non-stigmatized group may have less of a perception of the social stigma directed against methadone patients since they are not known to be members of that stigmatized group. To test the hypothesis that elementary school teachers may be less perceptive than methadone patients of the social stigma directed to methadone patients, the stigma scores were tested for significance. The t score ($t=1.16$, $p>.05$, $df=79$) did not reach significance. The hypothesis for this particular sample was rejected. There is, however, a tendency in the direction of the hypothesis since teacher's scores do have a lower ranking than the scores of methadone patients for social stigma directed to methadone patients.

Interrelationship Between the Stigmas of Methadone Treatment and Alcoholism

Interestingly, alcoholics who can be functionally impaired from drinking have a lower stigma score and ranking than methadone patients. This pattern was noted by Dr. Norman Gordon[1] (1973) who observed that discriminatory attitudes against methadone patients seem intractable. The following extended quote, although written in 1973, accurately reflects the patients' predicament concerning disclosure of their status as methadone patients in 1994.

> "...it amounts to a prejudiced set of attitudes, in which unfortunate experiences are extended to embrace even those who are attempting to turn their backs on a sordid past. The attitudes seem amazingly intractable to reason, despite the impressive records that methadone patients have

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1. Dr. Gordon is a psychologist who directed the administration of intelligence, psychological and motor coordination tests to methadone patients thus proving they are able to function unimpaired and within the normal range.

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shown by giving up lawbreaking activities and self-destruction and turning to society for help with their addiction. These attitudes were nowhere more apparent than in two hearings before a semi-public body which this writer attended as an expert witness.

... In both cases, the patients involved had worked successfully for periods of time while they were heroin addicts, with only relatively minor negative marks on their records for occasional absenteeism. They both received on-the-job promotions. Quite accidently, they were discovered to be methadone patients, and as soon as that happened, and for no other reason, they were suspended from their jobs. It should be emphasized that both individuals had voluntarily entered methadone treatment because they had become tired of the heroin-seeking rat race. The reason given for the suspensions was that no person can be employed who consumes narcotics without the permission of the organization's physician, and he would not give such permission. The argument given against permission was two fold. On the one hand, the fear was expressed that the individual might cease taking methadone and then revert to heroin, leading to employment of a potential criminal. On the other hand, the notion was expressed that since methadone as well as other narcotics are chemicals of unknown consequence to the body, the individual's behavior might be unpredictable. Yet, at the same time, this particular employer maintained a sizable facility for the treatment of employees who were alcoholics, and alcohol when consumed prior to important psychomotor tasks is known to lead to impairment. Yet no employee who confesses to having an alcohol problem and seeks treatment is summarily suspended. Here we find the apparent inconsistency

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> in attitudes: one condition leads to the branding of its victim as a social outcast and an employment risk. Even when faced with the detailed findings of our extensive research, the attitude could not be changed, and the suspensions were not lifted."

Mr. Stanley Novick (1994), the president of NAMA and a former methadone patient, reports that 12 step programs (Narcotic Anonymous and some Alcohol Anonymous groups) usually discriminate against methadone patients. He reported that local AA and NA groups regard methadone as a mind altering drug and will allow methadone patients to observe meetings but not actively participate. However, the national AA accepts methadone as a legitimate medication. This attitude, however, has not filtered down to local groups. Mr. Novick has been instrumental in attempting to organize 12 step programs for methadone patients known as Methadone Is Recovery. Also, Methadone Anonymous and Methadone Awareness groups are forming throughout the country because of the stigmatizing and rejecting attitudes of established 12 step groups to methadone patients.

Dr. Enoch Gordis (1991), director of the National Institute on Alcohol Abuse and Alcoholism, reported that there was a considerable amount of stigma against methadone patients in alcohol treatment programs throughout the country. Dr. Gordis has made the following observations about the interrelationship between alcohol treatment, 12 step AA programs and methadone maintenance:

> "Also at issue is a topic that has been of interest in recent years with so much polydrug use – the relationship between methadone maintenance and 12 step recovery programs. In my opinion, there has been an unwarranted philosophical obstacle set up by many alcohol treatment programs that require methadone-maintained alcoholics to withdraw from methadone use before receiving treatment for their alcoholism. Doing so places the methadone-maintained individual at clear risk for relapse to narcotic use and represents a misunderstanding by alcoholism treat-

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> ment programs of the pharmacology of methadone. Methadone maintenance is consistent with drug-free 12 step programs and should not be an obstacle to alcoholism treatment."

The problem that Dr. Gordis related in 1991 has not been resolved by 1995. In 1992, the New York State agencies devoted to funding drug and alcohol treatment merged. Treatment programs for alcoholism known as Alcohol Treatment Centers refuse to treat alcoholic methadone patients unless they withdraw from methadone. To address this problem, a pilot project was planned in 1994 to introduce a policy change that would permit alcoholic methadone patients to be treated at certain centers without withdrawing from methadone.

A patient in medical maintenance who has been employed for about 10 years in the personnel department of a major corporation in New York City advised that she cannot reveal that she is a methadone patient because attitudes of rejection and suspicion would arise. She knows this from conversations and meetings in the office. Furthermore, she will probably never get a promotion if the company were aware that she is a patient. Although there is an Employee Assistance Program (EAP), it addresses problems mostly related to alcohol. Drug abusers are regarded with suspicion since they may have acted illegally in the past. Alcohol is considered legal and is readily available. Furthermore, there are persons at all levels of the corporation who have alcohol problems. Alcoholics are given every chance before they are fired. Alcohol relapses are tolerated and alcoholics can get promotions even if they are not completely sober but are participating in a program and showing progress. This is not the policy directed to drug addicts. Addicts may be referred to treatment and be in treatment, but if there is a slip up then the company tries to get rid of the employee. Methadone is seen as just another drug. It also implies that the employee must have done something illegal such as past use of heroin or committed crimes to obtain money for drugs. Even if doing well a person with a drug abuse history, especially heroin, will probably never get a promotion. The patient participates in management discussions and indicated that excuses will be found to either dismiss the employee or prevent promotions.

An example of the stigma that is experienced by methadone patients in traditional AA and NA 12 step programs was relayed by a methadone patient in good standing who is also a recovering alcoholic. He

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related the following after revealing to an AA member that he is a methadone patient.

> "On the 18th of August, 1994 I attended an AA meeting. At a previous meeting I shared in front of the whole room that I was back on methadone. I was trying to be honest. It was a big mistake. I was immediately blackballed by my friends and other people in the room. Then at the current meeting, I shared with another member who had history of alcohol, heroin addiction and pills that I was currently on methadone. He was also on methadone for a period of time. He then insulted me by saying that he could never do what I am doing presently because if he were on methadone he would use other drugs. He stated that he is using on a self medication basis codeine #4, narcotic for a back problem. He considers himself clean and sober but he regards me a failure because I am on the methadone program. I have clean urines, am writing articles for local newsletters and have been given increased take home medication since the program is beginning to trust me. However, the people at AA whom I have helped in the past and never judged are now stigmatizing me, insulting me to my face and talking behind my back. I am going to find another group that is more accepting."

Another example of the relative stigma against methadone patients in comparison to alcoholics was relayed in an interview by an active member of the squatters movement on East 13th Street. This methadone patient in good standing is a graduate of a major university, is a writer and former college instructor. He is on the patient advisory board at a local hospital and has helped edit several neighborhood newsletters. In an argument with neighbors about policy of squatters talking to the media, he was insulted by being called a "junkie" by active alcoholics who were members of the squatters movement and were aware of his enrollment in a methadone program. His persona is one of a neatly groomed, sober, intelligent and literate individual.

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In oral histories conducted by this writer in the 1980s of Russian immigrants who were enrolled in methadone programs in New York City, it was reported that the stigma of opiate addiction was greater in Russia than being an alcoholic. The immigrants were addicted to opiates in the former USSR where possession of opiates is illegal. Alcohol is available legally and alcoholism, although widespread, is treated medically. The interrelationship of the relative stigmas of alcohol and opiate dependency appear to be the same in both the United States and the former USSR.

Discussion

The perception of social stigma directed towards methadone patients was examined in relation to other stigmatized groups. In the two samples that were interviewed, methadone patients and a contrasting convenient sample of elementary school teachers, the trends of perceived social stigma against methadone patients is high. The rank ordering of the stigmatized groups is similar for both the methadone patients and the school teachers.

The perceived social stigma against methadone patients is ranked within the cluster of the highly stigmatized groups — heroin/cocaine addicts, persons with serious criminal histories, persons with HIV/AIDS. In this cluster persons may be considered by the public and the media as responsible for the onset of their problems and conditions because of their behavior. Methadone maintenance therefore may be related in the public's perception to other major stigmas such as AIDS and criminal behavior that are associated and transferred to methadone itself.

There are about 115,000 methadone patients in the United States. They are currently being organized into advocacy groups by NAMA. Many are poor, distrustful of the medical profession, the government and fearful of retaliation in demanding quality treatment with dignity. The powerlessness, stigmatization and marginalization is reflected in the perceptions of patients with two or more invisible stigmas. Thus, patients with two or more stigmas regard their enrollment in methadone treatment as the greater.

Perhaps the most ironic trend is that the perceived social stigma is less for an alcoholic who may be severely impaired than for a methadone patient who may be functional. The lower perceived stigma of alcoholics in society may be attributed to their current organizational networks, political influence and

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educational strategies that transformed the public's understanding of alcoholism from a highly stigmatized condition to what is now considered a legitimate disease. Furthermore, treatment programs for alcoholics usually do not accept alcoholic methadone patients since methadone as prescribed in maintenance treatment is incorrectly regarded as a mood altering drug.

Neuroscientists have identified receptor sites and endogenous ligands, but a cohesive theory of addiction has, as yet, not been formulated. While a complete understanding of physiology does not exist for other recognized medical conditions (e.g., diabetes, epilepsy, alcoholism), medical treatments that have proven viable but less effective than methadone are accepted as legitimate. The perception of methadone as less than treatment marginalizes and stigmatizes this effective therapeutic intervention.

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X

Retention in Medical Maintenance

In this chapter the outcomes of medical maintenance treatment will be presented. This will include demographic data obtained at the time of intake and reviews of their records (Table 2). Also included will be a survival curve with data obtained from medical records concerning the duration of time in treatment, level of dose by employment at time of admission, a crude death rate and reasons for discharge (Figure 1 and Tables 3-5b). Follow-up on discharged patients will be reported.

Methods

Subjects: Selection of Patients

In 1983 an initial 23 patients were selected for a pilot project from Beth Israel Medical Center's methadone program. An additional 93 patients were interviewed from 1985 to 1989, but only 77 patients were selected based on the criteria listed below. They were referred from Beth Israel and other programs.

The criteria for admission to the program is as follows:

1. All applicants must have five consecutive years of methadone treatment.
2. No arrests or evidence of excessive illegal substance abuse or alcoholism within the last three years.
3. Must be employed in a verified stable job for at least three years.
4. Positive record in methadone treatment. No behavioral problems in the program. Patient must be cooperative with the rules and regulations.

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5. Patients with emotional and other medical problems must be under verified care to qualify for medical maintenance. They must also permit an exchange of information between the medical maintenance physician and other physicians.

6. Spouse must not be an active drug user. If spouse is in a methadone program, the spouse should be in good standing and will be considered for acceptance in medical maintenance.

7. Patient must have a safe place to store medication.

8. Patient and referring clinic are of the opinion that medical maintenance is important to improve the quality of the patient's life.

9. Patient must be recommended by clinic staff.

10. Patients must enter voluntarily.

Subjects: Rejection of Patients

The 16 patients who did not meet the above criteria were rejected for the following reasons:

1. Ten patients had episodes of cocaine or alcohol use within the three years period prior to the application.

2. Three patients had incidents of noncompliance with clinic rules.

3. One patient was rearrested within the past three years.

4. One patient had a spouse who was using cocaine.

5. One patient showed evidence of serious emotional instability.

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Survival Curve

The survival curve was calculated using the SPSS package. The observation period is 126 months for 100 admissions between 1983 and 1989 and continued to a final date of December 31, 1993. Dates of admission, treatment status and discharged date, reasons for termination and causes of death were obtained from physicians and medical records.

Crude Death Rate

A crude death rate was calculated in patient years. Patient years in treatment was determined by combining the years in methadone treatment and medical maintenance. Thus, the denominator in the calculation represented the total time the patients were maintained on methadone.

Follow-up Information

Information concerning the adjustments of discharged patients who were returned to the methadone clinics of origin was obtained from the Acting Director of the methadone program at Beth Israel Medical Center. This researcher was not permitted to interview the patients who had failed in medical maintenance and who in treatment at Beth Israel. The Acting Director felt that the situation would be embarrassing and somewhat traumatic for these patients. Information about the adjustments of patients who left in good standing was obtained through interviews either, with former patients, a family member or interviews with the physician. The follow-up information was obtained from 12 to 66 months after withdrawing from methadone.

Results

Demographic Data

Table 2 presents demographic information on the first 100 patients admitted to medical maintenance from 1983 to 1989. This cohort has an observation period of 57 to 126 months (4.75 to 10.5 years) ending on December 31, 1993. This group is not typical of methadone maintenance patients in clinic system. Fifty-nine of the patients either attended college, graduated or went on to graduate or professional school. This educa-

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tion was obtained while they were enrolled in methadone maintenance. All of the patients in medical maintenance are employed or in college in comparison to methadone maintenance programs where only about 28 percent of the patients are employed or going to school (Randall, 1994). Also, the patients in medical maintenance are predominately white and male. The ethnic breakdown for methadone maintenance programs in New York City is about 65 percent black and Latino and about 30 percent female. The patients in medical maintenance have been in methadone treatment for about 15 years as opposed to the rapid turnover in clinics and short retention of about 2 to 3 years for patients in the clinic system. The majority of patients in medical maintenance are married.

Several medical maintenance patients have previously attempted withdrawal from methadone, only to relapse and reenter the program. Seventy patients have one continuous episode of treatment, twenty-six have two episodes, three have three episodes and one has four episodes. Other medical maintenance patients who are on low doses have attempted to withdraw but had to be restabilized because of physical discomfort.

Life Table and Retention

Figure 1 is a life table showing retention in medical maintenance. For the 67 active patients there are five to ten years of observation depending on the year of entry into medical maintenance. Of the 33 terminations, twenty-nine (91%) occurred during the first five years of observation. Table 3 presents interval time in years for the life table, the number of patients entering during a particular year, the number being removed, the number discharged, the proportion remaining in treatment (surviving) and the cumulative proportion remaining (surviving) for each year. The median survival time is over 10 years (126 months).

Within the fifth year of observation, nineteen patients were removed from further observation because of lack of time in treatment. Subsequently, seventeen patients were removed in the sixth year, and eighteen were removed in the seventh year. The proportion of patients remaining in treatment for the first four years was 98, 94, 85 and 78 percent, respectively. Following the removing of patients in the fifth year because of lack of time, the cumulative proportion of patients remaining in medical maintenance was 70% for the fifth, sixth and seventh years of observation. The cumulative proportion of patients remaining in treatment decreases to 63% during the eighth year of observation, and to 54% in the ninth and tenth years of observa-

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Table 2

Demographic Data, Addiction and Treatment Histories of 100 Methadone Patients at Entry into Medical Maintenance

Category		(SD)
Mean Age at Admission to Medical Maintenance	43	(9)
Gender		
Male	78	
Female	22	
Ethnicity		
African American	9	
Latino/a	8	
White	83	
Marital Status		
Married	61	
Single	16	
Separated/Divorced	13	
Widowed	5	
Common-law	3	
Engaged	2	
Educational Level		
Less than High School	17	
High School	20	
Vocational	4	
Some College	38	
College Degree	14	
Graduate/Professional	7	
Means of Support		
Full Time Employment	97	
Part Time Employment	1	
College Scholarship, Veteran's Benefits	2	
Average Annual Income	$32,672	(18,450)
Average Age First Used Heroin	18	(4)
Average Age First Used Needles	19	(5)
Average Years Addicted to Heroin	8	(5)
Average Age First Arrested	20	(5)
Average Number of Arrests	6	(8)
Average Months Incarcerated	19	(31)
Average Age Entered Methadone Maintenance	28	(7)
Average Years in Methadone Maintenance	15	(4)

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Retention in Medical Maintenance

100 Patients Admitted 1983 - 1989

Data to December 31, 1993

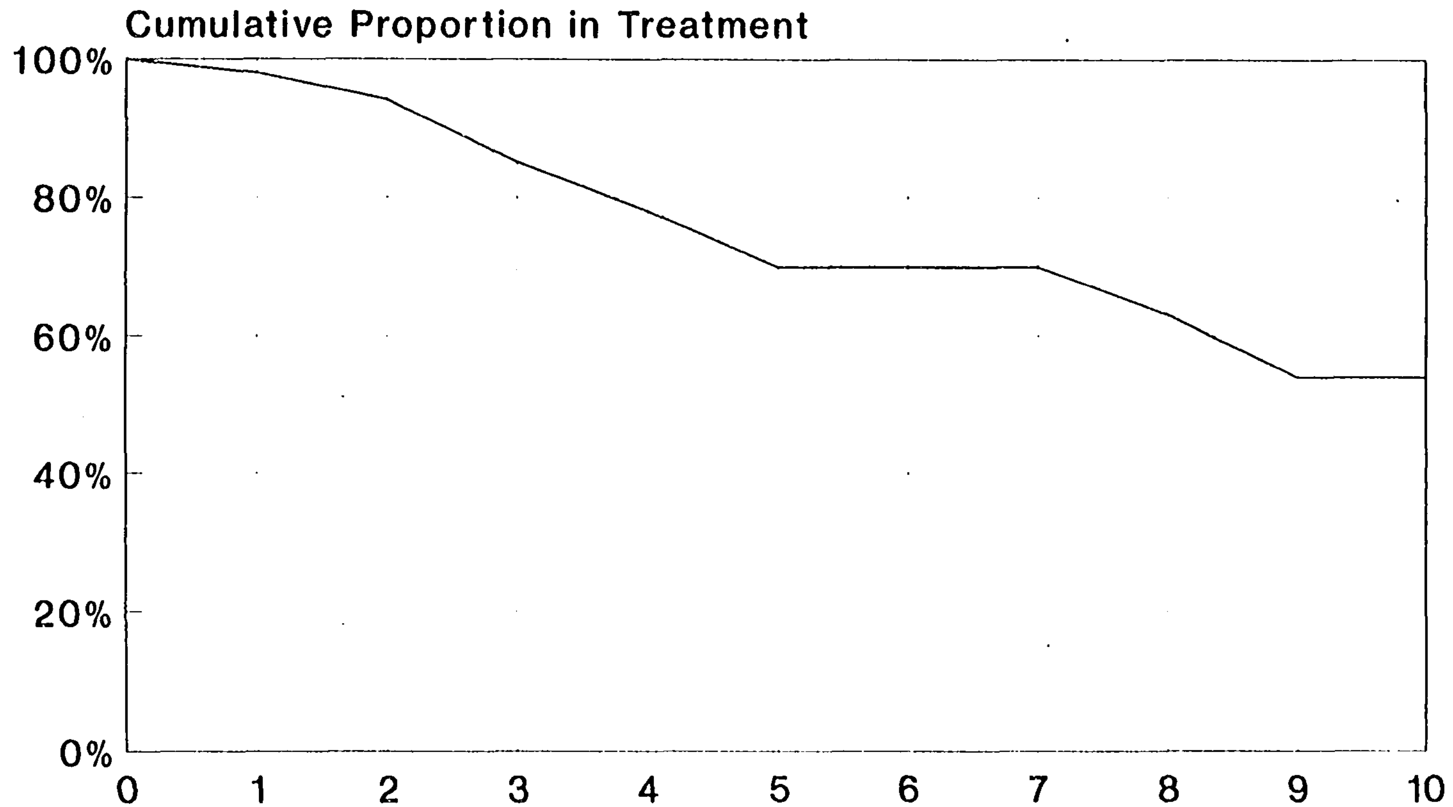

Figure 1

Figure 1

tion. This retention data compares favorably with a survival analysis of retention in methadone treatment in California of Anglo and Chicano men (45% and 57% retained respectively over a 20 month period) (Yih-Ing, Anglin and Yin, 1990-91). Gearing (1970a) showed in an analysis of retention using life tables that over 1530 men have an 86 percent probability of remaining in treatment for a year, and a 74 percent probability of remaining in treatment for 2 years. No statistical differences in retention was found for the three groups studied which included black, Hispanic and white. The retention in medical maintenance over a 24 month period is greater than the retention rate of patients in the general clinic population.

Deaths

There were seven deaths. The causes of death included heart attack, meningitis, homicide, stroke, leukemia and lung cancer, and one patient with terminal AIDS was transferred to a hospice and subsequently died. According to medical records, three of the patients who died (e.g., heart attack, lung cancer, and stroke) were heavy smokers. None of the deaths, according to the physicians were related to the use of methadone. The one AIDS death in this group was related to sexual behavior and not to drug addiction. However, there is one patient who became HIV infected in the 1980s from use of a contaminated needle to inject cocaine. The low incidence of AIDS in this group was due to their longevity in methadone treatment and stable adjustment.

The 100 patients had accumulated a total of 2,053 patient-years on methadone -- 1,470 in the clinic system and 583 patient-years in medical maintenance. The crude death rate is 3.4 deaths per 1000 patient years. The mean age of death is 52.7 years (SD=6). This mortality rate is far below that for patients in methadone programs which was estimated at about 15 deaths per 1000 patient years prior to the AIDS epidemic (Joseph and Appel, 1985). In the Beth Israel Medical Center, AIDS is now the leading cause of death for patients in methadone maintenance. All patients who died were in good standing in medical maintenance. The physicians treating the medical maintenance patients were able to coordinate medical care and the prescribing of pain medication with continuing methadone treatment.

Unfavorable Discharges

There were 15 unfavorable discharges from medical maintenance. These involved patients who were

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Table 3

Retention in Treatment as of 12/31/93 for 100 Patients Admitted to Medical Maintenance from 1983-1989

Year	Number Entered	Number Taken Out	Number At Risk	Number Discharged	Proportion Remaining In Treatment	Cumulative Proportion Remaining In Treatment
1	100	0	100.0	2	.98	.98
2	98	0	98.0	4	.96	.94
3	94	0	94.0	9	.90	.85
4	85	0	85.0	7	.92	.78
5	78	19	68.5	7	.90	.70
6	52	17	43.5	0	1.00	.70
7	35	18	26.0	0	1.00	.70
8	17	0	17.0	2	.88	.63
9	15	0	15.0	2	.87	.54
10	13	13	6.5	0	1.00	.54

Medium Retention Time in Treatment is 10+ Years

using cocaine/crack, were administratively unable to report as directed, and lost medication. These patients were returned to their clinic of origin. As noted in Table 4, this group had the highest percentage of patients who lost medication (71%) and all had problems with cocaine/crack. As of September 1994, six (43%) were still in treatment within the Beth Israel system and of these, three of the patients appeared to have resolved their cocaine problems and were employed. The other three had continuing problems with cocaine/crack and valium. Two patients (14%) were incarcerated. One (7%) patient withdrew by entering the Stuyvesant Square Program (Beth Israel Medical Center) and entered therapy, including a 12 step program. This patient who now appears to be doing well had 22 years of methadone treatment before attempting to withdraw. No information was available about the whereabouts of 5 (36%) of the unfavorably discharged patients.

Favorable Discharges

Ten patients successfully withdrew from methadone. They had accumulated a mean of about 16.7 years (SD=4) of methadone treatment. The favorably discharged patients also appeared to have the best records for care of their medication and the lack of illicit drug use. Information was obtained on all ten favorable withdrawals (100%) through patient interviews (5 patients), or information relayed through a relative (2

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patients), or from their former physicians (3 patients). It appears that the ten former patients are abstaining from use of heroin. Five consented to be interviewed: of which three are in therapy, one is in a 12 step program and one is functioning without therapy. One former patient in long term psychotherapy is also being prescribed antidepressants. However, one of the four, despite therapy, appears to be having some problems with drug craving: he had a dream about heroin within a two week period prior to the follow-up interview, has problems sleeping and has written a song about heroin. However, he has not relapsed to use of opiates.

Two of the former patients, a married couple with children, moved to a small town in a rural area. They were contacted by a sibling who is a patient in the medical maintenance program about participating in this study. The couple refused to participate or even be interviewed by phone. While on methadone, the husband completed college, professional graduate education and established a professional practice. The sibling advised this investigator that her brother would not cooperate because he feared a possible breach of confidentiality. Any suspicion of past addiction and methadone treatment could destroy his career. We were told that he and his wife are doing well and that there are no problems with drug use.

Information obtained from medical maintenance physicians on three cases indicated that the former patients moved to other locations and appeared to be doing well. One of the three, however, is an unemployed Vietnam veteran in receipt of disability benefits who is under psychiatric and medical care at a local Veterans Administration Hospital.

Favorable Voluntary Discharge: Return to Clinic

One patient decided to return to the clinic of origin because of confidentiality concerns. The patient used two names – one as a methadone patient in the clinic system and the other as an employee. Nobody at the patients place of work about the patients enrollment in the methadone program. This patient subsequently died of cancer after returning to the clinic program. The extreme caution that this patient took to conceal enrollment in the methadone program reflects the stigmatized condition that methadone patients must contend with. It is a prime example of a discreditable person trying to conceal their stigmatized condition so as not to become a discredited person (Goffman, 1963).

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Summary of Outcomes

Table 4 summarizes the outcomes of the 100 patients. Aside from the outcomes discussed above, sixty seven remain active and in good standing in medical maintenance. The only patients who did not succeed in medical maintenance were the 15 who received unfavorable discharges.

Of the 67 active cases, 6 (9%) have retired and are living on pensions with their families. The remaining patients are still employed in a variety of jobs that span the labor market in the metropolitan area or they are successful owners of their own businesses. Over a ten year period there were seven patients that had lost medication on one occasion and 3 that had transient problems with alcohol or cocaine. However, these problems were resolved with referrals to therapy, and the patients continued in good standing in medical maintenance.

Dose and Employment

Table 5a summarize the dose levels by type of employment of the active patients at the time of their admissions to medical maintenance. For active patients 45% entered medical maintenance on doses of 50 to 100 mg/day. Patients on lower doses started treatment on higher doses but over the years, reduced their dose to levels that were comfortable, allowed them to function without withdrawal symptoms, drug craving or illicit drug use. For Table 5b similar employment categories can be noted in every category (active, favorable and unfavorable discharges and deaths) and at every level of dose.

The medical maintenance patients in construction and electrical work are careful workers and report that methadone does not interfere with balance or coordination. They have accrued impressive safety records and have been employed in their jobs for up to 20 years without incident. Also, one patient obtained a pilot's license and another races boats as a hobby.

In summation, there is no association between level of dose, patient outcome, type of employment and ability to function. A physician who has treated about 60 medical maintenance patients reports that he would expect a variety of doses over time in methadone treatment. He compares it with the varied doses he prescribes to patients with diabetes and thyroid conditions. He indicated that from a clinical perspective, there are only appropriate doses and that these may vary for long term methadone patients as they do for patients with other chronic conditions. Those on higher doses are not "sicker" than those on lower doses. He

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considers dose to be a medical decision that permits patients to function optimally.

During the period 1985 though 1991, 28 patients received increases in their methadone above those prescribed at time of admission. The reasons were that patients were not feeling comfortable on the prescribed dose. They had tried to adjust to doses that were not adequate. The increases were in most cases minimal: four patients were increased by 5 mg/day, sixteen by 10 mg/day, five by 20 mg/day, one by 30 mg/day and two by 40 mg/day over an extended period of time. Two of those who were increased were subsequently sent back to their clinic of origin for cocaine use.

Tests of Significance

Tests of significance were carried out on certain variables to determine whether there were significant differences in outcomes between the following four groups of patients: 1) the sixty-seven who remained active, 2) the eleven who were favorably discharged (e.g., the ten who completed medical withdrawals and the one who voluntary return to the clinic), 3) the seven who died, and 4) the fifteen who received unfavorable discharges.

Analysis of variance was carried out on the following variables to determine whether significant differ-

Table 4

Outcomes of 100 Patients in Medical Maintenance 4.8 to 10.5 Years

Outcome	Number of Patients N (%)	Number of Patients with Incidents of Lost Medication N (%)	Number of Patients With Transient Substance Abuse N (%)
Good Standing in Treatment	67 (100)	7 (10)	3 (4)
Unfavorable Discharge	15 (100)	10 (66)	15 (100)
Withdrawal in Good Standing	10 (100)	0 (0)	0 (0)
Deaths	7 (100)	1 (14)	0 (0)
Voluntary Return to Clinic	1 (100)	0 (0)	0 (0)

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Table 5a

Level of Dose by Type of Employment for Sixty Seven Active Cases at Time of their Admissions to Medical Maintenance

Level of Dose mg/day	N (%)	Type of Work
05 - 20 mg/day	11 (16)	auto mechanic, bartender, 3 counselors, drafting, 2 maintenance men, owner of business, social worker , TV repairman
30 - 40 mg/day	18 (27)	agency administrator, computer operator, construction crane operator, 4 counselors, electronics salesman, elevator mechanic, musician, owns business, rental agent, secretary, skyscraper window cleaner, sports events coordinator, supervisor, teacher, warehouse manager
50 - 60 mg/day	11 (16)	bookkeeper/computer, 3 counselors, doorman, electrician, graduate student, musician, owns business, postal worker, sales
70 - 80 mg/day	14 (21)	bookkeeper, computer systems analyst, 2 counselors, electrician, fire department, 3 health workers, 2 owners of businesses patient advocate/benefits, quality assurance clerk, sales
90 - 100 mg/day	13 (19)	cab driver, clerk, computer software business, electrician/teacher, electrician, elevator operator, maintenance man, manager of store, office worker, 2 owners of businesses, paralegal, personnel manager

ences existed between the groups of patients: age first used narcotics, years of addiction to heroin, number of arrests, annual income at time of admission, duration of methadone maintenance treatment prior to entering medical maintenance, age admitted to medical maintenance and dose. Chi square tests were carried out on the variables of gender, ethnicity and level of education to determine if there were differences between the groups of patients.

Of the above variables, the only one that showed a significant difference between the groups was the number of arrests. The F value is 5.1283 (p=.0025). However while the major finding is that the patients who died had the highest average number of arrests (15) prior to entering methadone treatment, the last arrests took place about 15 to 30 years prior to the deaths. Criminal behavior was not in evidence while the patients were enrolled in methadone treatment. They were compliant patients in good standing with good jobs. Except for one homicide (an accidental stray bullet on the street), the patients died from medical deaths unrelated to

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Table 5b

Level of Dose by Type of Discharge and Type of Employment, for

33 Discharged Patients at Time of their Admission to Medical Maintenance

Type of Discharge and Employment

Level of Dose N (%)	Deaths N = 7	Unfavorable Terminations N = 15	Favorable Terminations N = 11*
10 - 25 mg/day	rare book dealer	government worker	disabled Vietnam vet, systems analyst, owns business, temporary jobs, health care analyst
30 - 40 mg/day	2 counselors, carpenter, owner of business	attorney, businessman, maintenance, skilled worker, stenographer, counselor	counselor, owns business
50 - 60 mg/day		Investment broker	owns business, clerk,** professional
70 - 80 mg/day	painting contractor, counselor,	cabinet maker, counselor, doorman, limo driver, musician, manager, programmer	office manager

* Favorable discharges include the ten patients who medically withdrew from methadone and the one patient** who voluntarily returned to the clinic system.

methadone treatment or their heroin addictions.

The trends in arrests for the other groupings show that those with favorable discharges had the lowest average number of arrests (2.3) prior to entering methadone treatment, followed by those who remained active (5.1), followed by those who were unfavorably discharged (7.7). These trends may reflect the extent of pretreatment deviant behavior that predict outcomes in medical maintenance. Further research with larger numbers of discharges is indicated to determine whether pretreatment arrests actually reflect outcomes in methadone treatment.

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Position of American Society of Addiction Medicine (ASAM), National Alliance of Methadone Advocates (NAMA), and the American Methadone Treatment Association (AMTA)

Both ASAM and NAMA have approved of the concept of medical maintenance (National Alliance of Methadone Advocates, April 1994). ASAM is preparing a resolution for adoption by the American Medical Association to approve the development of methadone treatment in private medical practice (Payte, 1994). ASAM is interested in developing a training program for private physicians and their nurses who will be linked to and receive referrals from appropriate methadone maintenance programs. The concept of medical maintenance has also been accepted by NAMA (Novick, 1994) and AMTA (Parrino, 1995). Therefore, the three major organizations of physicians (ASAM), patients (NAMA) and the providers (AMTA) are in agreement that medical maintenance is an appropriate treatment for select methadone patients who are socially rehabilitated and no longer in need of counselling or services offered by the clinic system.

Conclusion

Medical maintenance has shown itself to be a highly effective form of methadone treatment for selected socially rehabilitated and employed methadone patients. These patients were originally treated in the conventional clinic system. While this system has advantages for patients with serious social and medical problems, the system and its controls mitigates against the further rehabilitation of employed patients who are medically and socially stable. The continuation in regular methadone programs with serious restrictions on travel and scheduling are counterproductive for patients who have family, jobs and careers that demand freedom.

The current study has shown that the majority of patients who entered medical maintenance have continued and improved their social adjustments by performing well on their jobs, establishing businesses, obtaining college, graduate and other training and improving their family and social lives. Those who were unable to adjust in this program were returned to their clinic of origin. Ten patients withdrew from methadone in good standing and on follow-up were still abstinent. In summation this pilot project has demonstrated that selected socially rehabilitated methadone patients can be treated successfully in private medical practice. The concept has the backing of major organizations of physicians (ASAM), patients (NAMA) and providers (AMTA).

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XI
From the Viewpoint of the Practicing Physicians

The physicians recruited for medical maintenance were the first doctors permitted to prescribe opiates for maintenance in private medical practice by the FDA and the DEA since the passage of the Harrison Narcotic Act in 1914. Prior to the establishment of methadone maintenance, physicians were harassed and incarcerated if they prescribed narcotic drugs for anything but the alleviation of pain.

In this chapter of the study the following will be discussed: the transfer of medical maintenance from an isolated project at The Rockefeller University to the private medical practices of internists at the Beth Israel Medical Center in New York City; the backgrounds of the physicians selected to treat the patients; physicians' theoretical concepts of addiction and methadone treatment; the applicability of medical maintenance to private medical practice: a presentation of theories of addiction as promulgated by the medical research scientist, Dr. Vincent P. Dole and by the sociologist Alfred E. Lindesmith. The theories of Dole and Lindesmith form an overall framework that incorporate of both medical research and sociological formulations. Lindesmith's theoretical writing intertwines prophetically with the findings of modern neuroscience in the mid twentieth century.

From Pilot Project to Private Medical Practice

Six physicians were involved in medical maintenance. The first was Dr. Marie E. Nyswander who established the pilot project at The Rockefeller University in 1983 and recruited the first twenty-three patients from clinics at Beth Israel Medical Center. In 1985, the patients were transferred to the hospital-based private medical practice of Dr. David Novick.[1] Dr. Novick recruited four internists to continue medical maintenance

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1 This researcher assisted both Dr. Nyswander at The Rockefeller University and Dr. Novick at Beth Israel implement and evaluate medical maintenance. Novick graduated from medical school in the 1970s and indicated that when he was a student narcotics addiction, medical problems related to addiction and the use of methadone as a maintenance medication were not taught. He learned about addiction and methadone treatment as a physician associated with Beth Israel and The Rockefeller University.

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and eventually 100 patients were placed within their medical practices. Dr. Novick indicated that he had problems recruiting physicians because of the prejudices and mythologies that abound concerning methadone patients and methadone maintenance treatment. However, the four physicians that were finally recruited were responsible professionals with specialties in internal medicine and general medical practice. Dr. Novick moved from New York City in 1992, but the program has been continued at Beth Israel Medical Center with the four physicians. Medical maintenance was conceived of as the final phase of methadone treatment – namely the integration of methadone patients into private mainstream medical practice within the specialty of internal medicine and general medical practice.

In addition to his hospital-based medical practice at the Beth Israel Medical Center, Dr. Novick was associated with the research team at The Rockefeller University monitoring long term medical safety of methadone and its effect on liver, immune function and HIV infection. Novick was the first physician to treat methadone maintained patients in private practice within a major medical center. He also began to treat medical problems other than addiction within this patient group further integrating methadone maintenance treatment into general medical practice. Novick's philosophy about addiction, methadone treatment and the rationale for continued maintenance followed the writings of Dole, Nyswander and Kreek concerning the metabolic theory of addiction. He also contributed to this body of research and, therefore, became a link between clinical research and practice.

However, the practicing physicians who participated in the medical maintenance trials were practitioners without Novick's theoretical base and professional associations. The physicians are exceptional clinical professionals and represent the type of doctors who should be recruited. With the exception of one none worked in the methadone maintenance clinic system but they were employed on rounds as residents in the withdrawal wards caring for heroin addicts and seriously dysfunctional methadone patients. The physicians have active hospital-based medical practices with specialties in internal medicine and primary care. Methadone patients from the practices of the four physicians were interviewed and without exception the patients expressed a great deal of respect and admiration for the physicians and satisfaction with their services.

A Modern Theory of Addiction

In this section, the theories of Dole and Lindesmith will be presented. Although these theories were developed within two different disciplines – medical research and sociology – they take into account biological and sociological factors that create an addictive disorder. Dole (1994) summarized as follows the metabolic theory of addiction from its evolution over the past 20 years:

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> "A modern theory of narcotic addiction is that the compulsive (and quite specific) craving for narcotic drugs is a symptom of deficiency in function of the natural opiate-like substances in the brain. To be sure, sociological and psychological forces enter into the making of an addict, but these factors determine exposure – whether or not addictive drugs are available in the environment and whether a person chooses to experiment with them. In any person, with repeated exposure to a narcotic drug, the brain adapts and becomes pharmacologically dependent on a continuing input. In some susceptible persons – fortunately a minority of the population – the adaptation becomes fixed, and with the repeated use a regular input of narcotic becomes a necessity. The experimenter has become an addict. From this perspective methadone maintenance is replacement treatment, compensating for impairment in function of natural opiate-like substances."[2]

With this statement, a modern theoretical theory incorporates social, psychological and biological components, each within a defined place. The overlapping of psychosocial and biological concepts is eliminated and a definite boundary is drawn. Eventually biological forces take over irrespective of the psychosocial elements that may be responsible for experimentation or initial use. The role of methadone is clearly defined as a neurological corrective but not curative regimen. It functions as a normalizer of deranged physiology not as a mood altering narcotic.

However, prior to the discovery of the endogenous opioid system, Lindesmith conceptualized an insightful observation that attempted to take into account undefined biological elements. For Lindesmith (1968: 95-96) addiction is:

> "...reserved for those individuals who have the characteristic craving, whether it is in the form in which it is manifested during regular use, it exists in the abstaining addict impelling him to resume use."

2 Dr. Dole is referring to the endorphins and the endogenous ligands of the endogenous opioid receptor ligand system.

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Lindesmith (1968: 95-96) conceptualizes a theory of addiction that attempts to mesh biological and sociological phenomena with a conscious process of associating specific symptoms with a specific disorder.

> "... the sheer physiological or biological effects of drugs are not sufficient to produce addiction although they are indispensable preconditions. .... Persons who interpret withdrawal distress as evidence of the onset of an unknown disease act accordingly, and, if they are not enlightened, do not become addicted. Persons who interpret the symptoms of opiate withdrawal as evidence of a need for the drug also act accordingly and, from using the drug after they have understood, become addicted."

However, Lindesmith's (1968: 95-96) theory appears to have an element of choice that is mediated by social circumstances of use that enters into the development of addiction:

> "As the user applies to his own experiences and behavior the attitudes, symbols and sentiments current in society, he is faced with a problem of adjusting himself to the unpleasant implications of being an addiction a society that defines him as an outcast, pariah, and virtual outlaw. In his efforts to rationalize his own conduct, which he cannot understand or justify, and to make it more tolerable to himself, he is drawn to others like himself."

The above insightful statements of Lindesmith may have to be modified with input from current research in neuroscience. The changes within the central nervous system that are being unraveled appear to affect behavior on an instinctual level. While agreeing with Lindesmith about the outward organization of addictive behavior, this researcher is of the opinion that sociological and personal formations described as distinct addictive and learning behaviors are in reality sociological and personal behaviors created to meet the neurological and instinctual needs of a specific drug hunger. This has been shown in the methadone program and in medical maintenance. Socially rehabilitated methadone patients in this study have been able to change their lives and relinquish the social formations of addictive behavior with the proper prescribing of methadone that effectively relieves narcotic craving and withdrawal symptoms.

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Theoretical Understanding by Practicing Physicians

The conceptualization of theory influences the thought, attitude, behavior and, in the case of a physician, the prescription of medication, the amount and the duration of treatment. Optimally, physicians to prescribe methadone maintenance in private medical practice should have a firm grasp of the literature and how it evolved. However, this may not always be the case. Although there are review articles about methadone maintenance, the literature is scattered through many journals over a thirty year period and may not be readily accessible.

A major purpose of this section of the study is to obtain the practicing physician's conception of addiction, addicts and methadone treatment, prior to and after their acceptance of methadone patients within their private medical practices. None of the physicians were formally trained about addiction or methadone treatment since it is not taught in medical schools. Their conceptualizations will therefore be based on the empirical evidence presented in their medical practices and informal discussions with colleagues.

The four physicians agreed that the criteria set up for medical maintenance worked well as a screening device to identify patients who were appropriate for the program. When the physicians undertook the care of these patients they were employed and stabilized at appropriate doses of methadone. However, minor modifications in dose were prescribed for some patients (e.g., increases of about 5 or 10 mg/day). Also, patients who did not succeed in medical maintenance could be sent back to their clinics of origin without a break in treatment. This arrangement assured the treating physician of a backup system in the event that a patient proved to be inappropriate. The physicians' methadone prescriptions were filled by the hospital pharmacy, picked up by the physician, and stored in a special narcotic's cabinet in the doctor's office. Urine specimens were collected and forwarded for testing to the appropriate laboratory.

Physician 1

This doctor made the most far reaching changes in his thinking after undertaking the treatment of methadone patients in his private medical practice. Although he is an internist with a specialty in treating pulmonary disorders, his practice also includes patients with diabetes, epilepsy and HIV infection.

Prior to accepting the patients, this physicians's only experience with methadone patients was on the withdrawal wards of the Beth Israel Medical Center. On this service he saw only unemployed dysfunctional patients who were seriously abusing other drugs including cocaine and alcohol. His impression was that methadone maintenance "did not work as a treatment." He considered addiction "a matter of willpower," a "voluntary" condition and that addicts could "rehabilitate themselves if they wanted to." They were in his mind stigmatized people afflicted with "character disorders, ...liars, cheaters ...asking for methadone." He did not have too much respect for doctors who worked in this field as he considered it a "lower specialty."

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Although he harbored these conceptions, he was also sufficiently inquisitive to consider the hypothesis that addicts were "self medicating themselves" as an explanation for what he observed.

He was approached to participate in the medical maintenance project by Dr. Novick, a respected colleague in internal medicine. Despite his skepticism and apprehensions, he agreed to cooperate. He indicated that he did not feel that this would be a stigmatized project since it had the backing of Dr. Vincent Dole, whose high standing in the medical profession vitiated potential stigma. Initially, he agreed to accept four patients. They turned out in his mind to be "the nicest, most normal people you would want to meet. They were employed in a wide variety of jobs, some were more educated than others. They all seemed to be regular normal people." The patients were totally different from the dysfunctional patients he treated on the withdrawal wards. The physician than systematically studied the literature on methadone treatment from the 1960s to the present and integrated the theoretical concepts of the metabolic theory of addiction into his understanding of addiction disorders.

At the time of this study he was treating about 60 methadone patients in his private practice, and they "fit directly in." The methadone patients are like the usual patients he treats in internal medicine -- diabetics, epileptics, persons with hypertension except that the:

> "Methadone patients as a group appear to have less psychological problems than the usual patients seen by me. They are comparable that they look and act the same. Some may have their ups and downs."

For those who may have psychiatric problems, this physician obtained the services of a therapist who understands methadone. "I had experiences with a therapist who did not understand methadone maintenance and when I referred the patient all the therapist wanted to do was to withdraw the patient instead of addressing the patient's emotional problems." This physician then is able to separate emotional problems from methadone maintenance and addiction because of his theoretical orientation. He also refers patients with special medical conditions to appropriate specialists. Again he is careful to refer to doctors who understand methadone. This clinician is cognizant of the bias and ignorance that physicians harbor and realizes that these attitudes can be reflected in the treatment that patients receive.

His patients are on doses as low as 20 and up to 100 mg/day. He states that patients are on individualized doses that are appropriate to them and there is no such thing as those on lower doses being better, or those on higher doses being sicker. In other metabolic conditions he prescribes a variety of appropriate doses. He stated that:

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"The spouses of his patients do not understand this and in one case, the spouse was a nurse and insisted that her husband begin to withdraw. The dose was reduced from 80 mg/day to 50. The husband was a successful business man and could not function. He complained about sleeping and other problems related to an inappropriate dose. After a discussion with the wife, I restabilized the patient and the complaints disappeared."

If a patient is physically able to withdraw from methadone then this physician will assist the patient. If serious problems emerge during the withdrawal process he will suggest that the patient return to his or her regular dose. However, the physician indicated that because:

"Addiction is thought of as an emotional instead of a physical illness, there is a great deal of stigma attached to high doses or remaining on methadone. Several patients feel that they must withdraw even if this is an inappropriate decision. Even if they are told that continued addiction is a physical condition, they cannot accept this emotionally since they want to withdraw and get off of methadone.

Methadone patients are the most stigmatized of all the patients I treat. Some cannot tell members of their families, friends or employers. They accomplished remarkable things that they should be proud of but they cannot say anything about their treatment. The patients have overcome a terrible illness and they should be proud."

The physician has transformed his ideas about addiction from his years as a physician on the withdrawal service. The prescribing of methadone has been integrated into his private medical practice; addiction is placed as a chronic condition in the same conceptual framework as the treatment of other chronic conditions. He indicates that:

"...with any endogenous hormonal system, if a compound that either resembles the natural hormone or is the same is introduced (e.g., heroin) the homeostasis of the endogenous system will be adversely affected.

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> Replacement therapy is indicated to make the patients feel normal such as with patients who have a thyroid condition or in a metabolic illness such as diabetes with insulin. A medication must be prescribed that restores the homeostasis. When I prescribe methadone, I am doing something to restore the homeostasis in the endogenous opiate receptor system. Methadone treatment itself fits in with what I do as an internist. Methadone maintenance is one of the most beneficial things I am doing in my practice."

This physician realizes that medical maintenance itself can be limiting even though the patients report once every 28 days. He feels that the next stage should be renewable prescriptions that can be filled in pharmacies. The program is still too restricting for patients who may want to or be required to go on long trips or relocate outside the state. He has:

> "...reliable patients with careers who now are travelling long distances to pick up a monthly supply of methadone. Some patients may want to relocate to Florida or another state where there is no medical maintenance program. These patients should be treated like other medical patients and be allowed to fill prescriptions in pharmacies. Patients are now in medical maintenance for nine years. They may fly in to New York at tremendous expense to pick up a month's supply. The government regulations are hampering their freedom. They can be trusted with a two months supply of prescriptions."

He advised that five of his patients withdrew voluntarily from methadone. He is still in contact with three of the five, and they seem to be doing well. He is curious about the application of the metabolic theory since these patients do not appear to be concerned about drug hunger and are, so far, are living comfortably. He indicated that he would like, if possible to refer these patients to a posttreatment study of successfully withdrawn methadone patients at The Rockefeller University.

This physician is now lecturing on grand rounds to physicians in other services at Beth Israel and other hospitals about methadone maintenance. He related the following about physicians and methadone treatment:

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> "The average doctor does not know that successful patients exist and knows nothing about methadone maintenance, except a series of myths. I present the subject of methadone maintenance by debunking the myths. Most physicians if they know a patient is on methadone will attribute everything to the methadone. They do not understand pain medication. One patient planning to undergo cardiac surgery was told that he would not need pain medication since he was on methadone. One of my patients died from a stroke – a cerebral aneurysm and before the final cause of death was determined, the death was attributed to methadone. I pushed the autopsy because I knew that this patient did not have a drug problem and that methadone was not involved as a cause in this death. Two other patients were heavy smokers – one died from lung cancer - the other from acute infarction (heart attack). When I discussed their deaths with other physicians they blamed the methadone when both patients were prime candidates for the conditions that caused their deaths."

Physician 2

This physician has a specialty in internal medicine and primary care and earned a Ph.D. in Educational Psychology, concentrating on the problems of adolescent girls. In her medical practice at Beth Israel she treats a wide range of patients from young adults to the elderly with a preponderance of middle class patients over 50 who are interested in preserving their health. The practice is located in a Beth Israel satellite program located about twenty blocks from the main hospital.

Addiction was not part of the curriculum in either her medical studies or Ph.D. program. Her introduction to addiction was as a resident assigned to the withdrawal ward at Beth Israel Medical Center. There she treated dysfunctional drug abusing methadone patients. Her impression was that they were "lost souls, and she felt that "methadone was not effective." She did not formulate a theory of addiction at that time but expressed a compassionate feeling for the patients she was treating.

However, after being approached in 1985 by Dr. Novick to accept methadone patients in private practice, she felt it was a good idea and was willing to try it. She was not aware that Beth Israel had a large system of methadone clinics and knew little about the work of Dole and Nyswander. This physician relied on Dr. Novick's word that the patients were proper for private medical practice. She now treats six patients and indicates that the patients:

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> "... absolutely fit into my medical practice. They are exceptionally great patients. They are hard working with families and function on a very successful level."

As a psychologist she worked through an emotional crisis with one methadone patient. The patients have their own primary physicians. However, if problems should arise, she will make appropriate referrals. Since working with successful patients, she supports methadone maintenance. However, she does not actively speak at grand rounds or meetings but in private conversations defends methadone if there are misunderstandings about the medication. She is aware of the stigma that patients endure and the need to preserve confidentiality. She does not believe there is any stigma directed against her for treating methadone patients. If there were "it would not matter." Her patients receive methadone in the range of 20 to 80 mg/day. She advised that they entered her medical practice at these particular doses after years of treatment in the clinics.

This physician offered the following theory of addiction after initially considering the concept of an addictive personality:

> "There is a strong genetic component to addiction that predisposes people. This genetic predisposition is combined with emotional or psychological elements."

The physician emphasized the genetic and indicated that

> "individuals so predisposed must be careful. Emotional problems related to adult addiction were rooted in early childhood upbringing and taking drugs in adolescence to young adulthood was a way of coping. Methadone satisfies the genetic and at the same time the psychological elements that constitute an addiction."

The physician stressed, however, that her patients were emotionally stable, functioned well at diverse jobs and fitted into the middle class population that she was treating in her medical practice. While the endogenous opiate receptor ligand system was not included in her conceptualization, there was a recognition of a physiological component in the hypothesis about a genetic predisposition. Her recognition of patient functioning and stability and her instincts about theory concerning the physiological component of addic-

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tion give her an understanding that does not lead to further stigmatization of patients (e.g., character disorder).

In her conceptualization, methadone is regarded as "an ideal medication," since it addresses "the genetic as well as psychological components of an addiction." Also, psychological causes of addiction are not volitional on the part of the patients "but stem from unfortunate upbringing. With methadone, many of these problems are resolved" and the patient in her words is now able "to cope."

Physician 3

This physician graduated from medical school in 1980 and is an internist with a specialty in endocrinology. She is also chief of the diabetes service at Beth Israel. Addiction and methadone treatment were not included in her medical school studies. Her understanding about addiction evolved from her assignments at Beth Israel Medical Center (e.g., working on the withdrawal service and examining addicts who were entering the hospital for medical treatment). Initially, she felt that addiction is a "compulsion that could be controlled with willpower." Methadone was seen as an effective medication to withdraw addicts but she questioned the idea of long term maintenance: "Why can't patients take it (methadone) and then be drug free?" It was her impression that these ideas and questions were widely held sentiments among the other physicians in the hospital. However, in her mind this was not a moral issue. She concluded that some people were susceptible to opiate addiction and that it was a physical as well as a psychological problem.

She agreed to accept methadone patients in her private practice because she was a physician within the Chemical Dependency Service and was building her medical practice in internal medicine. Although she currently specializes in diabetes, the methadone maintained patients appeared to fit in with her practice. This physician states that her patients essentially fall into two categories – those who regard her as a primary physician including one patient who is diabetic and the others who come only for methadone maintenance. This physician has withdrawn two patients from methadone maintenance but continues treating them for other conditions as their primary physician.

She observed that the methadone patients in her practice have gotten their "lives together" and that in general "they are no different than the other patients in her medical practice." Medical maintenance, in her opinion, "can fit into a general internal medical practice." However, the physician must have an open mind, be calm and not have be prejudicial towards the patients. She indicated that there is a great deal of prejudice against methadone and patients within the medical profession. She now regards methadone as a "wonderful medication" for opiate addiction and wishes that she had a methadone-like medication that was able to control appetite (excessive eating) within her diabetes practice. Although she sees differences in the analogy of comparing methadone to insulin, in general, she accepts the analogy since both medications are used to

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control chronic conditions without curing them. When confronted with the criticism of "just substituting one addiction for another," she did not accept that as totally valid. To her, the word "just" is misleading, "When prescribing methadone you are changing the patient's life." In a "physical sense, the patient is addicted but the outcomes with methadone are so different." She indicated:

> "Some patients are living 'picture postcard' lives, except that they come in once a month for methadone. One couple has a successful business out of state and must get up at three in the morning once a month to drive to the hospital to get their methadone. They are forever thanking me for caring for them. They live in a city that has one program. They cannot risk exposure as patients by attending the local program, since exposure would ruin their business."

However, this physician is a great believer in therapy - one to one - and feels that with therapy more people would be able to withdraw from methadone. She believes that therapy should be integrated into medical maintenance especially for patients who wish to withdraw from the medication. She indicated that she successfully withdrew two patients very slowly over the course of a year. Both were in therapy[3]. She has approached the above mentioned couple about possibly withdrawing from methadone but they are not in therapy and she is uncertain about proceeding. This physician did attempt to withdraw a patient who was not in therapy but had to discontinue the procedure and restabilize the patient. Although she is aware of 12 step programs she feels that therapy is more effective.

The need for therapy is predicated on her belief that methadone maintenance has achieved a great deal for the patients. It has allowed them to rebuild their lives and resolve many of the emotional and social issues that caused them to use opiates. However, there may be "residual problems" that were not addressed and could be resolved in therapy thereby facilitating withdrawal. However, withdrawal should not be attempted until the

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3 However, one of these patients when interviewed for this study about two years after withdrawal from methadone has experienced a disturbing dream about narcotics (two weeks prior to the follow-up interview), has trouble sleeping, has written music about heroin and came into social contact with a heavily addicted friend. These are indications that the craving for heroin appears to have persisted although this particular patient has not yet relapsed and is still in therapy.

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patient has resolved many of the social and personal issues that may impact on drug use.

The physician indicated that in times of great stress some of the patients may resort to tranquilizers or use of additional methadone.[4] The physician contends that therapy would help patients resolve emotional or other crisis without recourse to medication. At present, her belief is that change of dose should be mediated by a therapist whether a patient requests an increase, decrease or withdrawal.

The theory of addiction conceptualized by this physician combines psychological and physical components. She believes that, "a potential addict has an affective disorder which is relieved with drugs. The type of drug - be it opiates, alcohol or cocaine - is determined by social availability. If opiates are used then there is a change in the number of opiate receptors which can affect the endorphin output. Methadone essentially replaces the function of natural endorphins that were affected by the change in receptors. However, with a slow enough withdrawal, the receptors can be regulated to normal." In her conceptualization this process could account for euphoria, withdrawal and physical dependency.

She indicated that "narcotic craving is another matter." She does not believe that anybody has, as yet, unraveled the source of this crucial element in addiction. She compared drug craving to food hunger and indicates craving, "...probably stems from biochemical or electrical changes within the brain which nay be reversible," However, she indicated that the issue of "irreversibility has yet to be answered" and that further research is needed to understand this phenomenon.

The physician does not give lectures about methadone treatment on grand rounds since she has not made a systematic study of the literature. However, in private, if the matter of methadone should arise, she will inform physicians about her positive experiences with medical maintenance. She is aware of the stigma associated with the program and the biased attitudes towards patients among physicians. When she moved her methadone patients into a new facility, there was initial resistance which she describes as a case of "NIMBY." She also related that she has had to insist that adequate pain medication be prescribed to methadone patients who may be hospitalized. She indicated that sometimes there is a tendency to under prescribe opiates for pain relief if the physicians learn that the hospitalized patients are enrolled in methadone treatment programs.

She advised that the stigma against the patients and the program would be a drawback to enlist new

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4 One incident involved the AIDS death of the only son of a methadone patient who took additional methadone to assuage the grief of his son's death. The other incident involved a patient who took a tranquilizer to alleviate anxiety while driving in a hazardous blizzard to keep an appointment.

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physicians. However, she sees that medical maintenance is a very cost effective way for the government to treat chronic addiction. If the program were made financially rewarding to private practitioners this may help recruitment. For this physician, the treatment of medical maintenance patients has not proved to be more difficult than treating patients with other conditions in internal medicine and that "in most cases it is quite easy."

Physician 4

The fourth physician received her medical degree in 1964 and has worked at Beth Israel Medical Center in substance abuse treatment for about 23 years. Her past and present duties include working on the withdrawal service and as a physician in a methadone clinic. She is currently an administrative physician who is the acting director of the methadone clinic system at Beth Israel Medical Center. She is an internist with a specialty in hematology.

The five medical maintenance patients are her "private hospital based practice." This physician was associated with Dr. Nyswander in the establishment of medical maintenance at The Rockefeller University. Also, she has known several of the patients in her medical maintenance practice from the clinic system. She will not be able to expand her practice because of administrative responsibilities.

The physician operates her medical maintenance practice from her administrative office which is about six blocks from the main hospital. She has to pick up the methadone from the hospital pharmacy since it must be received by an authorized person with a narcotics' license. Until recently, she also hand delivered the patients' urine specimens to the laboratory. Despite these time consuming chores, she continues to participate since the physician-patient relationship gives her a great deal of personal and professional satisfaction although the financial remuneration does not cover the time and effort expended.

This physician is the only one who had clinical exposure to addicts while in medical school. She learned the technique of withdrawing addicts from heroin using methadone on her psychiatric rotation in her senior year. However, the school did not offer formal lectures in addiction or the use of methadone as a maintenance medication. She states that she initially thought that addicts used drugs as an environmental response to the lack of a structured life. It never occurred to her that this was a metabolic disease. From her early experiences in the wards she thought that there were many reasons for persons to become addicted:

> "There was a void in their lives that they filled with drugs. Some stopped, others continued. Some were mentally impaired and started using substances – something to allay the symptoms. They would continue to use, when withdrawn the psychiatric symptoms would reappear and they would get readdicted."

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However, her concept of addiction has not changed radically over the years. She feels that addiction is multifactorial – physical, psychological and social. Although she is aware of the metabolic theory of addiction and the possible involvement of the opiate receptor ligand system, she indicated that she "does not believe this theory holds across the board. Successful withdrawal without subsequent relapse would be difficult if not impossible and discourage many patients in good standing who would want to withdraw. It puts up barriers." In her experiences in the clinic she has withdrawn patients in good standing.

However, she does not know whether the metabolic theory is applicable to her patients in medical maintenance since she has "not attempted to withdraw them as they are fearful of the procedure." She sees that her patients are doing well and likens the methadone to an orthopedic "crutch" which allows them to function.

She has had success and failures in medical maintenance. For this reason she indicates that patients have to be carefully selected and monitored. The monitoring is essential. She states that as a physician treating methadone patients in private practice she "... does not just dispense methadone," but:

> "... essentially offers the services of a clinic. I learn from my failures. One patient who did well in the clinic system and in an aftercare program became involved with cocaine while on medical maintenance. It took several visits for me to piece the problem together. The patient was late, missed appointments, appeared dishevelled. The urine bottle had to be felt because he might not submit the correct one. He was sent back to the clinic. I read his clinic chart a few months ago and unfortunately his situation had further deteriorated, as though he had never been in medical maintenance. This patient lost his job, family and became homeless. I had one patient who died that was morbidly obese - over 500 pounds – with many medical problems. The cause of death was probably a heart attack.
>
> The five remaining patients are doing well. Two work for the program and the others have a variety of jobs. Methadone maintenance has helped them tremendously. They were stabilized at a particular dose and in a particular life style when they came into medical maintenance. They are patients who can be treated successfully in private medical practice. One is an artist who developed a very successful business and expanded it while on medical maintenance. Another is a highly skilled construction

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> worker who is able to work overtime on high scaffolds and teach in his union at night. The patients that I treat are able to function intellectually, emotionally and physically without impairment just like you and me. Nobody can tell that they are on methadone. My patients, except for one, are on standard doses in the range of 50 to 100 mg/day. Sometimes they request a raise if they have problems and I inform them that this might be good for the short run but that they should try to resolve their problems without an increase. Methadone provides a steady state of well being."

When asked whether the patients still have the same problems or associations they had when they first became addicted, she replied that these have been resolved. When asked why the patients need the methadone she indicated that, "... methadone is something for them to take everyday to function, like a vitamin." She indicated that the daily need for methadone might be related to the dysfunction of the opiate receptor ligand system. She realizes that patients are fearful of withdrawal. She encourages patients to think about it since they are nearing retirement and may want to relocate where there are no methadone or medical maintenance programs.

Confidentiality, however is a major issue.

> "Patients who work for the program are not that concerned since they are accepted as methadone patients on the job. However, the others are fearful of telling members of their families, their employers and even their physicians that they are on methadone. Some of the patients will bring in an insurance form and if I treat them for other problems, I will put it down for reimbursement. Otherwise patients prefer to pay in cash. I cannot give my new business card to one patient since my position as assistant director of the methadone program is listed."

The physician, like the other doctors, is very involved in the medical and social problems that her patients present. If a patient is hospitalized she will contact the physician and explain about the use of methadone and pain medication especially if surgery is anticipated. She is now working with a patient and his physicians at another hospital regarding a future liver transplant operation. Also, if social crises arise, she recommends referrals to appropriate agencies. Although she is not the primary physician, she has tended to minor medical problems and has written needed prescriptions for infections, arthritis and other conditions.

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The doctor was successful in withdrawing one patient who was on methadone for over twenty years. This patient had previously withdrawn from methadone, but developed an alcohol problem and was restabilized. The patient resolved his alcohol problem and subsequently underwent a second withdrawal about five years ago.

This physician is aware of the biases and stigma surrounding methadone maintenance and the patients. She advised that stigma:

> "..is the reason that the program will probably never enter the main stream of internal medicine. Doctors do not realize that addiction is a disease and that addicts can be treated successfully in medical practice with methadone. Furthermore, the field is not sufficiently lucrative and few doctors that I have come in contact with have shown an interest."

She indicated that education has to start in the nursing and medical schools. In her opinion:

> "The physicians that provide medical maintenance should be internists with hands on experience, preferably with previous experience in the clinical system. Also, most importantly, they must understand the patient and not be biased. ... Medical maintenance may require more effort than other specialties in internal medicine since patients may need continued focus and support systems."

Discussion

As previously stated the four physicians interviewed in this section are the first doctors since the passage of the Harrison Narcotic Act in 1914 to treat legally maintained opiate dependent patients with methadone in private medical practice. While other physicians may have prescribed dolophines prior to the existence of methadone maintenance, the prescriptions were usually for withdrawal. However, some physicians in the 1950s did prescribe maintenance doses of dolophine as an alternate opiate to heroin addicts, but they did so without the current knowledge of medical research and evaluation. Furthermore, these attempts at early maintenance were usually aborted by the Bureau of Narcotics. An effective maintenance treatment for opiate addiction did not exist until methadone maintenance was conceived and a clinic system developed. However, this marginal highly regulated system, isolated from mainstream medicine, can be detrimental for the continued treatment of stable, working patients.

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Several issues emerge in the interviews with the physicians:

1. None of the physicians were educated about addiction and methadone maintenance while in medical school. Only one physician learned about withdrawal procedures.

2. Socially rehabilitated methadone patients fit into a private medical practice in internal or general medicine.

3. All of the physicians were initially exposed to seriously impaired dysfunctional patients on withdrawal wards. Their view of addiction, methadone treatment and methadone patients was initially shaped by this experience. All now regard methadone as a medicine that can help transform patients from dysfunctional alienated addicts to successful productive individuals.

4. The doctors are fully aware of the social stigma that is levelled against the patients and the need for strict confidentiality. Also, they are aware of the stigma and ignorance within the medical profession itself. When patients are hospitalized they inform doctors about methadone and proper protocols for pain. While all educate colleagues informally, one physician has undertaken a major education campaign within his own hospital and other institutions. Stigma and ignorance about addiction and methadone treatment will be the most crucial factor in trying to recruit doctors to expand the program.

5. The physicians conceptualize different theories of addiction but regard methadone as an effective medication for the treatment of opiate addiction. They interweave methadone into their individual conceptualizations. However, dose level is adhered to irrespective of theoretical considerations. One physician has systematically studied methadone and conceptualized a theory that coincides with other replacement therapies in medicine. The remaining physicians conceptualized theories that incorporate genetic or neuroscience factors. However, these were cast with a patina of residual emotional or behavioral problems that were attribut-

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> able to the condition of addiction – a bland recasting of older psychological and social theories of addiction which included fear of withdrawal.

The psychiatric, affective and behavioral aspects of the conceptualized theories appeared to mesh into interpretations and observations of the patient's behavior and goals of treatment (e.g., withdrawal or continued maintenance). However, ten patients in medical maintenance voluntarily withdrew. Two physicians felt that these were their most stable patients psychologically while another physician indicated that dose or whether the patient withdrew did not matter: it was the functioning of the patient that was paramount, either on or off methadone. These psychiatric underpinnings within a theory of addiction inadvertently stigmatize patients who remain on a high dose or continue in treatment because of metabolic factors (e.g., weak will, fear of withdrawing, strength of character or motivation).

The final point is that irrespective of theory, the four physicians were intensely dedicated professionals who saw their primary mission as treating their patients with respect and dignity while assisting them in every possible way with whatever problems arose in the course of treatment. The physicians all had a great deal of admiration for their patients and worked hard to facilitate their continued rehabilitation.

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XII

The Patients Speak

Sixty-nine former and current methadone patients were interviewed for this study. Without exception they stated that methadone saved their lives, permitted them to establish families and work across the range of employment – construction work, skilled white collar jobs, professional careers and the owners of successful businesses. Several were able to complete not only college but also graduate and professional education. However, notwithstanding their impressive achievements, without exception they are aware of social stigma that is directed to methadone treatment and patients, both current and former. Collectively they are a closeted group of individuals who cannot reveal their enrollment in a program that has saved their lives. They have witnessed the denigration of methadone treatment not only in the mass media but within their communities, their families, at their work and in the professions including medicine, psychology, sociology and the drug treatment establishment. They are silent voices. In this section oral taped interviews were combined into narratives that not only describe the accomplishments of the patients in medical maintenance but also the fear of discovery and the stigma that is attached to enrollment in the program. The emotion that they expressed was a combination of pride in their accomplishments with the concealed shame, of a "dirty secret (Murphy and Irwin, 1992).

Most of the interviews were held at the time the patients had appointments with their physicians in the morning before going to work. Therefore, the information had to be gathered within less then a half hour. Since this is a highly secretive and "hidden" group of persons, phone calls to the families were not made because of confidentiality issues. To preserve confidentiality, specific identifiers such as names, places, addresses and cities were omitted from the interviews. Only issues that were pertinent to the individual patients were included although certain issues such as reactions to stigma, a comparison of medical maintenance to the clinic system, and their current adjustments were covered.

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Living With The Dirty Secret

The following interview reveals how the issues of stigma and concealment affect patients. The patient is married, and resides with her husband and children in a small suburban community. She started injecting heroin as a teenager because of curiosity and peer pressure and subsequently became addicted. This particular patient did not use supposed "gateway" drugs such as marijuana, cigarettes or alcohol before using heroin. Prior to entering methadone treatment, she mainlined heroin for about four and a half years, was arrested on minor charges and was withdrawn from heroin only to relapse. She entered methadone in 1972 and medical maintenance in 1990. About ten years ago she successfully withdrew from methadone. However, after the withdrawal she constantly thought about heroin, eventually relapsed, considered buying methadone on the street but "did not want to do that" and within six months returned to the program. She has been continuously in treatment after her second admission.

> "The only ones who know that I am on methadone in my family are my husband and my sister. My mother is deceased but she knew. My older children knew when I was going to a clinic but since I have been in medical maintenance – I don't know whether they think I am still in the program. We never discuss it. My younger children do not know, they are teenagers. The older ones are in their twenties. My father knew the first time I was in treatment. I never told him about the relapse and that I went back to treatment. When I relapsed and went back to the program, I did not tell my husband for several months because I was ashamed. I finally told him, and he was understanding. He sees that methadone helps me. Nobody at work knows I am on methadone. On my job I work with computers, money and the public. I am considered a square. I don't smoke or drink. If they knew they would fall off their chairs. At work there is negativity about methadone and addicts. They know what they hear from the media – once an addict always an addict

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and that methadone is just another drug. I would tell them that even if methadone helps a small number wouldn't that be good. They don't say anything. They just don't know. My old friends who are now in methadone programs know but I do not tell new friends. I have not told another person I am on methadone since I am in medical maintenance.

My family doctor who lives in the same town does not know that I am on methadone. I live in a small town and I am concerned about people finding out. I have arthritis and go to a specialist who does not live in my town. He knows. If methadone prescriptions could be filled in drug stores I would not use a local pharmacy. I would like to be able to fill a prescription but I do like coming to see the doctor for methadone even though I know I am doing well. I like the doctor-patient relationship. Although I have insurance that will cover the costs of medical maintenance, I pay in cash so that there will be no record in my office or the insurance company."

This researcher briefly discussed Dole's metabolic theory of addiction and the character disorder theory of addiction with its implications of an emotional problem. She responded as follows:

"I consider addiction a physical condition like my arthritic condition. The methadone makes me feel normal and I am able to work. I do not feel anything when I take it. I have never heard of the Dole theory, perhaps it is right. The other theories, I find, are stigmatizing. They do not apply to me. I am like your person next door. I have a family, own a home, and two cars."

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This patient is also interested in community and political issues.

> "I go to meetings in the community and would like to participate more politically. I was asked to consider running for political office, but I am concerned about reporters finding out about my past. I do not want to embarrass my children."

About the comparison between the clinic and medical maintenance she replied as follows:

> "I could not work at my job if I were in a regular clinic because of the reporting regulations. I could not take the time off every week to pick up methadone. However, when I was in the clinic I did well. When I relapsed and returned I took advantage of the counselling. I am an outgoing person and was a cooperative patient always submitting urines and seeing my counselor -- I never avoided anything in the clinic. There is a big difference between the clinic and medical maintenance. In medical maintenance my whole life has been enhanced."

The major point that this patient is making is the "normalcy" of her current life - her family, her children, her accepting husband, her job and home. She is the neighbor next door. As Goffman (1963: 7) states:

> "The stigmatized individual tends to hold the same beliefs about identity that we do; this is a pivotal fact. His deepest feelings about what he is may be his sense of being a "normal person," a human being like anybody else a person, therefore, who deserves a fair chance and a fair break."

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This patient has followed what Goffman (1963) defines as a definite moral career. The career is of concealment to attain the goals that are important to her, to achieve a credible identity within her family, business and social life. What Goffman labels as a "virtual identity" is this patient's outward credible identity – the normal, working, family-oriented married woman as opposed to a hidden or "actual identity" of the stigmatized methadone patient. In this patient the two are both simultaneously fused and separate. With her trusted husband, sister and physician, the complete identity is known in a logical continuum that is defined within acceptable and understandable social mores. What must be hidden is hidden. The stage therefore is set for the normalcy of what Goffman (1973) refers to as The Presentation of Self in Everyday Life. The patient has her trusted "team" and is able to present her "real self" with methadone treatment further concealed in the medical maintenance program. The effect of the further concealment of methadone treatment is noted by the patient since her older children who were aware of her enrollment in the program when she was in the clinic are now not sure whether she is still in treatment.

As Miller (1974) indicated the stigma associated with methadone maintenance is derived from its status as a tertiary deviant state associated with the primary deviance of heroin addiction and the secondary deviance associated with heroin-related criminal activity. The patient has also experienced the deeply held stigma and hatred for heroin addicts and methadone patients from remarks of fellow employees. Their association of methadone with heroin – the transfer of the stigma of heroin to methadone – "as just another drug" and their inability to distinguish heroin addicts from methadone patients has justified the patient's decision to remain not only hidden but to be considered the most "square" person in the office who does not smoke or drink.

To protect her children she must be aware of the limits on participation in social and political activities. Also, the fear of becoming the "discredited person" extends to her personal physician who was not informed of her enrollment in methadone treatment (Goffman, 1963). The need for concealment extends into the privacy of her home: her younger children and father are not informed about the "dirty secret" and her older children who are now not sure whether she is still in treatment (Murphy and Irwin, 1992).

While the "virtual identity" of normalcy is the overt "stage" presentation, it is the hidden, or "actual identity" of the stigmatized methadone patient – what Goffman (1973) defines as the "back stage" with its

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"team" consisting of her physician and husband – that continuously shapes her behavior in every day life. The issues of concealment and stigma as analyzed in the above interview can also be identified in the following narratives.

In Business, Working as an Employer

This narrative illustrates the effects of travel restrictions in traditional methadone programs on patients who are in business and must maintain confidentiality about their enrollment in methadone treatment. The narrator is a patient who after entering medical maintenance was able to establish a successful business.

> "The Beth Israel methadone program has saved my life. When I was in the clinics I had to travel frequently for business. The program arranged through TRIPS[1] that I pick up methadone in cities where I did business. I travelled with salesmen who did not know. When we arrived in a city I would first have to locate the methadone clinic and fit in the clinic schedule with business appointments. The excuses I made – I would get up very early in the morning and sneak out. My partners would ask about having breakfast, and I told them that I just wanted to take a walk and would meet them later.
>
> Once a clinic was slow in giving me the medication and I was late in

1. TRIPS is a service organized for methadone patients. If patients have to travel, clinics may not trust them with extra medication for the trip. TRIPS is contacted by the patient's program and arrangements are made for the patient to pick up methadone in clinics in cities that the patient is visiting. However, this is a very inconvenient arrangement and has created difficulties especially for patients on business trips.

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returning to the hotel – We grabbed a cab since we were late for our appointment and were carrying about $500,000 in diamonds that were set in gold. When we got to the department store, the manager was angry because we were late -- they had another appointment for a $20,000 ad to put in the newspaper, and they were waiting for us. This is what I went through. I can't tell you the pressure, the tension that I was under with TRIPS - the excuses and the places where the clinics were located.

Now I have my own business. I am very successful. I employ six people - three are in my family. I organized this business since I am with the doctor (medical maintenance) and pick up once a month. My wife (also a patient) and I leave at three in the morning - drive in to pick up the methadone. Why do we come into New York City? If it should get out where we live that my wife and I are on methadone our business would be ruined. It is the confidentiality. There are two methadone clinics in the state where we live and if my car should be parked in front or we are seen walking into those clinics people would talk. The business is very successful but if customers and accounts found out that I was a methadone patient they wouldn't understand they would think I was a drug addict.

It's the media. Every time I read something or see a TV show about methadone and see these professionals - psychologist and sociologist types - they call it substituting one addiction for another. This is not true - they don't know what they are talking about. When the public hears substituting they don't understand the difference between heroin and methadone. Here I am a very successful businessman with a wife, son and a beautiful home - methadone for me is medicine. I am on 80

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mg. I take it once a day, don't get high and feel normal.

> I tried coming down but didn't feel right. My wife detoxed but she had to go back on. We told our teenage son -- he doesn't like it that we are on the program. He feels it is our fault. We have to be careful if it ever gets out, neighbors probably wouldn't allow their children to be friends with him or come to our house - they would think we have drugs. The only people who know we are on methadone are in my family - some work for me but the other employees don't know. I don't know about detoxing. This is a medical condition. My wife detoxed and had to go back on."

Here is an example of a successful family. The mother and father are working hard to provide a good home for their teenage son. The stigma is so deeply rooted that the son has rejected any explanation for their enrollment in the program. The son regards their condition (heroin addiction) as volitional -- "he feels it is our fault." He does not see methadone as a medication but regards it as another drug. The son has been brought into the family's "dirty secret" and fears that the stigma will be visited on him. The perception of his parents is painfully lowered.

The next patient is in his mid thirties and lives in small suburban community. He owns a thriving business, has a beautiful home, is married to a nurse and has a child.

> "When I was addicted to heroin I was wild in the streets. In 1978 I went into a therapeutic community and graduated in 1980. But I relapsed in 1981 and went into the methadone program. The clinic I was in - I was well liked by staff, had lots of friends and within 2 weeks I got a job. What I didn't like about the clinic was the negativity that I was exposed to (e.g., dysfunctional, drug using patients). Although there is a methadone clinic in the community that I live in, I could not attend it since

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people would eventually see me going there. If I were identified as a methadone patient I would not be allowed in places to do business. However, even in the clinic in Manhattan I had problems, a customer worked for the program and I saw some people in the program that lived in my community. I had to duck. In medical maintenance, I have a one to one relationship with my doctor and more trust than in the clinic. My confidentiality is better preserved by reporting once a month and I have more freedom to work. I do not tell local doctors in my community that I am on methadone.

Last year I had extensive dental work. I did not tell the dentist because I did not want to be looked at as one of those people (e.g., an addict). I was concerned about my confidentiality in the community since the dentist was a local dentist. I do not have a private doctor but I tell my medical maintenance doctor if there are problems.

The only ones who know I am on methadone in my family are my wife and older brother who successfully detoxed from methadone about six years ago. He does not pressure me to detox. My younger sister was on the methadone program, did very well and decided to detox. She moved to a neighborhood where she had friends and support. Everything appeared to be going well. Within a year she was dead from an overdose of heroin and cocaine.

At first my wife pressured me to detox her attitude was – when are you going to get off, when are you going to get off – and I decided to try. She thought that methadone was short term and even though she was a nurse she had only stereotypes. She was against maintenance. I went

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from 80 down to 50 and felt terrible. It was affecting my life. My wife spoke with the medical maintenance doctor and he explained everything. I went back to 80 and now feel normal. I don't get high or have any effects from the methadone and take it everyday like a vitamin. She sees that I am doing better -- in such a short time. We have a beautiful home, a child and I have a thriving business with men working for me. Everything is now normal. She sees that I can function in society. She has no contact with my medication. She now defends methadone when other nurses may say anything about it, but she has to be careful to avoid suspicions about me. She would feel embarrassed if somebody found out through the grapevine. She also tells me what they think about methadone patients if one should be in the hospital. They are put "on the back burner," they are not respected.

I saw the 60 Minutes program from Texas and felt angry and frustrated. I wanted to come forward and speak but it challenged my confidentiality. I have two other friends on methadone who are doing well. I've seen it work. Methadone is not substituting one addiction for another. It does not get me high, I can work. I also believe this is a physical problem."

Question: If you saw the title of a book called Methadone Maintenance: A Technological Fix (Nelkin, 1973), what would your reaction be?

Answer: "I don't like it. It is still marking me a junkie."

Question: If you saw the title of an article, "It takes your Heart" (Hunt, Lipton, Goldsmith, Strug and Spunt, 1985-1986) or the statement, "Methadone causes a film over the

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emotions," what would your reaction be?

Answer: "I can still cry, I can still feel. – Who is writing this? They don't know what they are talking about."

With this interview several issues emerge. The patient comes from a white working class family where the three children - his brother and sister - were involved with heroin. The outcomes are dramatically different. The older brother who is employed withdrew six years ago and has remained abstinent. However, the sister attempted abstinence and within one year had relapsed and died from an overdose of heroin and cocaine. This patient attempted to withdraw after being pressured by his wife and was unable to.

The wife is a nurse and originally incorporated all the bias and stereotypes against methadone treatment. Initially she was not a member of what Goffman (1973) describes as "the team." The medical maintenance physician explained in professional terms the theory of addiction and the use of methadone as replacement chemo-therapy. Once she understood her husbands condition, she accepted it and he was restabilized. She is cognizant of the stigma against methadone patients within the medical profession and now defends methadone but in a circum-spect manner to avoid suspicions about her husband.

The third issue concerns the titles of sociology studies and papers that create, augment and reinforce stigma directed towards methadone patients, irrespective of the contents.

The following patient is a business woman. She has been a patient for about 15 years.

> "Methadone has allowed me to be a mother, a wife and a business woman. Before I came into methadone treatment I was addicted for about five years and tried to detox by going into a therapeutic community. I stayed there over a year, I believe. It was terrible. I don't know what they do now, but they pulled you apart, broke everything down, would not let you call your family. They were against methadone treatment

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but when I got out I relapsed and entered the methadone program. Since getting into the program I have always worked, and I been a model patient. At first, I was in sales and had to travel. The clinic staff was understanding but the regulations caused problems.

On business trips I was placed on TRIPS and was sent to clinics in different cities to pick up methadone. I had to be very organized. One day I would pick up in New Orleans, another day in Dallas. Plans had to be worked out about a week in advance. On one trip I was in Texas and had to fly on a Friday to Dallas to pick up my methadone about 80 miles from my business meeting. A dust storm prevented the plane from taking off. I was in such a panic that I told a fellow passenger about my situation. I actually revealed that I was on methadone. He also had to go to Dallas and was very supportive of my situation. We hired a car. I called the clinic and told them I was driving. We drove through the storm to the Dallas clinic but arrived after 2:00 PM, after the clinic finished dispensing methadone for the weekend. I explained the situation but they insisted that they had rules and that I would not be medicated. They made no exceptions and indicated that I knew I had to be there by 2:00. I cannot tell you the panic I felt. It was Friday and I was in Texas with no methadone for the weekend. I called my brother in New York and I told him what happened. My clinic in New York City was also closed.

I then boarded a plane back to New York City – again I can't tell you the panic and anxiety I felt. My brother bought street methadone. This was the only time I was forced to do something wrong in all of my years

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on methadone. The TRIPS program is just not good enough if your job involves a lot of travel. At that time I was making between $80,000 and $90,000 a year on this job and they would not trust you to handle extra medication.

The medical maintenance program gave me the freedom to travel for work. At present, I have my own business which I developed on medical maintenance and work about 10 hours a day. I report once a month and attend to my business and my family. My husband is in sales. I am happily married with two beautiful daughters. The babies were born within the last seven years. I was maintained on methadone during my pregnancies. I took off time from work after the births of my daughters. The girls are doing well, there were no problems with withdrawal or other effects.

Who knows that I am on methadone – my mother, brother and husband. My father does not know because he would not understand. Nobody in the town where I live knows that I am on the program. The press is negative and people wouldn't understand. In my mind methadone is not substituting one addiction for another, it is a medicine, and it has not only saved my life but has allowed me to have a family, a home and business. I live an idyllic life. No I don't see myself as being weak willed or having a character disorder. Methadone: A Technological Fix (Nelkin, 1973), "Methadone - It Takes Your Heart" (Hunt, Lipton, Goldsmith, Strug and Spunt, 1985-1986). Who writes this stuff? Some Ph.D.s wrote this – doesn't impress me! It is not true. Of course it is stigmatizing. This gets me very angry. I am currently on 20 mg/

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> day. I feel comfortable at that dose, no withdrawal or sleeping problems. I have no intention of getting off methadone – I have lived a wonderful life and I see no reason to get off."

The impression of a drug addict is one who has a character disorder, weak will and is disorganized. This patient belies this image: she is organized, intelligent and building a successful business. In addition, she is a responsible mother. Her two children were born while she was a patient and neither child was born dependent on methadone. Her reaction to the titles of sociological publications was anger and disbelief.

The following patient became addicted to heroin while serving in Vietnam. After returning to the United States, he continued his addiction for about six years, withdrawing several times before entering a methadone program.

> "When I first entered methadone I got a lot of odd jobs working around carnivals. However, my counselor advised me to go to college and I got a BS in electronics. Then I started to get jobs in the electronics field. I didn't use other drugs, was considered a good patient and was placed on once a week reporting. I never had problems in the clinic. When I started medical maintenance, I began to build my own business, and now I am very successful with nine people working for me. I could not build a business in the regular clinic because of the reporting regulations. I have my own home, but nobody in the town where I live knows I am a patient. My family knows but they do not accept it even though I am very successful – more successful than my brothers who have technician jobs. They only want to know when I am getting off. They have never told me that I am doing great. I am on 90 mg, feel fine, don't get high and am able to do all types of work without any effect from the

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> methadone. My employees do not know that I am a patient. People, if they know you are a methadone patient will think you are an addict and look at you differently. Medical maintenance is much better then the clinics, I report once a month, it is faster, the doctor will change his schedule if I can not make it. Most of all, nobody knows you are in the program. The confidentiality is better."

This patient brings up an important point. His family does not accept methadone treatment and has never encouraged him even though he is more successful than his brothers.

The next patient became addicted to narcotics while in the army in the 1960s. After returning home he continued to use heroin and after several years of addiction and attempts at withdrawing.

> "When I first came on methadone, I worked at several jobs. I also attended college, got a degree and got married. However, the problem with the clinic was the reporting regulations. I never had problems with the staff, they cooperated but the hours I put in at work and the travel really made the clinic program inconvenient. When I was transferred into medical maintenance, I was able to work and expand the business without worrying about the clinic schedule. Now I am the owner of a very successful business.
>
> Who knows that I am on methadone? My wife is the only one. I am the most successful person in my family and belong to social clubs in my community. All of this can be destroyed if they knew I was on methadone. I have two teenage children – they do not know. Medical maintenance helps me hide the fact that I am a patient. There are no daily bottles of methadone to hide – just a months supply of tablets that fit

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> into a small medicine bottle. I am on 50 mg/day and feel no side effects. I feel normal. I associate with many people in my business, family and social life. Nobody can tell I am on methadone. If they did it would destroy everything because people rely on me.
>
> It is the publicity. One night I was watching a TV show about Rikers Island. They showed the prisoners taking methadone. My teenage son also saw the show and indicated that all they have at Rikers are heroin addicts. I did not say anything."

This patient demonstrates the fear of social ostracism which is so great that he can only confide in his wife. He rightfully fears that the knowledge of his current treatment can destroy his business and social status -- unraveling everything he has worked hard for, including the respect of his own children.

Working As An Employee

Methadone patients work at a variety of jobs. They perform jobs that demand skill, intelligence, good coordination, and in some cases physical risks such as working on scaffolds. The following patient is a highly skilled construction worker and electrician with a 20 year safety record.

> "I've been on methadone since 1972. Before I was on methadone I used heroin for about seven years, must have had about 11 convictions and spent a few years in jail. I learned electrical work in jail but was never able to hold down a job until I got on methadone. I've been working on the same job for about 20 years. None of the bosses know because I would be fired. I'm on 100 mg/day and I feel fine - normal - no side effects. I work on scaffolds, and extension ladders up to 30 feet, walk over rooftops and install electrical wiring. In 20 years I have never had

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an accident on the job! At night I teach twice a week at the union school. My hobbies – I race boats and have lots of trophies. If they knew I was on methadone they would not let me race – they look at it as a drug! You can't even drink beer before the race, that's how strict they are. They do not let liquor near the boats, so they would not let methadone.

Everybody in my family knows I am on methadone. My family has only seen the good that methadone has done. They remember the stealing when I was addicted to heroin. They can't understand the negative publicity. Every time I read an article - like the Village Voice - they only present the negative never the patient like myself who is working.

I never had too many problems in the methadone clinics. Sometimes the nurses had an attitude. I was on once a week for years because I always worked and never had a dirty urine. Medical maintenance makes things easier for me. I can work overtime, teach at night – no problems. However, there is stigma. Once I accidently cut myself and had to go to a hospital clinic. Everything was fine until I told the nurse that I was a methadone patient. Her attitude changed immediately - you could see it in her face. No, I don't consider methadone substituting one drug for another. I don't get high and I can work, I don't get arrested."

Everyone in this patient's family knows about his enrollment in the program, is supportive of him and accepts the medication. They do not understand the negative publicity because of his dramatic improvement while on the program. Yet, he is cognizant of the stigma in his work and social life.

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This particular patient has worked for a federal agency and received several promotions. He is now in an important position supervising over one hundred people.

> "The only one who knows I am on methadone is my wife. My parents, brothers and sisters do not know and I am not going to tell them. Its been about 17 years that I've been in treatment and have not used heroin. They will not understand I still need methadone. They think that I stopped using drugs. None of my friends know. The publicity is so negative. I saw the 60 Minutes show from Texas - it was all one-sided. While on methadone I got a job and received about five promotions. Today I supervise over 100 people. I have also gone to college and got a straight A average. I'm on 60 mg/day. I feel normal at this dose. Medical maintenance does not interfere with my job. I pick up once a month and nobody knows.
>
> However, I hated the clinic - if you were the president of General Electric you would still be treated like a junkie in the clinic. Once you walked in the door and had to stand on line with patients who were still using drugs - I used to get an anxiety attack being exposed to all of this. Also the hours were not good in the clinic – from 6:00 AM to 2 PM. The clinic and my job were in opposite directions from my house. Sometimes I would have to sneak out of my job leaving my station and supervisory duties to get the methadone. This is something you don't do if you want a promotion. Here (medical maintenance) I am treated like a patient. The once a month reporting does not interfere with my job and if a problem comes up at work I can call the doctor and make other arrangements to pick up."

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This patient cannot reveal his enrollment in methadone treatment to his family. The narrative also demonstrates the need of medical maintenance for a group of patients who find the clinic system degrading and bereft of dignity. [2] For this patient the methadone clinic did not enhance his functioning, but impeded it. The medical maintenance program restored his dignity and assured this patient that his job concerns will be respected and further progress in life will not be restricted.

The next patient is a highly skilled health care worker. She was addicted to heroin for about eight years before entering methadone maintenance.

> "I was what you might call a controlled addict. I started to use as teenager among friends. But I was careful with needles and from whom I bought drugs. I never had to sell myself in the streets, I've had a lot of close calls but I always managed to get drugs since I was always working - I was one of the lucky ones, I only used about two bags a day to keep me straight. My family thinks that I stopped using drugs. They are strictly middle class and do not approve of methadone, and that includes my two sisters. My father is an engineer and my mother a school aide. My sisters have good jobs -- one in a bank and the other is a medical professional. Still the stigma against methadone is so great that I cannot tell them.
>
> On methadone I was able to complete college and take professional courses. I now have a wonderful job which demands a lot of responsi-

2. According to NAMA most patients feel this way about the clinic system. How can addicts be expected to change their lives and regain their self esteem when they feel denigrated. Like any other patient, methadone patients deserve to be treated with respect and dignity.

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bility, education and skill. My boyfriend is also a patient and an engineer. I have friends who are on the program. Many of them went through therapeutic communities and 12 step programs only to relapse. I was in two clinics before being transferred to medical maintenance. One clinic was horrible, the staff had attitudes about the patients. I transferred out and the second clinic was much better. The staff was interested. However, as I began to work, the reporting regulations interfered with my job. Medical maintenance is perfect. I like my doctor. If I cannot make my monthly appointment because of a job conflict I can call and make other arrangements. Right now I work about 70 hours a week and am on 90 mg/day. I have received small increases in my dose. I did not feel comfortable on lower doses. At 90 I am able to function, don't feel high or have any effects from the methadone. However, I do feel some withdrawal before the 24 hours – I will discuss this with the doctor, if the 90 level is sufficient. Methadone has allowed me to live without compromising my ethics or values, which may not have been possible if I continued to use heroin. This is very important to me.

Unfortunately, there is a lot of stigma against patients and ignorance about methadone in the health professions. I am considered very competent and skilled. Physicians trust me since in my specialized field I know practically as much as they do. This has given me a great deal of satisfaction. I work with highly skilled professionals – If they knew I was a methadone patient I would either loose my job or be restricted in my duties.

I have lost one job because a nurse in my former clinic left, and obtained a job in the agency where I was working and obviously informed

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> the management since they laid me off within a few weeks after she got the job. I reported this to the Legal Action Center. They said I had a case but I did not pursue it because it would have meant divulging my status as a methadone patient to a number of agencies."

This patient comes from an upper middle class family with a strong work ethic and value system. Mthadone has helped to maintain these values which would have been destroyed had she continued using heroin. She has become a skilled professional and is cognizant of the biases within the medical profession that are directed towards methadone treatment and patients. Also, in this narrative is an example of the bias within the methadone treatment system. She was enrolled in one clinic where staff attitudes towards patients were punitive.

A patient who works for a major corporation as an electrician advised that he was employed by the corporation about 20 years ago and that personnel knew he was a methadone patient when they hired him. However, he relates the following:

> "I have an excellent safety and attendance record. I also have received good evaluations. For the past 20 years I have had to take urine tests about every two months (120 tests). They're all clean. I've never used drugs since I've been in the methadone program and the urine tests in the methadone program are all clean. Drug users at work are placed in special programs. If the other workers find out they don't associate with you. So nobody I work with knows that I am in the program. I never got a promotion and I think it was because of the methadone. They have no complaints about my work. After 20 years they are still taking urine tests. Who knows I am on methadone - people in the personnel office and my wife – she knows that I am a good man. My children do not know. Medical maintenance lets me work overtime. The clinic hours were very hard if you had a steady job."

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This is an example of the deep rooted bias. This patient has a good work record, yet he is not trusted. After twenty years on the job he is still subjected to random urine tests and has never received a promotion.

Another patient is employed as a window cleaner on skyscrapers. He has been employed in this work for over 15 years since he was on methadone.

> "I never had any problems in the clinic. I always worked as a window cleaner on skyscrapers. Nobody at the job knows. I've never had an accident and work on scaffolds and even attachments to the buildings. The reason nobody knows is that I work with two other men on scaffolds and any worker can refuse to go up on the scaffold if he feels it is not safe. I cannot tell my boss or the other men that I am a patient because they would not work with me. I am considered a good worker and the men trust me. With medical maintenance I can work overtime. My wife is the only one who knows I am in the program. I am on 50 mg/day. The methadone has no effect - at work I am very steady and work on buildings over 50 stories high."

This narrative demonstrates that patients are capable of performing dangerous work However, because of the misconceptions and the image of methadone patients he cannot divulge his enrollment in the program.

The next patient is a retired counselor. He is also diabetic and is treated by his medical maintenance physician for both conditions. He has been admitted to the diabetic practice where he is treated for diabetes and receives his monthly supply of methadone. He related the following:

> "Compared to medical maintenance, the clinics were impersonal and dehumanizing. You stood on line and waited for your turn. However, I did well in the methadone programs - never had any problems - it saved my life. In medical maintenance it is more personal. The doctor

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> talks to you and is interested. Practically everybody I know knows I am a diabetic, but not too many people know I am a methadone patient. I am a little ashamed of this dependency. I tell people I am taking insulin what's wrong with me taking methadone to stop killing myself."

This patient demonstrates the power of stigma and bias directed towards methadone. Even though the patient worked in methadone treatment, he is open about his diabetes but circumspect in admitting he is a methadone patient. This patient has two metabolic diseases: diabetes which is treated with insulin and is socially acceptable, while the other, opiate dependency treated with methadone, is not.

One patient has a career that involves international travel and refused to be tape recorded because of confidentiality. He believes that his career would be placed in jeopardy if it were known that he has been a methadone patient for over 25 years. Several years ago he withdrew from methadone but had to be restabilized. Currently, he is on 50 mg/day and indicated that he feels normal and is not impaired from the medication. He advised that he would not have been able to develop an international career if he were treated in the clinic system with the rigid reporting regulations.

The Stigma of a Yawn

Goffman (1973) stresses the performances that persons create in everyday life. "Performances" are essential for patients to conceal the discreditable state of being on methadone. These "performances" include the control of calculated behaviorisms to emphasize "normalcy" or simulate behavior that adds to the performance - that of the creditable productive person. The small gesture may reveal the invisible stigma. As Goffman (1973: 52) asserts:

> " ... a performer may accidently convey incapacity ... by momentarily losing muscular control. He may trip, stumble, fall; he may ... yawn, ... scratch his body, .."

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Of all the incapacities the yawn is the most innocent, yet for the methadone patient, the yawn is the most dangerous -- it may convey the impression of a narcotized state. As Goffman (1973: 66) states:

> "Whether an honest performer wishes to convey the truth or whether a dishonest performer wishes to convey a falsehood, both must take care to enliven their performances with appropriate expressions, exclude from their performances expressions that might discredit the impression being fostered, and take care lest the audience impute unintended meanings."

As one medical maintenance patient who is in the field of merchandising and design indicated:

> "I have a demanding job. I travel, buy and select merchandise. Medical maintenance has enabled me to work long hours and to travel extensively on foreign and local business trips. My job involves international and exotic design. I could not do this job if I were in the clinics. I am seen as a hard worker and eventually I would like to have my own business. Suppose everybody knew I was on methadone. It's not that I would be blamed if a pocket book were missing in the office - I wouldn't since this rarely happens and I'm out a lot. But if I yawned in the office and felt a little tired, they would think I was stoned on methadone."

The methadone patient, therefore, must guard against the most harmless and ubiquitous act, to maintain as Goffman (1973: 51) states, "expressive control." What happens when the patient reveals to friends that she or he is a methadone patient. One medical maintenance patient relayed the following:

> "I work in management and put in very long hours. I am also registered in graduate school for my masters. Recently I told two close friends that

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> I was on methadone. I tried to explain it but they now insist that I try to get off. Before they knew I was a patient, they accepted that I was tired after a day at the office and school. If I yawned or went to sleep early -- this was normal. Now if they see me yawning or going to sleep early it is not accepted as normal but that the methadone is causing me to yawn and be tired. Before I was napping, now I am nodding.
>
> This is getting me quite angry ...I feel no effect from methadone. The only reason I told these two friends is that nobody knows I am a methadone patient and I wanted someone to know. I told my two closest friends and now I am almost sorry that I did."

The patient in her personal life became involved in a "double bind" situation - to tell or not to tell the truth to her close friends. The result at best could be considered ambiguous - it has distorted the friends' perceptions of the patient's behavior. This is an example that the majority of all methadone patients face, they cannot divulge their accomplishments while on methadone or the perception of their normal behavior will be distorted.

The 'expressive control' of small 'inconsequential acts' becomes a major conscious scenario for patients who have revealed themselves. Methadone patients who are 'out of the closet' must convince their audience that methadone does not impair functioning or alter their conscious state. They are normal people pursuing a career within conventional society. The following patient revealed her status as a methadone patient and sought to resolve issues related to mythologies about possible impairment from the medication:

> "I attended NYU Law School while maintained on 90 mg of methadone a day. The methadone has no effect. This is my dose and I feel normal. After graduation I passed both the New Jersey and New York Bar examinations. However, I decided to reveal my status as a methadone patient since they asked about drug abuse and criminal histories. I wanted to be

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honest and reveal my enrollment in the program rather then not tell the truth. I wanted to avoid problems if anybody should find out about my enrollment in a methadone program in the future. The New Jersey Bar refused to admit me to the bar unless I went through a hearing about my character and methadone treatment. The New York Bar indicated that they would accept the decision of the New Jersey Bar. The New Jersey Bar put me through a cross examination for hours. The most intimate questions were asked about my relationships. At one point I wanted to close my eyes and pray silently that I get through this ordeal. But I realized that if I closed my eyes or had an itch – if I scratched – this might be misinterpreted by the legal committee as an effect of the methadone. I had to watch everything I did – my mannerisms, my movements – I was very conscious of the smallest movement. Finally, they agreed to let me practice but only under the close scrutiny of an approved lawyer. I was never so humiliated in my life. I was an exemplary patient for over ten years, never had a dirty urine and they were going to treat me like a delinquent attorney who needs supervision. I was so angry that I hired a lawyer and took the case to the New Jersey Supreme Court and won a reversal of the decision. I am now able to practice in both states without being supervised. However, they did not make this a written precedent making decision. Methadone patients in good standing who follow me will have to go through the same procedure."

Favorable Discharges

Seven of 11 patients who were discharged in good standing were contacted. Six of the seven still regarded the stigma of methadone as very powerful even though they were successfully withdrawn and have not relapsed to heroin use. All preferred medical maintenance over the clinic system because of the restricting rules and regulations. The following are summaries of contacts with the former patients.

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1) The first patient was employed at a variety of jobs and recently finished college. She has two professional siblings who never knew about her heroin addiction or enrollment in a methadone program. Because of her short period of heroin use (about 2 years), she advised that life time maintenance on methadone was "unacceptable" to her. With the help of her medical maintenance physician and the support of her therapist she successfully withdrew from methadone after about ten years of treatment. She has retained her medical maintenance physician as her primary doctor.

2) The second patient is a partner in a business and indicated that he cannot tell anyone in his firm and social circles that he was a methadone patient. However, within his family: his father (physician), mother (teacher), wife (graduate degree) and siblings (banker and physician) know about his addiction history and successful episode of methadone treatment. While enrolled in methadone treatment this patient married, went to college and graduate school and began working in the business of which he is now a partner.

3) A married couple was withdrawn from methadone and moved to a rural community. The husband finished college and graduate education while enrolled in the clinic system and the medical maintenance program. However, the couple refused to cooperate with this study because of a perceived compromise to their confidentiality. Possible exposure about their past as former methadone patients could, in their opinion, ruin the husband's career.

4) Another patient who successfully withdrew from methadone is a successful businessman and part time musician. Among his musician friends he will discuss methadone treatment and addiction. This former patient has referred musician friends who are

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addicted to withdrawal programs. However, he lives and owns a business in a rural suburban community. He does not discuss his past heroin addiction problems or his prior enrollment in methadone treatment with new friends, business associates and neighbors. Although he is withdrawn from methadone he has kept his medical maintenance doctor as his primary physician.

5) The sixth person interviewed is a counselor in a methadone program. He states he is currently attending Narcotics Anonymous. Since he is employed as a counselor in the methadone program and attends Narcotic Anonymous, he is open about his past heroin addiction and methadone treatment.

Although methadone has saved their lives and they were able to build successful business while on medical maintenance, five of the six are unable to reveal their former status as methadone patients to business associates and friends.

The Stigma of Pain Medication

Methadone patients are not the only ones who are stigmatized by the use of methadone. Patients with serious chronic conditions involving malignant and nonmalignant pain are now being maintained on opioids, including methadone for relief of pain. The procedures vary but the regimens are successful in relieving pain and allowing pain patients to resume functional lives.

However, these patients are experiencing the social stigma reported by methadone patients. In an article by Elizabeth Rosenthal (1993) for the New York Times, it was reported that probably the pain treatment's worst side effect is social stigma. One pain patient's husband, a physician, tried to sabotage her treatment by telling pharmacies not to fill her methadone prescriptions since she was an "addict." The article concluded with a comment by a pain patient who indicated that:

"I'm not doing anything wrong or illegal, but I feel like I am every time

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I go to the pharmacy. Each time you confront your fears of being discovered and their bias. In a sense it would be easier to have cancer."

Discussion

Medical maintenance treatment is an exemplary program to expand the patient's life opportunities and at the same time to better conceal the stigma of methadone treatment. This holds for the patients currently enrolled in the program and those who were withdrawn. Unfortunately, the stigmatized status has also been transferred to pain patients treated with opiate medications that may include methadone.

The problem of stigma will be difficult to resolve. American society perceives addiction as a behavioral disorder -- a "blemish of individual character" (Goffman, 1963). Acceptable solutions to addiction have targeted the "blemish" with legislation, imprisonment and therapeutic approaches that attempted to rid the blemish. Theories that conceptualize addiction to include biological factors as the primary cause have not been accepted as legitimate since the "perceived character blemish" has not been extirpated.

The first step in the reversing of stigma rests with the medical profession claiming addiction as a metabolic disease. This is beginning to occur with the emergence of neuroscience. Also, the American Society of Addiction Medicine is beginning to adopt and support positions concerning the legitimacy of methadone maintenance as a procedure that can be placed within the mainstream of medical practice. The report issued by the Institute of Medicine (1995) recognizing the effectiveness of methadone maintenance treatment can facilitate its acceptance within the medical profession.

Secondly, successful patients are the creditable proof that methadone treatment can work. Few successful patients can now "come out of the closet." However, with NAMA helping to organize local advocacy groups, methadone patients have begun to demand the respect and dignity that they rightfully deserve.

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XIII

Conclusion and Discussion

During the course of this investigation, historical and social data were obtained as background to validate the assumption that methadone patients are a stigmatized group. The historical material showed that there has been an accretion of stigma directed towards opiate dependent people over the past two centuries. This development began with a moral religious fervor during the nineteenth century that argued against the taking of opiates. Opiate addiction was seen as a 'vice' or an extension of the concept of moral insanity that incorporated religious ideas of morality with the emerging science of psychology in 19th century England. Moral insanity, the religious and value laden concept was then transformed and objectified into the scientific concept of psychopathic personality in German 19th century psychology. Psychopathic personality became a basis for classifying a troubling set of behaviors, that were not clearly explained within existing parameters of knowledge, but which clearly conflicted with accepted social mores, consciousness and behavior. Moral insanity and psychopathic personality inferred there were no 'moral brakes' or conscience to deter aberrant behavior. Thus the little understood compulsive behavior of addiction became linked to a concept that was defined, codified and scientifically accepted, namely the psychopathic personality.

With racial fears coupled with the potentially revolutionary movements of a white underclass, the stigmatization of addicts became an underlying current in the formation of theories. Theories of addiction evolved from a mixture of values and beliefs, observed behavior, the extent of knowledge and the class of persons who were afflicted. Thus theories of addiction change as the era changes, incorporating the contemporaneous disciplines and perceptions of a given era. Nevertheless, contradictions exist in the formation of theories that incorporate an undercurrent of social and ethnic class formations. Persons from various economic, social and ethnic groups have become addicted in every era, although certain groups at any given time may predominate. Nevertheless, the outward parameters of addiction persists: irrespective of class, historical era or ethnic background, opiate dependency for many who were affected is a chronic relapsing

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condition. Tolerance, the primary and secondary abstinence syndromes, the specific narcotic craving or hunger leading to relapse are the common elements of opiate addiction that transcend cultural factors which shape the outward expression of addictive behavior.

The historical section of this study traced the emergence of addicted risk groups and the development of theories in different historical eras. In each era, there was an accretion of stigma as the risk populations were transformed and new theories emerged – an upper class vice or pathetic condition in the 19th century to a psychopathic character disorder describing the poor ethnic and minority addicts in the 20th century. Thus, the development of modern stigma against opiate dependency was rooted in the social history of the last century.

After the passage of the Harrison Narcotic Act in 1914 the stigma became institutionalized at the federal and local levels with the backing and encouragement of the federal government's Bureau of Narcotics (Gewirtz, 1969). Drug addicts especially those from minorities, immigrant and the lower economic classes became a deviant group replete with criminal sanctions, stigmatization and legal control at every level of government. This stigmatization and criminalization extended to sympathetic physicians who continued prescribing narcotics.

The second part of this study introduces the medication methadone and the work of Dole, Nyswander, Kreek and other investigators. Included in this investigation is a review of the major medical, epidemiological and follow-up studies that show that methadone maintenance to be an effective medication to treat chronic opiate dependency. However, irrespective of 'good science,' this study validates the transfer of stigma from heroin addiction to methadone maintenance, led by the Bureau of Narcotics and its successor the DEA and followed by academia, the media, other researchers, physicians, adherents of drug free orientations to treat addiction and finally the community. The scientific reviews in this study refute the mythologies and the stigmatization that have emerged against the program, the medication and the patients. The stigma that methadone patients feel is a real phenomenon and in comparison with other social stigmas appears to be entrenched in the collective social consciousness of the country at every level of society.

In a speech delivered at a meeting sponsored by the Albert Einstein College of Medicine on November 4, 1994, Dr. Alan Leschner, the director of NIDA, stated that stigma was the greatest problem facing the

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delivery of services to addicts, especially methadone treatment. Leschner is of the opinion that addiction is a disease of the brain expressed in a social context that shapes the behavior of the affected individual. With the emergence of advanced neuroscientific research, biological factors are now being included in theories about addiction. These theories maintain that independent of the personality, an individual can become addicted to opiates: therefore methadone maintenance for some patients may be indefinite. For most patients methadone maintenance is a corrective, not a curative procedure. According to Leschner, the inclusion of metabolic and neurological factors in the theories lessen the stigma of methadone treatment previously associated with theories that focussed on psychopathic personalities and character disorders as the major points of conceptualization.

There are crucial unanswered questions that should be researched. Is chronic addiction symptomatic of a permanent or transient deranged neurological and physiological phenomenon? Why can some persons remain abstinent after a period of methadone treatment while others relapse? What is the role of the bioneurological mechanisms - the opiate receptor system and the endogenous ligands - in opiate addiction?

This study then focuses on a group of highly functional patients who are being treated by physicians in hospital-based medical practices in the specialty of internal medicine. The patients are employed either in good paying jobs or are owners of businesses. For the most part, they are married with families living within the middle and upper middle class. However, the concealment of their enrollment in methadone maintenance treatment is a major factor in their lives. Methadone treatment for this group is not substituting one addiction for another but as Goffman indicated in the case of the stigmatized person, an attempt "to correct his condition," or in the case of methadone patients "to correct their addictions." The central concern of the discreditable person with a stigma is "acceptance." Methadone treatment permits social acceptance since it essentially eliminates the outward signs of addiction. The methadone patients in this study are free to interact with 'normals' without telltale signs of addiction. Their stigma was 'corrected' and hidden. Old scars lightened or disappeared or could be covered with clothing. The hard working, high achieving methadone patient belies the character disorder and weak willed heroin addict. However, in a social sense methadone treatment, is an 'in-between' status. Methadone patients in this study regard methadone treatment as legitimate medical treatment, while professionals and society-at-large regard methadone

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treatment as substituting one addiction for another - still a stigmatized condition with a patina or shadow of the psychopathic characteristics of heroin addiction.

Both the patients and the four physicians in medical maintenance are cognizant about biases against methadone patients and the widespread ignorance about methadone maintenance that exists in the medical profession. The physicians have intervened for their patients by explaining the procedure to other health professionals who may be treating their patients. Never in the history of medicine has a therapy been so thoroughly evaluated as methadone maintenance for effectiveness and safety and yet subjected to such distortion, stigmatization and regulation. The stigmatization has become so entrenched that it figuratively extends through the patient to the molecules of methadone itself.

The plight of socially rehabilitated, employed methadone patients fits into a classic conceptualization of stigma as described by Goffman (1963). Patients have two separate social identifies:

1. **Virtual Identity**. This is the identity that patients present to the world and members of their families. The responsible adult who is capable of functioning on a high level within society as a law abiding citizen. Addiction and methadone treatment are not mentioned. The outward picture is of normalcy.

2. **Actual Identity**. This is the hidden identity of the patient who although currently functioning on a high level is burdened with a past of heroin addiction that included illegal activity and in some cases arrests and incarceration. Although currently enrolled in medical maintenance, the patient is afraid of discovery because of the stigma attached to the medication, the program and the past. Furthermore, the older theories of addiction imply a weak will and character disorder. Since methadone treatment is seen by society simply as substituting one addiction for another, the patient fears being seen as a dependent legal drug addict with the unsavory traits associated with heroin addicts.

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In Goffman's conceptualization of stigma, methadone patients are examples of persons harboring an invisible stigma. He classifies the stigma as associated in the social consciousness with a blemish of character – alcoholics, homosexuals, criminals and political radicals. Since the stigma is invisible, the methadone patient is a discreditable but not discredited person.

Social acceptance according to Murphy and Irwin (1992) is dependent on keeping 'a dirty secret.' What makes the stigma even more difficult is the fact that the acquiring of an addiction is regarded as an act of willful behavior as opposed to a stigmatized condition that arouses compassion such as a congenital deformity of the body or the loss of a limb through an accident or being born retarded. Since addiction is perceived as self inflicted, compassion is not forthcoming. The socially rehabilitated patients within this study entered methadone treatment to change their lives and to correct a pathological condition. Instead as previously discussed, the stigma of heroin addiction has been transferred to methadone.

The labelling of methadone patients as 'methadonians' and 'methadone addicts,' vitiates the attempts at normalcy. The highly accomplished group of patients in this study belie the labelling that creates, according to Miller (1974), a state of tertiary deviance. Central to this labelling is the belief that methadone maintenance is not perceived as a legitimate medication for a legitimate medical condition but as a means to obtain a legal high. Miller indicates that methadone treatment is perceived as a "rehabilitation without honor." The drug-free orientation of American society and proponents of drug-free programs regard methadone maintenance as 'substituting one addiction for another.'

According to NAMA the stigma attached to methadone treatment is almost as painful, if not more so, than being addicted to heroin. Addicts enter methadone treatment to eliminate the pathological condition of heroin addiction and instead find themselves faced with a new more subtle and even more damaging stigma. The addict has traded the heroin monkey (drug hunger) for the methadone gorilla (social control). Thus, methadone patients remain in limbo between the social 'normals' and the world of the stigmatized heroin addict. Therefore, to be accepted in society on equal terms they must remain silent about their status as patients and their accomplishments while maintained on methadone. In no other field of social service or medical treatment has a procedure shown such potential efficacy only to be nullified by the effects of stigma.

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The hypothesis of this study will be reformulated as follows considering the results of this study with 100 socially rehabilitated patients in medical maintenance:

Does the further concealment in medical maintenance because of its individualized medical treatment and reduced reporting schedule:

1. Preserve or enhance the social functioning of socially rehabilitated patients maintained on methadone?

2. Lessen the perception of social stigma of being maintained on methadone?

The answer to part 1 of the hypothesis is:

1. An unqualified yes for 77 patients, of whom 67 are still in the program and 10 medically withdrawn from methadone in good standing. With the removal of procedures, regulations and controls that many found demeaning and restricting in the clinics, they developed positive trustful relationships with their physicians. Many took advantage of the freedom that medical maintenance offered by creating and expanding their businesses, attending college, graduate and professional school, improving their employment skills and, in one case, building an international career in the arts which would been impossible in the clinic system.

2. A qualified yes for the seven patients who died and the one patient who returned voluntarily to the clinic of origin. The seven patients who died from medical causes were all patients in good standing. The qualification is that their continued good adjustments were affected either by prolonged illnesses leading to death or sudden medical deaths. For those who became terminally ill during treatment,

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medical maintenance offered a team approach to their care. Their medical maintenance physicians oversaw the continued use of methadone and the prescribing of adequate medication for pain. The patient who returned voluntarily to the clinic system was employed and appeared to be making an adequate adjustment until her death from natural causes.

3. An unqualified no for the 15 patients who were discharged with cause. Despite screening, interviews and recommendations from the clinic system, these patients needed the regulations and counselling services of the clinic to maintain their functioning. Some became involved with cocaine/crack and others could not manage a month's supply of medication. They were all employed some owning their own businesses when they entered medical maintenance and met the other criteria for acceptance. There do not appear as yet, sensitive screening procedures that could adequately predict success or failure in this particular program.

The answer to part 2 of the hypothesis that medical maintenance lessens the perception of stigma associated with methadone maintenance is an unqualified no. With all of its advantages of concealment and personalized treatment, medical maintenance does not remove or lessen the perception of social stigma of being a methadone patient either among active or former patients who were successfully withdrawn. The perception of stigma persists irrespective of the patient's treatment status and extends into the post treatment period for those who were successfully withdrawn from methadone. In general the patients in medical maintenance do not inform employers or friends about their enrollment in a methadone program. Although spouses are usually informed, some patients have not revealed their status as patients to members of their families including parents and children.

Goffman (1963) defines the pathway that stigmatized people choose as a moral career - one that reflects a given set of values common to the group. The patients in this study chose 'to correct' the highly stigmatized condition of heroin addiction by becoming methadone patients within a marginalized clinic

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system. While in the clinic system, they proved their reliability by conforming to the rules of a highly regulated clinic system, maintaining employment and adopting a life-style free of criminal behavior, use of illicit drugs and excessive alcohol. The multitiered regulations of the clinic system reflect the stereotypes that the public harbor about methadone patients. Although some patients may need the regulations and control of a clinic, the majority do not. For compliant patients the rules and regulations are more controlling than probation or parole.

Medical maintenance is conducted in private - in secrecy before a trusted doctor. However, both doctor and patient must still adhere to regulations whose origins are couched in federal policy for a clinical setting serving patients some of whom may have serious unresolved personal and social problems. A primary function of the regulations is to prevent diversion of methadone. The question arises - Are persons who are employed, own businesses or have celebrated careers going to divert a dose of methadone on a street black market that caters to untreated addicts? Some methadone patients in medical maintenance are earning up to and over $100,000 per year and will not sell their medication on the streets of New York or any other city for an extra $10.00 a dose. However, they are caught in the web of regulations that is intended to control a marginal population – which denigrates and infantilizes them. Although with medical maintenance travel is more flexible, patients must live in a geographical area where medical maintenance is available. The marginalization of the clinics has been moved into a concealed private practice with a quasi-normalization.

In the clinic the adherence to these regulations for employed complying patients is the moment when the full reality of the stigma is realized. No matter what the patient accomplishes it is those clinical moments - the submitting of random urines and the drinking of a dose of methadone on a line - that may define him/her as a former stereotypical heroin addict: the lying, untrustworthy, weak willed, sociopath who must be forever subjected to control; whose urines must be forever investigated; whose 'career' of a heroin addict although in the past still threatens the 'moral fabric of the greater society.' As one patient explained at a graduation ceremony for counselors in methadone programs, "It doesn't matter who you are outside the clinic. When you are in the clinic you are lowered, as though you are not the person you are on the outside who works or has a family" (Finneran, 1994). The clinic process equalizes patients and essentially forces patients to change their identity and self image. Some patients feel bereft of dignity. On that

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line it does not matter whether they are complying and rebuilding their lives or loitering and destroying their lives, everybody is the same - urines on demand, the return of bottles and the drinking of a dose of medication in front of a nurse. And always suspicion – for those few minutes, they are subjected before other patients to controlling regulations and the decisions of a staff that have the potential and impact of pervading every aspect of their lives. Arguments about dose are public and in some clinics the submission of urine tests are observed to make sure the patient is not 'cheating.' Everything is geared to controlling the non-compliant not enhancing or rewarding the compliant.

However, in medical maintenance the regulations of control are couched within the context of a doctor-patient relationship – both must participate in this monthly ritual and it takes on a different contextual meaning. The public line of the clinic has been exchanged for the privacy of the doctor's office. The rituals of control have been disguised and transformed into the rituals of private examination. The stigma remains but in the office of the doctor it is smoothed out and deemphasized. It is the tacit agreement of the rules of a 'team' – the doctor and the methadone patient for credence and support to survive and maintain a moral life. The silent agreement is about the ever present secret, opiate dependency, unseen by the world – the invisible worm in William Blake's poem, The Sick Rose.

The stigmatization of methadone treatment has resulted in the following major issues:

- Inability to open new programs because of community and political opposition despite the increasing transmission of HIV and drug resistant tuberculosis among untreated heroin addicts.

- Inability to obtain adequate funding for increasing capacity of the clinic system in the United States; only one out seven addicts in the United States is enrolled in methadone treatment.

- Methadone maintenance is illegal in about ten states and, in others, daily doses may be limited by statute or regulation and be inadequate for a substantial number of

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patients; time limits may be set for the duration of methadone treatment.

- Overregulation of clinics at federal, state and local levels; overregulation can result in punitive and overcontrolling policies thereby limiting the functional potential of patients.

- Inaccurate and potentially destructive presentations about methadone in the media (e.g., television, newspapers, books, journals, magazines).

- Inadequate doses prescribed to patients as a matter of clinic policy or ignorance about methadone maintenance.

- Discrimination against patients; patients must develop strategies to conceal their status as patients with their families, friends and employers.

- The development of destructive mythologies about methadone treatment (e.g., it rots the bones) among untreated addicts that prevents them from:

  - applying for methadone treatment.
  - agreeing to take an effective dose of medication.
  - remaining in treatment for a reasonable length of time if they should enter.

- The development of misinformation about methadone (e.g., methadone patients do not need postsurgical pain medication) among professionals including physicians, nurses, sociologists, psychologists, social workers, etc. that results in poor treatment practices and a fundamental misunderstanding of the patient's needs, motivation and behavior. These misunderstandings lead to biases and further stigmatization of the patients and a lack of support for the treatment.

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Recommendations

Initially the approach to overcome stigma against methadone patients involves a rethinking of the concept of addiction and treatment. As developed in this study, social and psychological theories of addiction have incorporated the moral and stigmatizing beliefs of a given era. There is an overlay of stigma that is latent in most theories that attempt to explain a prolonged compulsive addictive disorder (e.g., psychopathic personality, weak willed individual, sociopathic behavior). The theory must differentiate between availability of the drugs within a social context, the behavior of the individual within this social context and long term compulsive use. The social and psychological factors concern the availability of the narcotics and experimentation. However, a predisposition to development of long term addiction with its chronic relapsing nature implies the introduction of biological forces irrespective of social and psychological factors that may have led to experimentation.

The following are recommendations that should be considered.

- A reformulation of social and psychological theories of addiction to take into account the discoveries of neuroscience since World War II. Opiate addiction would then be considered a legitimate medical disease with a legitimate method of treatment. The findings of neuroscience may then lessen the stigma associated with methadone treatment.

- The continuing acquisition of a greater knowledge base including neuroscience findings, clinical practice and post treatment outcomes. An evaluation procedure would add to the knowledge base, determine the type of patients that can benefit from medical maintenance and the type of physicians and medical programs that could effectively treat patients who could treat them. Most importantly, a continuous evaluation could identify and prevent unethical or questionable practices among prescribing physicians and programs.

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- To impact on current policy a follow-up study that incorporates physical and neurological examinations as well as social and psychological factors. This has implications for the clinics where patients are encouraged to withdraw sometimes within the first two years of treatment or less or policy limits the length of time in treatment. To date the majority of follow-up studies indicate high relapse rates even among patients with a lengthy time in treatment and who are doing well. For the majority of current patients both in medical maintenance and the clinic system, withdrawal from methadone in the foreseeable future may not be a realistic goal.

- The education of physicians and related health care professionals about methadone maintenance that incorporates theoretical questions about the causality of addiction and the implications of discoveries in neuroscience. Clinical knowledge is important for effective practices such as prescribing adequate doses of methadone for maintenance and adequate pain medication if the patient should be hospitalized. However, the theoretical work is important to dispel prejudicial and biased attitudes towards patients. This is of special importance since patients have reported widespread bias within the medical and related health care professions against them.

- Strategies to reduce stigma by modifying existing theoretical concepts and beliefs are needed. One such strategy would be the organizing of an interdisciplinary team of scientists, physicians and patients to write articles for various journals and textbooks concerning the theoretical basis of addiction that embraces the new findings of neuroscience including the problems patients face because of the overregulated clinic system and the prejudice directed at methadone treatment and patients.

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- The formation of patient advocacy groups should be encouraged. Patients are now beginning to protest against repressive regulations of clinics, distorted media presentations and the theoretical concepts that add to their stigmatization. NAMA has been formed and now has over twenty-three chapters in fifteen states and five international groups in three countries with a patient membership of about 7,000. This organization and several member organizations publish newsletters about methadone, addiction theory, oppressive regulations and the stigma that is associated with the program. Also, accurate medical information is presented to patients in there newsletters and other publications that include dosage, pregnancies, side effects, medical procedures and HIV infection.

- The formation of patient advisory groups which deal primarily with clinic problems should be encouraged. In contrast to advocacy groups, an advisory group is appointed by clinic staff and patients to serve as their representatives in issues dealing with clinic problems and policy. Also, patients should be included in meetings about regulations and policy at the city and state level. Methadone patients should be encouraged to participate in national and international methadone conferences.

- To improve possibilities of methadone expansion, physicians, administrators, scientists and patients should meet with political and community leaders to develop new programs in communities where the establishment of new programs has been obstructed. The expansion of methadone programs is critical if the HIV epidemic is to be controlled within this population.

- An aggressive campaign should be undertaken with providers and patients working together to educate community planning boards, real estate developers, phy-

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sicians and public health officials about the efficacy of methadone maintenance treatment. Most importantly, educated and successful methadone patients can help change the public image of methadone treatment from the stigmatized program of just substituting one drug for another to the legitimate medical treatment that saves and transforms lives.

- Medical maintenance should be expanded with a careful evaluation procedure. A network of physicians affiliated with a major hospital should be organized and trained about methadone treatment. Socially rehabilitated methadone patients could then be removed from the clinic system and treated as private patients in medical practice. Health care organizations could also be enlisted for the treatment of methadone patients, thereby expanding treatment in a most cost effective manner. Methadone treatment should also be covered with health insurance.

- Education of staff is essential with ongoing training so that professionals can upgrade their knowledge and skills. This is important to ensure quality methadone treatment and that patients be treated with the dignity and respect they deserve.

Ultimately rigid controls and stigma can further impede the expansion of possibly the most effective treatment devised not only for the treatment of addiction but one of the most effective therapies in the treatment of any chronic condition in the field of medicine. The public health consequences of the stigmatization of methadone treatment are now being seen with the spread of HIV infection and drug resistant tuberculosis among injecting heroin addicts, their sexual partners and children not only in the United States but in Europe. The regulations imposed on this treatment by several interwoven governmental bodies has backfired and has not permitted the expansion of this program or the treatment of patients to proceed in a way that would optimize the advantages of methadone maintenance for the patient and society. While regulations are necessary to prevent diversion and unethical practices, guidelines are also necessary to im-

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prove treatment, modify the multitiered regulations and expand treatment. This is beginning to occur with the recent publication of the Treatment Improvement Protocols Series by the Center for Substance Abuse Treatment (CSAT).

This study concludes with the following statement by Dr. Marc Reisinger (1993), editor of AIDS and Drug Addiction in the European Community: Treatment and Mistreatment. Although this statement applies to the European community which has stigmatized and opposed methadone treatment, it is equally applicable to the United States where methadone treatment is overcontrolled and in some localities, forbidden. Heroin addiction as a vector for the transmission of HIV is now becoming a worldwide public health crisis and:

> **"...the supply of methadone is inferior to the demand almost everywhere in Europe. This might be seen one day as an unpardonable error of judgement which will cost the lives of hundreds of thousands of persons and wreak havoc on the health care budgets of several European countries."**

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Appendix

and

References

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Appendix

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Committee for

EXPANDED METHADONE TREATMENT

2035 Fifth Avenue New York, N.Y. 10035 / 831-6561

(In Formation)

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JAMES HAUGHTON
Co-Chairman

HERMAN BADILLO
BEATRICE BERLE
IRVING BLUMBERG
RONALD CONWELL
TIMOTHY J. COONEY
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PERCY SUTTON
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GILBERTO GERENA VALENTIN
STANLEY S. WEITHORN

Science
Advisory
Committee
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JOSEPH TERENZIO
RAY TRUSSELL
WARREN B. WESLEY
ISREAL ZWERLING

PROPOSAL FOR A GRANT OF $30,000

TO SUPPORT THE WORK OF THIS COMMITTEE

IN 1970

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Comparison Chart of Illicit Heroin Addiction and Stabilized Methadone Maintenance

Topic	Illicit Heroin Addiction	Stabilized Methadone Maintenance
Onset of action	immediate	30 minutes
Duration of action	4 to 6 hours	24 to 36 hours or half life
Route of administration	injection, snorting, smoking, several times a day	orally administered once per day
Effective dose	not applicable	for many patients 60 mg/day is lowest effective dose; doses between 80 and 120mgs/day are most effective for preventing HIV transmission, retention in treatment, reducing the use of other drugs and increasing social productivity
Overall safety	potentially lethal	medically safe, no toxic effects found in patients maintained on methadone for up to 18 years
Overdose	can die from overdose of narcotics; potentially lethal, even for tolerant individuals death can occur quite fast without proper medical treatment with narcan	a degree of protection from overdose is achieved when receiving 100 mg/day or more; methadone is potentially lethal for non tolerant individuals, death can occur but more slowly than heroin overdose however, overdose reaction can be reversed and person's life saved if narcotic antagonist such as narcan is prescribed for 24-36 hours
Narcotic effects of other opiates (if tried)	feels narcotic effects of opiates	at 80mgs/day or more narcotic effects of opiates are blocked
Withdrawal syndrome	onset begins within 3 or 4 hours, can be severe, but can be controlled with methadone	onset begins after 24 hours, less severe than heroin but more extended, can be controlled by slow reduction in methadone dose
Mood alteration	constant swings	none, if patient is not emotionally disturbed or using other drugs
Euphoric effects	approximately 2 hours duration after administration	none after administration
Tolerance level	increasing dosage needed	stable level at same dose
Narcotic craving	recurring	relieved and blocked
HIV transmission	effective transmission	transmission of HIV by injection reduced or eliminated for patients who remain in treatment
Immune system and Endocrine functioning in HIV- persons	impaired	normalizes during treatment
Immune system in HIV+ persons	rapid progression to AIDS	preliminary studies indicate that progression to AIDS is slower
Hypothalamus Pituitary Adrenal Axis	suppressed	normalizes during treatment

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Topic	Heroin Addiction	Stabilized Methadone Maintenance
Sexual functioning and libido	impaired	normalizes during treatment
Female menses	impaired	normalizes during treatment
Pregnancy	serious problems difficult to treat	problems can be brought under control with medical, social and prenatal care
Fetal environment	stressful for fetal development	not stressful, helps create stable environment for normal development of the fetus
Emotional affect	impaired	normal, if patient is not emotionally disturbed or using other drugs
Pain and emotion	blunted	feels normal pain and experiences normal range of emotions if not abusing other drugs
Intellectual functioning	impaired	normal if person is not emotionally disturbed or using other drugs
Physical reaction time	impaired	normalizes during treatment
Personal relationships	disrupted	restored with counseling
Social functioning	impaired	normalizes with counseling
Vocational rehabilitation and education	high proportion of failure	high proportion of success in vocational rehabilitation, education and employability
Employment	difficult if not impossible to hold a job	can function in every level and type of profession e.g. bus driver, lawyer, doctor, teacher, pilot, researcher
Mental illness	difficult to treat	treatable if integrated resources exist, however many psychiatric services discriminate against methadone patients and will not accept them
Poly drug abuse	high level (alcohol, crack, cocaine, nicotine)	high level but potentially treatable
Criminal activity	constant high level	reduced level or eliminated
Effect on community	destructive, high crime and death rates, transmission of disease	a good methadone program contributes to public safety, reduces crime, reduces mortality and improves quality of life for all
Criteria for addiction	fits the criteria for addiction as listed in the "Diagnostic and Statistical Manual of Mental Disorders"	does not fit criteria for addiction, methadone maintenance is a thoroughly researched and effective medical treatment
Life-style	"Heroin addiction is about acquired infection and death"	"Methadone maintenance treatment is about good health and life" Methadone chemotherapy normalizes a deranged physiology so that patients can stabilize their lives

This chart was prepared by Joycelyn Sue Woods and Herman Joseph and is reprinted from The Chemical Dependency Research Working Group Monograph Series. METHADONE TREATMENT IS RECOVERY, A Manual for Methadone Maintenance Treatment, 1994, No 1: p 20-21. New York: The New York State Office of Alcoholism and Substance Abuse Services and Mental and Health Research Association of New York City, Inc. For more information about the activities of the Chemical Dependency Research Working Group contact the Chair, Herman Joseph at (212) 961-8491, FAX (212) 961-8318.

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BUREAU OF
DRUG ABUSE

OHIO DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION / DIVISION OF MENTAL HEALTH
2329 Kenny Road, Bldg. B-207/Columbus, Ohio 43221

April 18, 1975

Mr. Hanhardt
Director, Film Library
Whitney American Museum
945 Madison Avenue
New York City, New York 10021

Dear Mr. Hanhardt:

It has been brought to our attention the Whitney American Museum is presently showing a film entitled "An American Way of Dealing' which depicts a Methadone Treatment Center in Dayton, Ohio.

The Ohio Bureau of Drug Abuse wishes to formally and officially register a protest in regard to this particular movie being used to demonstrate the quality and effectiveness of Methadone centers in general, and the Dayton, Ohio clinic, in particular.

The Ohio Bureau of Drug Abuse has never given any sanction to the filming and/or presentations of this above mentioned film; and was not aware of its being produced. If the content of this film were true at the time of the filming, it is no longer so.

Since the inception of methadone programs in Ohio, much money and many overall efforts have been spent on improving the quality of care for the client, and acceptability of the programs.

In the particular clinic portrayed in the movie at mention, there has been a complete change of administrative personnel on three occasions, and the third occasion also involved a large number of staff changes. We are satisfied with the improvement of the administrative features of the program, the care for the client, and the facilities of the center.

The primary purpose of this letter is to ask you to discontinue showing the movie. The request is made because the movie is not valid, does not fairly depict the methadone treatment program in Dayton—in fact, it is unjust and bordering on slander. Not only is this in relationship to the program, but also to the individual client and to the staff. Furthermore, it does not show any of the good features of the program.

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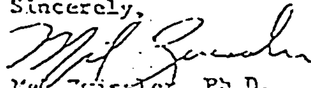
The State of Ohio, through the Ohio Bureau of Drug Abuse, is committed to the care of the client who is suffering from drug addiction. Methadone is one of the methods for/of this care. We are also committed to having programs that are acceptable and respectable.

We will appreciate any action you take to discontinue showing the movie, and informing others of our position regarding the movie.

Sincerely,



Mel Zwissler, Ph.D.
Chief
Ohio Bureau of Drug Abuse

MZ:mg

cc: Ed Lampton, Director
Dayton BuDA

Regina Roby, District 2 Consultant

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September 30, 1975

Mr. Richard Russo
Assistant Commissioner
Alcohol, Narcotic and Drug Abuse Control
Division of Narcotic and Drug Abuse Control
109 West State Street
Trenton, New Jersey 02625

Dear Mr. Russo:

I am writing this letter in protest of the film "Methadone: An American Way of Dealing." The film was made in Dayton, Ohio in 1973. At the time, the clinic where it was filmed had been in existence approximately 20 months.

I am a subject in this movie and a former client at the clinic where it was made. I was a member of the clinic for two years before my twenty-one day detoxification from methadone, and had been maintained on a dosage of 100 mgs. which was the highest allowable dosage at this particular clinic.

I have since become drug-free and have made great advances mentally, physically, socially, and financially. I can testify that methadone was a successful factor in my rehabilitation from the drug culture. Prior to my admission to the Dayton clinic, all other attempts to become drug-free had failed.

An agreement was made with the filmmakers that the film would never be shown in the Dayton, Ohio area. I personally witnessed the screening of the film in this area on two different occasions.

This film reflects a negative image of methadone clinics in general and the Dayton, Ohio clinic in particular and it should not be used to demonstrate the quality and effectiveness of these programs.

This film has proven to be extremely detrimental to my image in the community and to my progress and survival and has caused me a great deal of mental anguish.

On several occasions in July and September of 1975, Edward C. Brown, who also appears in the film, and I had telephone conversations with the filmmakers Julia Reichert and James Klein. We attempted to make them realize the damage their film is causing us personally as well as the damage it is causing the image of all methadone programs. We requested that they stop the distribution of the film. However, our efforts were to no avail, and they continue to disregard our objections.

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Any assistance you might offer in preventing any further screening of this film will be deeply appreciated by me personally as well as by all staff and clients of methadone clinics throughout the country

I hereby give my consent for you to release the contents of this letter to all concerned parties within your bureau, any other appropriate authorities and to the National Coordinating Committee on Drug Education.

Again, thank you for your assistance in this, and all matters of mutual concern.

Sincerely,

Fred Stroud
Dayton BuDA, Inc.
25 North Clinton Street
Dayton, Ohio 45402

FS:jk
cc: Susan Davidoff
Herman Joseph
Jeremiah Gutman

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COMMITTEE OF CONCERNED
METHADONE PATIENTS & FRIENDs

PROTESTS

THE CONTEXT AND CONCLUSIONS MADE IN THE FILM: "Methadone, An American Way of Dealing", CURRENTLY BEING SHOWN AT THE HIGHER GROUND CINEMA.

WE STRONGLY OBJECT TO THE BIGOTED, AND DISCRIMINATORY UNDERTONES DIRECTED AT METHADONE PATIENTS, AND THEIR MODALITY OF TREATMENT.

WE OBJECT TO THE DELIBERATE ATTEMPT, ON THE PART OF THE PRODUCERS, TO STRENGTHEN THE CREDENCE OF THEIR PLOT THROUGH MISREPRESENTATION, INSINUENDOS, AND LIES BY SUGGESTION: i.e. E. DOBBS (who throughout the film is insinuated to be an M.D.) IS ACTUALLY A Ph.D., AND INCOMPETENT TO ANSWER THE TYPE OF QUESTIONS ADDRESSED TO HIM.

WE FURTHER OBJECT TO A FILM, SUPPOSEDLY DEPICTING METHADONE TREATMENT, AND WHICH IS HIGHLY SUGGESTIVE OF HAVING EDUCATIONAL MERIT, BEING PARTIALLY FUNDED BY A TREATMENT MODALITY SUCH AS R.A.P., INC.......A PROGRAM KNOWN TO UTILIZE INACCURATE, ANTI-METHADONE PROPAGANDA AS SELF-INTEREST, COMMUNITY INDOCTRINATION GIMMICK.

THIS FILM DOES NOT PRESENT A TRUE PICTURE OF METHADONE MAINTENANCE TREATMENT OR ITS PATIENTS. ASIDE FROM THE INCONSISTENCIES AND DISTORTION OF FACTS, THE CLINIC PORTRAYED IN THE FILM IS NOT REPRESENTATIVE OF METHADONE CLINICS AND PATIENTS THROUGHOUT THE COUNTRY, PARTICULARLY IN THE NEW YORK CITY AREA.

WHILE WE ARE NOT IN A POSITION TO DISPUTE THE VIEWS AND EXPERIENCES OF INDIVIDUALS APPEARING IN THE FILM, WE CAN FIRMLY ATTEST THAT THESE ARE NOT THE OPINIONS AND COMMENTS OF THE VAST MAJORITY OF METHADONE PATIENTS BEING TREATED IN THIS AREA.

OUR COMMITTEE IS A NON-PROFIT ORGANIZATION, FORMED FOR THE PURPOSE OF ASSURING ALL PATIENTS ENROLLED IN METHADONE CHEMO-THERAPY PROGRAMS AS OPPORTUNITY TO COUNTER-ACT THE DISRUPTIVE DISCRIMINATORY, AND ADVERSE PUBLICITY, SUCH AS PRESENTED IN THIS FILM. WE ARE FURTHER DEDICATED TO THE PROPOSITION OF IMPLEMENTING AND/OR INFLUENCING PROGRESSIVE POLICIES WHICH GOVERN METHADONE TREATMENT FACILITIES AS THEY RELATE TO METHADONE PATIENTS.

CCMP IS A COMMUNITY RELATIONS ORIENTED GROUP AND WOULD BE DELIGHTED TO ANSWER ANY QUESTIONS YOU MAY HAVE REGARDING METHADONE CHEMO-THERAPY OR METHADONE PROGRAMS. SEND ALL MAIL TO:

211 EAST 23rd STREET SUITE 8MM NEW YORK, N.Y. 10010

(IMPORTANT: Please See Attachments)

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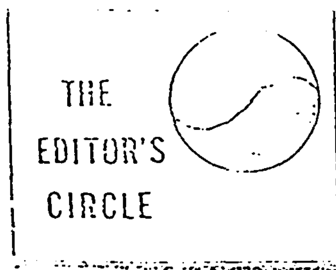

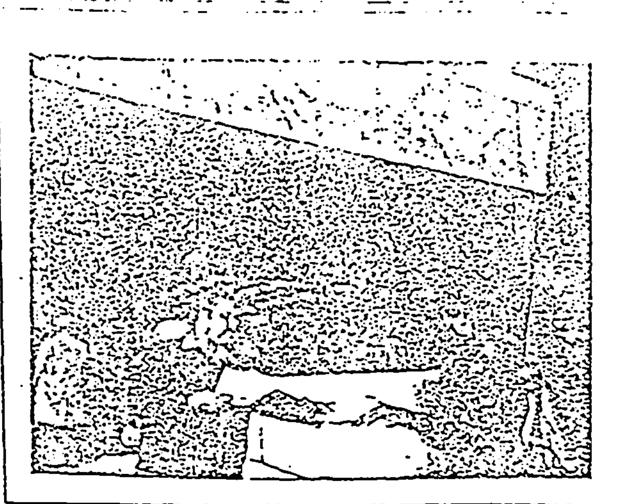

BY KIM CARLO

C.C.M.P. Verses Whitney Museum Film

C.C.M.P. members were right on the 'ball', or should I say 'scene', at Whitney Museum's seven-day-showing of a discriminatory film on Methadone Maintenance entitled "Methadone, An American Way Of Dealing". The picture depicted a poorly operated Methadone Center in Ohio, whose patients were thoroughly demotivated, and whose idea of clinical therapy was to encourage patients to attend something which might be described as 'Group-nodding' sessions.

However, what was inspiring, and somewhat heart-rending, was the sight of job-holding, patient volunteers standing about the theatre entrance soliciting commentary interviews with parading moviegoers, and distributing prepared, contradictory fliers. (Pictures shown above, & right) Each member seemed resigned to the probability of having to uncloset him or herself as living proof of the disparity between the projected, Methadone patient stereotype, and the real patient.

Spectator response ranged from utter astonishment to sincere, open-minded concern. Oddly enough, many of the younger set had already formulated sophisticated opinions, and felt the movie to be a gross misrepresentation of Methadone therapy, and in general poor taste. Other viewers, of varying professional backgrounds, stated that they had made previous attempts to obtain positive Methadone information, but had always been reciprocated with the same negative type material, and had begun to wonder if any impartial studies even existed. One woman, a health worker, had been sent by her facility as an observer for the purpos of reporting her perceptions back to their staff. After speaking with Committee members, she became apologetic of her situation, and hoped we would

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EDITOR'S

WHITNEY VS. C.C.M.P. cont.

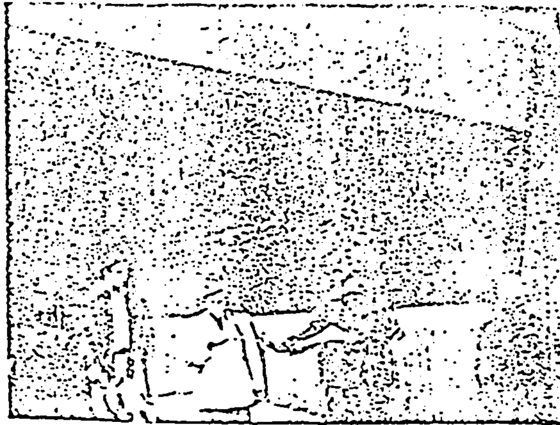
not forget to contact her if a more objective film were ever presented.

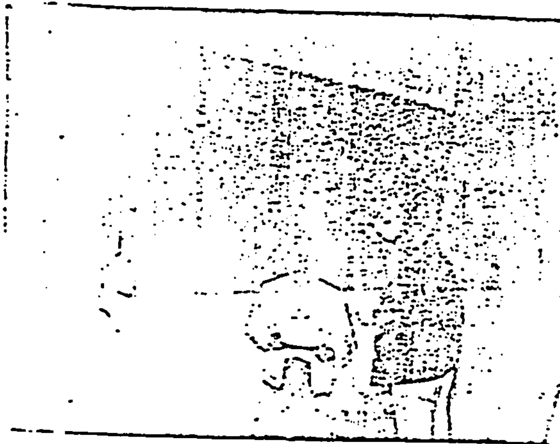
A few old ladies from the surrounding area agreed that the film was probably biased, but felt more resolved that it should not have been shown in their vicinity, because the problem of Methadone or Addiction really didn't pertain to them.

There is little doubt that the Committee's presence at this event put something on the minds of moviegoers, as well as, the providers, but I can't help wondering if the moving display of comradery interacted between members during the operation, didn't have the most significant impact of all.

* * *

(Note pictures on the right of CCMP members interviewing moviegoers, and passing out leaflets.)





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United We Win

A Newsletter of the Ad Hoc Coalition for a Viable Neighborhood - Vol. 1, Number 1 - 8/1992
535 West 110th Street, Box 3H, New York, NY 10025, TEL:(212) 642-5805

Too Many Methadone Clinics =Genocide?

Adolfo Profumo, C.S.W.
Director of Social Services,
Minority Task Force on AIDS*

*[illegible]

I am a psychoanalyst and a social worker who has treated drug users and methadone patients for ten years and I am opposed to the opening of the 110th Street methadone clinic. Not only because of Beth Israel's failure to address in a respectful and satisfactory way the questions that have been raised by our community - but first and foremost because, in my professional experience, methadone is largely ineffective and profits mostly the hospitals/clinics that run methadone programs (see, for example, "Cashing In on Methadone: Two Clinics Give Minimal Care and Take In Millions", Newsday, 6/20/1989).

In 1990, in The International Journal on Drug Policy, (Vol. 2 No 2) Edith Springer, an expert in the drug treatment field, reports that "(methadone) programs put out false statistics indicating 70% success rates (...) The actual success rates are probably at around 10% based on my experience in the system. (...) Staff are poorly trained and with few counseling skills. (...) Caseloads are often impossibly high (50-90 clients per worker)."

As early as 1977 - after having studied a large New York City methadone program and after having conducted an in-depth analysis of the scientific literature related to methadone treatment - P. Kleinman, I. Lukoff and B. Kail, in their article "The Methadone Fix," (published in Social Problems, Vol. 25, No 2) reached similar conclusions: "(...) at first glance, data from (...) methadone programs appear to show much more favorable results. However, close scrutiny reveals that the bulk of these reports are based on analytic methods so weak that almost no conclusion can be drawn from them.".

I have seen methadone work only for a handful of people who have had access to the rare model programs which provide extensive supportive services such as psychotherapy and employment counseling. The majority of methadone programs are "dispensaries" which provide none of the above.

Do not misunderstand me. Some individuals do need methadone. The same way others are entitled to have access to needle exchange programs. These treatment models must remain available. What is not acceptable is that our society seems suspiciously eager to create these kind of programs and much more stingy in its efforts to create compassionately-run, drug-free, long-term therapeutic communities.

In 1990, in his article "Retention and Outcome at A.C.I., a Unique Therapeutic Community" (published in The International Journal of the Addictions, Vol. 25, No 1), C. Winnick reports that in drug-free treatment programs of the kind described above (which are usually privately owned, for profit programs, accessible mostly to members of the White middle-class), the staff/patient ratio is excellent (one staff member per three patients, compared to one staff member per fifteen patients in publicly funded, non profit programs of the same kind) and the success rate can be as high as 85%.

The majority of methadone patients are male members of the African-American and the Latino community. They have almost no access to drug-free therapeutic communities because the private (better) ones are too expensive, and the publicly funded ones have often 6 months waiting lists.

Given this tragic state of things, we seem to be using methadone in a way frighteningly similar to the way we used alcohol to repress and control Native People (Native Americans). In fact, methadone reminds me of the small-pox-infected blankets that European colonists distributed to Native People in 1763.

In this context, as a member of the Upper West Side Jewish community faced with the prospect of yet another methadone clinic, I feel like saying "Never again!"

We must speak up loud and clear against the abusive way in which methadone continues to undermine rather than empower communities of color.

A Fair Share Issue

Philip Shelly
Ad Hoc Coalition Member

The Ad Hoc Coalition for a Viable Neighborhood, have been accused of being driven by a NIMBY (Not In My Back Yard) attitude in its fight against the location of a Beth Israel Methadone Clinic at 110th Street and Broadway. This is an absurd charge: it is designed to intimidate us - historically liberal Upper West Siders - and thereby kill the necessary dialogue on the crucial issue of fair share of social services facilities.

We all support drug treatment programs! We have helped elect leaders who have made these programs possible. We know that true support of social services requires us to welcome drug treatment facilities into our neighborhood, and we have welcomed more than our fair share of them.

We oppose methadone maintenance programs because the majority of them profit only the hospitals that run them, and maintain people in the misery of addiction. Our opposition to this methadone clinic is also based on a justifiable concern for the quality of life in our

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neighborhood.

For years the City has concentrated social service facilities in our neighborhood. Throughout Community Board #7, which runs from 59th Street to 110th Street on the West Side, there are 22 residential facilities for alcoholics, psychiatric patients, drug users, and for individuals and families who need transitional housing. Thirteen of these sites - over half of them - are located north of 96th Street. Out of their total of 1600 beds, 946 are located north of 96th Street. (These disproportionately high numbers also impact on the southern end of Community Board #9, which runs from 110th Street to 155th Street.)

"More than our fair share!" is a valid and substantial concept, with real meaning for our community, especially since substance abuse treatment and mental health facilities, methadone clinics, and transient housing facilities, tend to adversely impact the neighborhoods in which they are located. These facilities serve individuals with extensive behavioral problems. failure rates are high for many of these programs - and the patients who fail inflict themselves on the communities in which they live.

The very high concentration of these facilities in our neighborhood has brought a disproportionate number of dysfunctional and often dangerous people into our community. Drug and alcohol abusers, panhandlers, and loiterers, have turned our community into an unsupervised open air asylum.

As they are inadequately supervised, the majority of these individuals suffer from this unfair situation as much as we do. Unprotected from themselves and those who would do them harm, they fare poorly in this dysfunctional environment, and many of them become the main source of support for the drug market in our community. This atmosphere also hurts clients of other social service programs: our seniors, our mentally ill, and our children. They, too, need help, but this threatening atmosphere has trapped them in their facilities, just as it has pushed many of us indoors.

This depressing situation and the anger which permeates it, has severely demoralized our community and has placed it in critical condition. Stable and productive people from all ethnic groups, people who are necessary for the survival of our community, wonder why they should stay here and endure this unhealthy situation.

The opening of a methadone clinic for over 400 addicts at the intersection of 110th Street and Broadway can only increase the negative tensions in our community.

We are taking a stand against the wanton siting of this kind of facilities in our communities and we *demand* that they be more equally distributed throughout the city.

What's Wrong with this Picture?

Carolyn Birden
Ad Hoc Coalition Member

One day towards the end of May, I was walking down 110th Street, heading towards Broadway, when I noticed that the dumpster placed on the sidewalk in front of West Side Market's new rear entrance was spilling over again. The once-beautiful Chemical Bank front was covered with graffiti, and the garbage on the street had been sorted and rearranged several times. I noticed a woman going in the side door and asked if she was from West Side Market, and if she could do anything about the garbage on the sidewalk. She replied that she was "from the clinic that's going in here" and went in, closing the door on the garbage and on me.

A call to Community Board #9 confirmed that yes, Beth Israel Medical Center was planning to open a methadone maintenance clinic at that site. A call to Ed Sullivan was met with surprise: he would call me back. When he did, he said it was the new location of the clinic that had been above the Chemical Bank on 113th Street for many years, not to worry. I wouldn't even know it was there.

Shortly thereafter, together with a few neighbors, I attended the June 2nd meeting of the Board's Health and Hospitals committee, headed by Joyce Miller. There we protested the lack of notice about the clinic: Ms Miller told us that Beth Israel had no need for a hearing, because the clinic was being moved "within the neighborhood."

At that same Health and Hospitals committee's meeting we learned that HRA was presenting a request for space for yet another social service facility - a Family Preservation Unit - next door to the bank (it is not known whether that request has been approved by the Board as of this date).

Later we found out that the building had been nominated for landmark status in 1991 but that the person doing so had not followed through with the application. We also learned that the methadone clinic had originally been presented to the Board's Land Use Committee as a Beth Israel community counseling center and not as a methadone clinic, and that it had been "referred" to the Board's Health Committee without a vote by the members of the Board's Land Use Committee.

Our questions at this point are:

-What did Sullivan know and when did he know it?
-Why did the Land Use Committee "dump" this crucial land use issue onto an inappropriate committee?
-Why did the Beth Israel's representative misrepresent the nature of the clinic to the Board?
-Has HRA's request to open a Family Preservation Unit been approved?
-What is the programmatic structure of HRA's planned Family Preservation Unit (is it a clinic or an office space?)

We welcome the assistance of any politician and/or community member who can assist us in answering these vital questions.

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A Former Methadone Counselor Shares Her Experience.

Sheri Nappi worked at Albert Einstein College of Medicine and was a Vocational Counselor within the substance abuse methadone clinic from August 1988 to April 1990. She now works as a mother.

After a recent community meeting concerning the proposed methadone clinic at 110th Street and Broadway, Ms. Nappi agreed to be interviewed by a member of our coalition. This is an excerpt of the interview.

Q. It is our understanding that the sale of methadone takes often place outside the clinic. Is it true?

A. Yes — This does happen and the patient uses the money to buy heroin and other drugs.

Q. Does crime increase in the area?

A. I think so. Patients mill about. One time the trailer (methadone is can also be distributed from a trailer) was pumped full of gun shot holes. Patients and/or community members are often mugged for money or medication. More guns are brought into the neighborhood. Some of the patients are pushers and they carry guns. Our director, I forgot his last name, was shot at.

Q. Did he make it?
A. "Yes", he survived.

Q. Do you see methadone as a helpful treatment model?

A. About 30% of the patients dropped out of my program. Most people leave because of incarceration. After discharge they come back to the program. On my case load, most were incarcerated at least once. Mostly men. I did not see anyone who was truly getting better. Almost no one tested drug free. They were using illicit drugs along with methadone. Anything, from alcohol to cocaine. This is the way it was then. It may have changed for the better since.

Myths & Facts About The Proposed Meth. Clinic.

Myth: There will be no negative environmental impact on our community.

Fact: An Environmental Impact Study (EIS) - as required by law - of the effects of the clinic on the surrounding area was never conducted.

Myth: The 110 clinic would be an exact replacement of the 113 Street clinic within the same community, and no environmental impact study is needed.

Fact: The 113th Street clinic closed in January: its patients were directed to other clinics. The 110th Street clinic is for all intents and purposes a new clinic. Also, there is a world of difference between 113th Street and 110th Street. 113th Street is a quiet residential street, where loitering and other unlawful behaviors could easily be seen and stopped. *110th Street and Broadway* is an extremely busy commercial intersection, with heavy pedestrian and vehicular traffic. The area already functions as a meeting area for peddlers and drug and alcohol users, who, due to the abuses and injustices that they suffer in our society, often display aggressive and intimidating behaviors. Beth Israel does not have the resources to ensure appropriate security in this already socially stressed area.

Myth: No one from the 113th Street Clinic was ever reported to have committed a crime.

Fact: Misinformation! The police does not keep records of whether or not perpetrators of crimes are members of methadone programs, and a number of officers told us privately that many of the individuals they arrest has a methadone ID card.

Myth: A well-run methadone clinic does not bring loitering and drug dealing to a neighborhood.

Fact: It is common knowledge that methadone patients often sell their methadone to buy crack, cocaine and/or heroin, and that the majority of Beth Israel's methadone clinics are poorly run methadone dispensaries that do not include supportive counseling, detoxification programs, or job training for their clients.

Myth: The methadone patients who will use the clinic have always lived in our community.

Fact: Janet Wing, from the New York State Office of Alcoholism and Substance Abuse Services (OASAS), confirmed that 70% of the clinic's patients will come from Community Board #7 and Community Board #9, which cover an area encompassing 100 blocks north to south!

Myth: The clinic would be open during the same hours as the 113th Street clinic: from 7 AM to 3 PM, five days week and on Thursday evenings.

Fact: The proposed new clinic's hours are: from 6:45 AM to 5 PM, six days a week (evening hours have not been announced as of yet).

Myth: Methadone works and provides a needed service to heroin users and our society at large.

Fact: Health care professionals who have worked with methadone patients for many years confirm that the majority of their methadone patients continues to use other drugs as well as alcohol while on methadone. They are also aware that the hospitals/clinics that dispense methadone profit greatly from this venture (Beth Israel will reportedly collect $1,000,000.00 per year in Medicaid fees for the proposed clinic). Finally, health care professionals in the drug treatment field report that many of their methadone patients decide to use methadone because there are only a handful of drug-free, long-term treatment programs and that the average waiting time to access these programs is six months.

Join us in this healthy fight!
We need volunteers!
Call (212) 642-5805

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METHADONE

Methadone was invented by Nazi scientists at Adolf Hitler's request. It was named "Adolfene" after Hitler.

Methadone is 10 times as addictive as heroin. Withdrawal can last up to three months. Common effects of regular methadone use include constipation, excessive sweating, swollen hands, sexual impotency, insomnia, abnormal menstrual periods, slurred speech, drowsiness, lung failure.

Current information on methadone-related deaths is hard to find. It is believed that well over 1500 methadone-related deaths have occurred since 1971. On November 10, 1972, then Health Services Administrator Gordon Chase announced that no new statistics on methadone deaths would be released "because the publicity has been damaging to City programs." In 1987, NYC hospital emergency rooms treated over 1000 methadone overdose cases. It is estimated that approximately 200 persons a year die from methadone overdoses.

Degenerative brain damage has been found in methadone victims. Some years ago, Dr. Roizen, a neuropathologist, examined the brains of 14 persons who had died of no causes other than methadone overdose. He discovered degenerative brain damage in young people comparable to changes usually associated with 80-year-old people. No other barbituate or narcotic causes these changes.

Hailed by its proponents as a means to limit the spread of AIDS, methadone in fact, contributes to the spread of AIDS which because of its toxicity severely depresses the immune system thus predisposing users to opportunistic infection. Illegal-street methadone sales has helped to initiate an explosion in IV cocaine use, adding to the already 100,000 persons infected through IV drug use in NYC.

Methadone "maintenance" means that a person is given large daily doses of methadone equal to $150.00 worth of heroin to "block" the person's desire to use heroin. Methadone has all the physical and psychological effects that heroin does. Tolerance develops so there is no real blocking.

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The New York State Division of Substance Abuse Services (55 West 125th St., 1-212-870-8362) monitors the "clinics" which distribute methadone in NYC report 31,000 persons registered in the programs. This number excludes those thousands in NYC area who obtain methadone through illegal means.

NYC's $80 million methadone system, the largest in the country, provides the cheapest form of "drug treatment" available for addiction. Spending an average of $1-3,000 per year per patient (as compared to $15,000 a year per patient in drug free programs in middle class communities), the 36 clinics

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city-wide do nothing but dispense methadone, offer no counseling or guidance other than to mandate a "lifetime commitment" to "The Program." In addition, these clinics generate millions of dollars in profits for loosely regulated programs run by: absent doctors, private entrepreneurs, non-profit groups and others, whose finances are rarely audited. Since 1985, two methadone clinics (East Harlem, Times Square) have collected more than $8 million in Medicaid payments and other fees for Doctors Richard Koeppel and Eugene Silberman, monies which were invested in real estate deals in Queens (see NY Newsday, 6/12/89). Urine testing has labs gross at least $500,000 a week from these programs; money is often distributed in the form of kickbacks.

Eli Lilly and Company, Giant narcotics profiteer based in Indianapolis (1-317-276-2000) manufactures methadone diskets on the order of 5,000 lbs a year. Eli Lilly, which also manufactures Prozac, which has been linked to suicide and violent behavior, has one of the highest profit ratings of any US company with operations in at least 26 countries, including South Africa. The family of President George Bush is heavily invested in the company. In 1947, Lilly mysteriously obtained exclusive patent rights to methadone. They continued to use the brand name "Adolfene" for a time.

In November of 1978, the Eli Lilly Co. along with Mayor Ed Koch, succeeded in shutting down the Lincoln Detox Center, an alternative health, holistic drug treatment center for addiction which rejected methadone treatment. During this same period, a doctor at the South Bronx based detox center, Doctor Richard Taft, was murdered, found with a heroin needle stuck in his back.

During the 1960's, Rockefeller University Doctors Vincent Dole and Marie Nyswander, developed the methadone treatment approach which has become the policy in NYC. In April 1989, the Federal Food and Drug Administration, Regulatory Management Branch, 1-301-443-6245, along with the National Institute on Drug Abuse, 1-301-443-6245, proposed allowing clinics to set up "interim" sites modeled on the Harlem based clinics developed by Beth Israel Hospital in NYC. These "cop and bop" operations, whose aim is to make methadone "treatment" more available do nothing but dispense methadone. Beth Israel, which is the largest methadone provider in NYC with 23 clinics, has taken a leading role in the promotion of methadone. In fact, the head of the hospitals board of trustees, Doctor Morton Hyman, in his role with the NY State Public Health Council, actually approves clinics as methadone sites.

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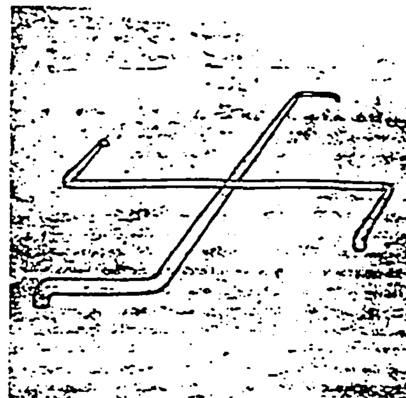

He and Doctor Robert Newman, whose editorials and letters consistently inform the NY Times pro-methadone stance (most recently "This Drug Treatment Works" 4/8/90) are some of the most ardent proponents of methadone. A very powerful family, Doctor Hymans father, head of an oil family, ran the Overseas Shipbuilding Group, which like the Bush family, became rich through the oil and pharmaceutical industries.

In spite of all studies showing how common vitamin deficiency in poor communities leads to an underdeveloped capacity to think, there exist no state of federal vitamin maintenance programs. In fact, more government aid (disguised via state and private funding) support methadone more than any other single medical treatment while federal funding of methadone programs is 20 times as great as the funding of drug free programs.

DESTROY THAT WHICH DESTROYS YOU

The United States government, which for years shipped heroin to American ghettos in the caskets of Vietnam war dead, while more recently has engaged in contra/cocaine maneuvers, is actively involved, alongside the corporate drug profiteers, in widespread chemical warfare against the poor, especially African and Latino oppressed nations within the U.S.

These drugs allow the state to criminalize large segments of the community, providing the climate and the pretext for police intervention and occupation of these areas by the 'colonial army,' while all along rationalizing to the racist middle classes the overt police repression designed to 'stop drugs.'

These drugs are weapons of the health (read: death) establishment. The so-called clinics, mental health offices, counseling centers and correction liaison are the appendages of a medico-psychiatric apparatus of repression which criminalizes deviance as readily as it creates it.

These drugs, perfect consumer products, are primary instruments of social control and genocide, which meet a real, if thwarted, need for a new world, a new reality. The problem is that these drugs make it impossible to resist and actually realize a new world.

These drugs, second only to bombs in overall GNP, provide the basis for a market that offers the state, via legal and illegal means, the way in which to prop up a crisis-ridden economy where drug infusion equals capital infusion. Lastly, these drugs assist the state in its effort to stabilize the ghetto via grassroots survival drug economies, which along with military recruitment lessen the pressure of high unemployment.

Frank Morales

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Perception of Social Stigma Test Scale

We are interested in your perception of the degree to which society at large harbors bias, prejudice, stigma, or negative feelings against particular groups of people.

Circle a number from 0 to 5 as the degree of bias, prejudice, stigma or negative feeling that society holds against the groups of people listed below. 0 is no bias, prejudice, stigma, negative feelings. The numbers from 1 to 5 represent increasing degrees of bias, prejudicc, stigma or negative feelings. For example, 1 is a small degree, 2 is a greater degree, 3 is a even greater degree, 4, is greater still and 5 is the greatest degree.

1)	People with HIV Infection or AIDS	0	1	2	3	4	5
2)	Heroin and/or Cocaine Addicts	0	1	2	3	4	5
3)	Physically Disabled, Amputees, Blind, Deaf, Uses a Wheelchair	0	1	2	3	4	5
4)	Persons with Serious Criminal History (e.g., felony arrests)	0	1	2	3	4	5
5)	Persons of Color (minorities)	0	1	2	3	4	5
6)	Methadone Patients	0	1	2	3	4	5
7)	Homeless People	0	1	2	3	4	5
8)	Gays and Lesbians	0	1	2	3	4	5
9)	Alcoholics	0	1	2	3	4	5
10)	People with Histories of Mental Illness or Mental Retardation	0	1	2	3	4	5

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References

"A community says no." 23 January 1995. Editorial. Staten Island Advance. A16.

Abadinsky, H. 1989. Drug Abuse: An Introduction. Chicago: Nelson-Hall Series in Law, Crime, and Justice.

Alksne, H. 1980. "The life cycle of addiction: A conceptual framework for the examination of careers in drug abuse." Unpublished dissertation. New York: City University of New York.

"A.T.F. dosage survey." 1993. Addiction Treatment Forum 2(3): 1, 3, 5.

Ausubel, D.P. June 1968. Why compulsory closed-ward treatment of narcotic addicts? Reprints of the New York State Narcotic Addiction Control Commission, Number 1(5). Available from the New York State Office of Alcoholism and Substance Abuse Services.

Azatian, A., Papiasvilli, A. and Joseph, H. 1994. "A study of the use of clonidine and naltrexone in the treatment of opioid addiction in the former USSR." Journal of Addictive Diseases 13(1): 35-54.

Ball, J.C. and Chambers, C.D. eds. 1973. The Epidemiology of Opiate Addiction in the United States. Springfield, Illinois: Charles C. Thomas.

Ball, J.C., Lange, W.R., Myers, C.P. and Friedman, S.R. 1988. "Reducing the risk of AIDS through methadone maintenance treatment." Journal of Health and Social Behavior 29(3): 214-226.

Ball, J.C. and Ross, A. 1991. The Effectiveness of Methadone Maintenance Treatment. New York: Springer-Verlag.

Barrett, D.H., Luk, A.J., Parrish, G. and Jones, T.S. 1993. Medical examiner cases in which methadone was

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detected in Harris County, Texas, 1987-1992. Atlanta, Georgia: Unpublished internal report to the Centers for Disease Control.

Bateson, G. 1987. "Double bind." In Steps to an Ecology of Mind. Northvale: Jason Aronson. 271-278.

Bayer, R. 1978. "Methadone under attack: An analysis of popular literature." Contemporary Drug Problems (Fall): 367-399.

Becker, H.S. 1963. Outsiders. New York: New York Free Press.

Borg, L., Ho, A. and Kreek, M.J. 1992. "Correlation of methadone blood levels from three laboratories with dosage and abstinence symptoms: A pilot study." In Problems of Drug Dependence 1992. Proceedings of the 54th Annual Scientific Meeting of the Committee on the Problems of Drug Dependence. Keystone, Colorado: Committee on the Problems of Drug Dependence.

Bratter, T.E. and Pennacchia, M.C. 1976. "The negative self-fulfilling prophecy of methadone maintenance." In Martin, C.V. ed. Basic Readings in Corrective and Social Psychiatry. Olathe, Kansas: Corrective and Social Psychiatry.
Licit and Illicit Drugs. The Consumers Union Report on Narcotics

Brecher, E.M. 1972. Licit and Illicit Drugs. The Consumers Union Report on Narcotics, Stimulants, Depressants, Inhalants, Hallucinogens, and Marijuana. Boston: Little, Brown and Company.

Brown, B.S., Jansen, D.R. and Bass, U.F. 1974. "Staff attitudes and conflict regarding the use of methadone in the treatment of heroin addiction." American Journal of Psychiatry 131: 215-219.

Brown, J. 23 September 1993. "The methadonians." Our Town. 18-20.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Burroughs, W. 11 November 1977. "Heroin maintenance: Methadone kills you faster than junk." The New York Times. 60.

Caplehorn, J.R.M. 1994. "A comparison of abstinence-oriented and indefinite methadone maintenance treatment." International Journal of the Addictions 29(11): 1361-1375.

Caplehorn, J.R.M. and Bell, J. 4 February 1991. Methadone dosage and retention of patients in maintenance treatment. Medical Journal of Australia 154: 195-199.

Caplehorn, J.R.M., McNeil, D.R. and Kleinbaum, D.G. 1993. "Clinic policy and retention in methadone maintenance." International Journal of the Addictions 28: 73-89.

Carlo, K. 1975. "CCMP versus Whitney Museum Film. The Editor's Circle." CCMP Newsletter 1(1): 9.

Chemical Dependency Research Working Group. 1994. Comparison Chart of Illicit Heroin Addiction and Stabilized Methadone Maintenance. New York: Available from NYS Office of Alcoholism and Substance Abuse Services.

Committee of Concerned Methadone Patients and Friends, Inc. 1975. CCMP Protests. Flyer. New York: Available from the archives of the National Alliance of Methadone Advocates.

Committee Of Methadone Program Administrators (COMPA). 1993. Personal communication.

Community Treatment Foundation and The Rockefeller University. 1974. Report. New York: Available from Dr. V. P. Dole, The Rockefeller University.

Cooper, J.R. 1992. "Ineffective use of psychoactive drugs: Methadone treatment is no exception." Journal of

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the American Medical Association 267(2): 281-282.

Corradi, A. 18 1994 October. Personal communication. Assistant Commissioner, New York State Office of Alcoholism and Substance Abuse Services.

Courtwright, D.T. 1982. Dark Paradise: Opiate Addiction in American Before 1940. Cambridge: Harvard University Press.

Courtwright, D.T., Joseph, H. and Des Jarlais, D.C. 1989. Addicts Who Survived: An Oral History of Narcotic Use in America, 1923-1965. Knoxville: University of Tennessee Press.

Crocker, J. and Major, B. 1989. "Social stigma and self esteem: The self protective properties of stigma." Psychological Review 96(4): 608-630.

Cushman, P. 1980. "The major medical sequelae of opioid addiction." Drug and Alcohol Dependence 5: 239-254.

Des Jarlais, D.C., Friedman, S.R., Novick, D.M. et al. 1989. "HIV-1 infection among intravenous drug users in Manhattan." Journal of the American Medical Association 261: 1008-1012.

Des Jarlais, D.C., Joseph, H., Dole, V.P. and Schmeidler, J. 1983 "Predicting post-treatment narcotic use among patients terminating from methadone maintenance." Journal of Alcohol and Substance Abuse. 57-68.

DeLeon, G. 1984. Program based evaluation research in therapeutic communities. In Tims, F. M. ed. Drug Abuse Treatment Evaluation: Strategies, Progress and Prospects. NIDA Research Monograph 51. Washington, D.C.: U.S. Government Printing Office. #017-020-01218-1. 64-87.

DeLong, J.V. 1972. Dealing With Drug Abuse: A Report to the Ford Foundation. New York: Praeger

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Press. Cited in Miller, R. 1974. "Towards a sociology of methadone maintenance." In: Winick, C. ed. Sociological Aspects of Drug Dependence. Cleveland: CRC Press. 169-198.

Dole, V.P. 16 July 1994. Personal Interview at The Rockefeller University.

Dole, V.P. 22-29 April 1992. "Hazards of process regulations: The example of methadone maintenance." Journal of the American Medical Association 267(16): 2234-2235. Commentary.

Dole, V.P. 25 November 1988. "Implications of methadone maintenance for the theories of narcotic addiction." Journal of the American Medical Association 260(20): 3025-3029.

Dole, V.P. December 1980. "Addictive behavior." Scientific American 243(6): 138-154.

Dole, V.P. and Joseph, H. 1978. "Long term outcome of patients treated with methadone maintenance." Annals of the New York Academy of Sciences 311: 181-189.

Dole, V.P. and Nyswander, M.E. 1976. "Methadone maintenance: A ten year perspective." Journal of the American Medical Association 235(19): 2117-2119.

Dole, V.P. and Nyswander, M.E. 1967. "Heroin addiction: A metabolic disease." Archives of Internal Medicine 120: 19-24.

Dole, V.P. and Nyswander, M.E. 1965. "A medical treatment for diacetyl morphine (heroin) addiction: A clinical trial with methadone hydrochloride." Journal of the American Medical Association 193: 646-650.

Dole, V.P., Nyswander, M.E. and Kreek, M.J. 1966. "Narcotic blockade." Archives of Internal Medicine 118: 304-309.

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Dole, V.P., Nyswander, M.E. and Warner, A. 16 December 1968. "Successful treatment of 750 criminal addicts." Journal of the American Medical Association 206: 2710-2711.

D'Aunno, T. and Vaughn, T.E. 8 January 1992. "Variations in methadone treatment practices." Journal of the American Medical Association 267(2): 253-258.

Epstein, E.J. 1975. "Methadone: The forlorn hope." Public Interest (Summer): 3-22.

Epstein, E.J. 1977. Agency of Fear. New York: G.P. Putnam's Sons.

Finnegan, L.P. October 1993. The success of methadone in the treatment of pregnant opiate dependent women. Presented at the Second European Symposium on Drug Addiction and AIDS. Sienna, Italy.

Finneran, K. 9 September 1994. Presentation at the graduation of Beth Israel Medical Center's special program to train methadone patients as counselors.

Fleetwood, B. 17 October 1977. "Psst, kid .... Wanna be a junkie? Try methadone." New York Times Magazine. 68-72.

Foster, J.D., Dinitz, S. and Reckless, W.C. 1972. "Perceptions of stigma following public intervention for delinquent behavior." Social Problems 20: 202-209.

Food and Drug Administration. 2 March 1989. FDA Regulations in the Federal Register. 21 CFR. Part 21. Washington, D.C.: U.S. Food and Drug Administration.

Galea, J. 15 November 1994. Personal communication. Bureau of Special Studies, New York State Office of Alcohol and Substance Abuse Services.

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Gardner, E. 1992. "Brain reward mechanisms." In Lowinson, J.H., Ruiz, P., Millman, R.B. and Langrod, J.G. eds. Substance Abuse: A Comprehensive Textbook. Ed. Baltimore: Williams and Wilkens. 70-99.

Garr, D. 24 November 1975. "How MDs gross methadone millions?" Village Voice. Cover, 9-10.

Gearing, F.R. September 1970a. "Evaluation of Methadone Maintenance Treatment Program." International Journal of the Addictions 5(3): 517-543.

Gearing, F.R. 1970b. Success and failures in methadone maintenance treatment of heroin addiction in New York City. Proceedings of the Third National Conference on Methadone Treatment. Rockville, Maryland: U.S. Public Health Service. #2172. 2-16.

Gearing, F.R. and Schweitzer, M.D. 1974. "An epidemiologic evaluation of long-term methadone maintenance treatment for heroin addiction." American Journal of Epidemiology 100: 101-112.

General Accounting Office. 1990. Methadone Maintenance: Some Treatment Programs Are Not Effective; Greater Federal Oversight Needed. Rockville, Maryland: U.S. Govt. Printing Office. GAO/HRD-90-104.

Gewirtz, P. 1969. "Methadone maintenance for heroin addicts. Notes and Comments." Yale Law Review 78: 1175-1211.

Goffman, E. 1973. The Presentation of Self in Everyday Life. Woodstock, New York: Overlook Press.

Goffman, E. 1963. Stigma: Notes on the Management of a Spoiled Identity. Englewood Cliffs, New Jersey: Prentice Hall.

Goldsmith, D.S., Hunt, D.E., Lipton, D.S. and Strug, D.L. 1984. "Methadone folklore: Beliefs about side

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effects and their impact on treatment." Human Organization 43(4): 330-340.

Goldstein, A. 1994. Addiction. From Biology to Drug Policy. New York: W.H. Freeman & Company.

Gordis, E. 1991. "From science to social policy: An uncertain road." Journal of Studies on Alcohol 52(2): 101-109.

Gordon, G.W. 1994. "Methadone maintenance vs. treatment." Professional Counselor (August): 41-42.

Gordon, N. 1970. "Reaction-times of methadone treated ex-heroin addicts." Psychopharmacologia 16: 337-344.

Psychopharmacologia

Greenstein, R.A., Fudala, P.J. and O'Brien, C.P. 1992. "Alternative pharmacotherapies for opiate addiction." In Lowinson, J.H., Ruiz, P., Millman, R.B. and Langrod, J.G. eds. Substance Abuse: A Comprehensive Textbook. Baltimore: Williams and Wilkens. 552-573.

Gunne, L.M., Gronbladh, L. and Ohlund, L.S. 4-6 October 1993. The street life and treatment response of 105 heroin addicted women. Presented at the Second European Symposium on Drug Addiction and AIDS. Sienna, Italy. 18.

Hartel, D., Schoenbaum, E.E, Selwyn, P.A., Davenny, K., Kline, J., Klein, R. and Friedland, G. 1995. "Heroin use during methadone maintenance: Importance of methadone dose and cocaine use." American Journal of Public Health 54: 83-88.

Hartel, D., Selwyn, P.A., Schoenbaum, E.E. et al. 8-14 June 1988. Methadone maintenance treatment and reduced risk of AIDS and AID-specific mortality in intravenous drug users. Presented at the IV International Conference on AIDS. No. 8546. Stockholm, Sweden.

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Helmer, J. 1975. Drugs and Minority Oppression. New York: Seabury Press.

Hentoff, N. 1969. A Doctor Among the Addicts: The Story of Marie Nyswander. Chicago: Rand McNally and Company.

Himmelsbach, C. 1968. "Clinical studies of morphine addictions." In Harris, L.S. ed. Proceedings of the 49th Annual Scientific Meeting of the Committee on Problems of Drug Dependence. Rockville, Maryland: U.S. Dept. of Health and Human Services. National Institute on Drug Abuse. Research Monograph Series 81. Nathan B. Eddy Memorial Award Lecture.

Howe, L.P. 1973. Methadone and morality: Toward a sociology of addiction. Proceedings of the V National Conference on Methadone Treatment. New York. 587. Cited in Miller, R. 1974. "Towards a sociology of methadone maintenance." In Winick, C. ed. Sociological Aspects of Drug Dependence. Cleveland: CRC Press.

Howe, H.S. 1957. "An alternate solution to the narcotics problem." Law and Contemporary Problems (Winter) 22: 131-137.

Hunt, D.E., Lipton, D.S., Goldsmith, D.S., Strug, D.L. and Spunt, B. 1985-1986. "It takes your heart: The image of methadone maintenance in the addict world and its effect on recruitment in to treatment." International Journal of the Addictions 20(11-12): 1751-1771.

Inciardi, J.A. 1988. "Some considerations in the clinical efficacy of compulsory treatment: Reviewing the New York experience." In Leukefeld, C.G. and Tims, F.M. eds. Compulsory Treatment of Drug Abuse and Clinical Practice. Rockville, Maryland: U.S. Dept. of Health and Human Services. National Institute on Drug Abuse. Research Monograph Series 86. ADM 88-1578.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Ingolia, N.A. and Dole, V.P. 1970. "Localization of *d* and *l*-methadone after intraventricular injection into rat brains." Journal of Pharmacology and Experimental Therapeutics 175: 84-87.

Institute of Medicine. 1995. Federal Regulation of Methadone Treatment. Washington, D.C.: Academy Press.

Jaffe, J.H. 1990. "Drug addiction and drug abuse." In Gilman, A.G., Rall, T.W., Nies, A.S. and Taylor, P. eds. Goodman and Gilman's The Pharmacological Basis of Therapeutics. 8th edition. New York: Pergamon Press. 522-573.

Joseph, H. 1992. "Substance abuse and homelessness within the inner cities." In Lowinson, J.H., Ruiz, P., Millman, R.B. and Langrod, J.G. eds. Substance Abuse: A Comprehensive Textbook. Baltimore: Williams and Wilkens. 875-889.

Joseph, H. 1988. "The criminal justice system and opiate addiction: A historical perspective." In Leukefeld, C.G. and Tims, F.M. eds. Compulsory Treatment of Drug Abuse and Clinical Practice. Rockville, Maryland: U.S. Dept. of Health and Human Services. National Institute on Drug Abuse. Research Monograph Series 86. ADM 88-1578.

Joseph, H. and Appel, P. 1993. "Historical perspectives and public health issues." In Parrino, M. chair/editor. State Methadone Maintenance Treatment Guidelines. Rockville, Maryland: U.S. Dept. of Health and Human Services. 11-24.

Joseph, H. and Appel, P. 1985. "Alcoholism and methadone treatment: Consequences for the patient and the program." American Journal for Drug and Alcohol Abuse 11(1&2): 37-54.

Joseph, H. and Des Jarlais, D.C. 1980. Methadone Patients in Conventional Society. New York: NYS Office of Alcoholism and Substance Abuse Services. Unpublished internal report of the Research Bureau.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Joseph, H. and Dole, V.P. 1970. "Methadone patients on probation and parole." Federal Probation (June): 42-48.

Joseph, H. and Springer, E. 1990. "Methadone maintenance treatment and the AIDS epidemic." In The Effectiveness of Drug Abuse Treatment: Dutch and American Perspectives. Malabar, Florida: Robert E. Krieger. 261-274.

Kandall, S.R. (consensus panel chair). 1993. Improving Treatment for Drug-Exposed Infants. Rockville, Maryland: U.S. Department of Health and Human Services (DHHS). Center for Substance Abuse Treatment (CSAT). Treatment Improvement Protocol (TIP) Series 5. (SMA) 93-2011.

Kaltenbach, K. and Finnegan, L.P. 1992. "Methadone maintenance during pregnancy: Implications for perinatal and developmental outcome." In Sonderegger, T. ed. Perinatal Substance Abuse: Research Findings and Clinical Implications. Baltimore, Maryland: John Hopkins University Press.

King, R. 1972. The Drug Hangup: America's Fifty Year Folly. New York: W.W. Norton.

Kleber, H.D. 1988. "Cocaine abuse: Historical, epidemiological and psychological perspectives." Journal of Clinical Psychiatry 49: 3-6. 2 suppl.

Kleinman, P.H. and Lukoff, I.F. 1975. Methadone Maintenance: Modest Hope For a Few. New York: Columbia University, School of Social Work. Unpublished paper.

Kleinman, P.H., Lukoff, I.F. and Kail, B.L. 30 August - 3 September 1976. The magic fix: A critical analysis of methadone maintenance treatment. Presented at the annual meetings of the American Sociological Association. New York, New York,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Kreek, M.J. 1992. "The addict as patient." In Lowinson, J.H., Ruiz, P., Millman, R.B. and Langrod, J.G. eds. Substance Abuse: A Comprehensive Textbook. Baltimore: Williams and Wilkens. 997-1011.

Kreek, M.J. 1988. "Summary of presentation at 1988 meeting of the Committee for the Problems of Drug Dependence." NIDA Notes (Fall): 12, 25.

Kreek, M.J. 1987. "Multiple drug abuse patterns and medical consequences." In Meltzer, H.Y. ed. Psychopharmacology: The Third Generation of Progress. New York: Raven Press. 1597-1604. Chapter 172.

Kreek, M.J. 1986. "Tolerance and dependence: Implications for the pharmacological treatment of addiction." In Harris, L.S. ed. Problems of Drug Dependence. Proceedings of the 48th Scientific Meeting of the Committee of the Problems of Drug Dependence, 1986. Rockville, Maryland: National Institute on Drug Abuse. DHHS No. (ADM)87-1508.

Kreek, M.J. 1978. "Medical complications in methadone patients." Annals of the New York Academy of Sciences 311: 110-134.

Kreek, M.J. 1973. "Medical safety and side effects of methadone in tolerant individuals." Journal of the American Medical Association 223(6): 665-668.

Kreek, M.J., Dodes, L., Kane, S., Knobler, J. and Martin, R. October, 1972. "Long-term methadone maintenance therapy: Effects on liver function." Annals of Internal Medicine 77(4): 598-602.

Landess, J. 5 April 1988. "Hooked: The madness in methadone maintenance." Village Voice. 31-38.

Langrod, J., Lowinson, J. and Joseph, H. 1977. "Complaints of methadone maintenance treatment program patients attribute to the methadone medication." In Lowinson, J. and Langrod, J. ed. Drug Detoxi-

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

fication: A Comprehensive Examination. Oceanside, New York: Darbor Science Publications.

Leonard, H., Epstein, I.J. and Rosenthal, M.S. 1972. "The methadone illusion." Science 176: 883. Cited in Miller, R. 1974. "Towards a sociology of methadone maintenance." In: Winick, C. ed. Sociological Aspects of Drug Dependence. Cleveland: CRC Press. 169-198.

Lindesmith, A.R. 1966. The Addict and the Law. Bloomington: Indiana University Press.

Lindesmith, A.R. 1965. "The problems in the social psychology of addiction." In Wilner, D., Kassenbaum, D.M. and Kassenbaum, G.G. eds. Narcotics. New York: McGraw-Hill.

Lindesmith, A.R. 1940. "Dope fiend mythology." Journal of the American Institute of Criminal Law and Criminology 31: 199-208.

Lowinson, J.H., Marion, I., Joseph, H. and Dole, V.P. 1992. "Methadone maintenance." In Lowinson, J.H., Ruiz, P., Millman, R.B. and Langrod, J.G. eds. Substance Abuse: A Comprehensive Textbook. Baltimore, Maryland: Williams and Wilkens. 550-561.

Markam, J.M. 17 April 1973. "Methadone therapy programs." New York Times. 30. Cited in Miller, R. 1974. "Towards a sociology of methadone maintenance." In Winick, C. ed. Sociological Aspects of Drug Dependence. Cleveland: CRC Press.

Marmor, M., Des Jarlais, D.C. and Cohen, H. 1987. "Risk factors for infection with human immunodeficiency virus among intravenous drug abusers in New York City." AIDS 1: 39-44.

Martin, W.R. and Jasinsky, D.R. 1969. "Physiological parameters of morphine dependence in man - Tolerance, early abstinence, protracted abstinence." Journal of Psychiatric Research 7: 9-17.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Martin, W.R., Wilker, A., Eades, G.C. et al. 1963. "Tolerance and physical dependence on morphine in rats." Psychopharmacology 4: 247-260.

McGill, D. 15 February 1995. Personal communication. New York State Office of Alcoholism and Substance Abuse Services, Community Relations.

McKenna, S. 4 January 1995. "Profile of Patrick Perri." Newsday. Section B. 7.

McLellan, T.A., Arndt, T.O., Metzger, D.S., Woody, G.E. and O'Brien, C.P. 1993. "The effects of psychosocial services in substance abuse treatment." Journal of the American Medical Association 269(15): 1953-1959.

Mehan, H. and Wood, H. 1975. The Reality of Ethnomethodology. New York: John Wiley & Sons.

Meiselas, H. 25 January 1995. Personal communication.

Methadone: An American Way of Dealing. 1974. Producers Reichert, J. and Klein, J. Documentary film.

Miller, D. 1969. "Letter to the Yale Law Journal." Cited in Gewirtz, P. 1969. "Methadone maintenance for heroin addicts. Notes and Comments." Yale Law Review 78: 1175-1211.

Miller, R. 1974. "Towards a sociology of methadone maintenance." In: Winick, C. ed. Sociological Aspects of Drug Dependence. Cleveland: CRC Press. 169-198.

Molinari, S.P., Cooper, J.R. and Czechowicz, D.J. 1994. "Federal regulations of clinical practice in narcotic addiction treatment: Purpose, status, and alternatives." Journal of Law, Medicine and Ethics 22(3): 231-239.

Morales, F. 8 August 1992. "Methadone" Your House Is Mine. New York: Published by Bullet Space. 8.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Murphy, S. and Irwin, J. 1992. "Living with the dirty secret: Problems of disclosure for methadone maintenance clients." Journal of Psychoactive Drugs (Jul-Sep) 24(3): 257-264.

Musto, D.F. 1992. "Historical perspectives on alcohol and drug abuse." In Lowinson, J.H., Ruiz, P., Millman, R.B. and Langrod, J.G. eds. Substance Abuse: A Comprehensive Textbook. Baltimore, Maryland: Williams and Wilkens. 2-14.

Musto, D.F. 1973. The American Disease: Origins of Narcotic Control. Republished and expanded edition. 1987. New Haven: Yale University Press.

National Alliance of Methadone Advocates. April, 1994. Policy statement on medical maintenance.

National Alliance of Methadone Advocates. May, 1994. Policy statement on client vs patient.

Nelkin, D. 1973. Methadone Maintenance: A Technological Fix. New York: George Braziller. Cited in Miller, R. (1974) "Towards a sociology of methadone maintenance." In Winick, C. ed. Sociological Aspects of Drug Dependence. Cleveland: CRC Press.

New York City Department of Health. 1974. Annual Vital Statistics Report. New York: Bureau of Epidemiology and Vital Statistics.

Newman, R.G. and Cates, M. 1977. Methadone Treatment in Narcotic Addiction: Program Management, Findings and Prospects for the Future. New York: Academic Press.

Novick, D.M. and Joseph, H. 1991. "Medical maintenance: The treatment of chronic opiate dependence in general medical practice." Journal of Substance Abuse Treatment 8: 233-239.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Novick, D.M., Joseph, H., Croxson, T.S. et al. 1990. "Absence of antibody to human immunodeficiency virus in long-term, socially rehabilitated methadone maintenance patients." Archives of Internal Medicine 150: 97-99.

Novick, D.M., Khan, I. and Kreek, M.J. 1986. "Acquired immunodeficiency syndrome and infection with hepatitis viruses in individuals abusing drugs by injection." Bulletin of Narcotics 38: 15-25.

Novick, D.M., Ochshorn, M., Ghali, V. et al. 1989. "Natural killer activity and lymphocyte subsets in parental heroin abusers and long-term methadone maintenance patients." Journal of Pharmacology and Experimental Therapeutics 250: 606-610.

Novick, D.M., Richman, B.L., Friedman, J.M., Friedman, J.E., Fried, C., Wilson, J.P., Townley, A. and Kreek, M.J. 1993. "The medical status of methadone maintenance patients in treatment for 11-18 years." Drug and Alcohol Dependence 33: 235-245.

Novick, S. 10 October 1994. Interview with officers of the National Alliance of Methadone Advocates.

Nyswander, M.E. 1956. The Drug Addict As A Patient. New York: Grune & Stratton.

Office of the Federal Register. 1993. Code of Federal Regulations. No. 21. Parts 200 to 299. Washington, D.C.: U.S. Government Printing Office, 1993. National Archives and Records Administration.

Olds, J. and Milner, P. 1954. "Positive reinforcement produced by electrical stimulation of septal area and other regions of rat brain." Journal of Comparative Physiology and Psychology 47: 419-427.

Pagan, C. 13 January 1995. "Community Planning Board 3 shuns methadone clinic." Staten Island Advance. A1

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Parrino, M. 24 February 1995. Personal communication.

Parssinen, T.M. 1983. Secret Passions, Secret Remedies: Narcotic Drugs in British Society 1820-1980. Philadelphia: Institute for the Study of Human Issues.

Payte, J.T. 24 September 1994. Personal communication. Physician chair of Methadone Maintenance Committee. American Society of Addiction Medicine.

Payte, J.T. and Khuri, E. 1992. "Principles of methadone dose determination." In Parrino, M.W. chair/ editor. State Methadone Maintenance Treatment Guidelines. Rockville, Maryland: U.S. Department of Health and Human Services. Center for Substance Abuse Treatment.

Payte, J.T., Khuri, E., Joseph, H. and Woods, J. 1994. Methadone patients and the treatment of pain. In: Chemical Dependency Research Working Group Methadone Treatment Works: A Compendium for Methadone Maintenance Treatment. Part 1. New York: NYS Office of Alcoholism and Substance Abuse Services.

Perez, J. 15 February 1995. Personal communication. Bureau of Methadone Planning and Policy.

Portnoy, D. 1995. Personal communication. Sloan-Kettering Institute.

Primm, B. 15 January, 1995. Personal communication. Director of Addiction Research and Treatment Corporation (ARTC).

Profumo, A. August, 1992. "Too many methadone clinics=genocide?" United We Win. Newsletter of the Ad Hoc Coalition for a Viable Neighborhood 1(1): 1.

Randall, J. 12 July, 1994. Personal communication. Asst. Commissioner of Rehabilitation Services New

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

York State Office of Alcoholism and Substance Abuse Services.

Reisinger, M. 1993. ed. AIDS and Drug Addiction in the European Community: Treatment and Mistreatment. Brussels: European Monitoring Center for Drugs and Drug Addiction.

Research Assistants and Patients. 17 April 1975. Memo to Drs. H. Gollance, H. Trigg and J.W. Robinson.

Rosenblum, A.R., Magura, S. and Joseph, H. 1991. "Ambivalence towards methadone among intravenous drug users." Journal of Psychoactive Drugs 23(1): 21-27.

Rosenthal, E. 28 March 1993. "Patients in pain find relief, not addiction, in narcotics." The New York Times. 1, 24.

Schuster, C. 1989. "Methadone maintenance: An adequate dose is vital in checking the spread of AIDS." NIDA Notes Spring/Summer: 3. Director's Column.

Scro, A. 25 September 1994. Personal communication. Methadone Maintenance Licensing Inspector. New York State Office of Alcohol and Substance Abuse Services.

Simpson, D.D. 1981. "Treatment for drug abuse follow up outcomes and length of times spent." Archives of General Psychiatry 38: 875-880.

Simrell, E.V. 1973. "The history of legal and medical issues in narcotic abuse in the U.S." In all, J.C. and Chambers, C.D. eds. The Epidemiology of Opiate Addiction in the United States. Springfield, Illinois: Charles C. Thomas. 22-35.

"60 Minutes." 21 February, 1993. Columbia Broadcasting System. Livingston, New Jersey: Burrelle's

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Information Services. Transcript.

Stephens, R.C. 1991. The Street Addict Role: A Theory of Heroin Addiction. Albany: State University of New York Press.

Stepherson, B.M. 1994. "Mobilization of drug users to protect their welfare." The Ombudsman 1: 1, 5.

Stimmel, B., Goldberg, J., Cohen, M. and Rotkopf, E. 1978. "Detoxification from methadone maintenance: Risk factors associated with relapse to narcotic use." In Kissen, B., Lowinson, J.H. and Millman, R. eds. Recent Developments in the Chemotherapy of Narcotic Addiction. New York: New York Academy of Sciences.

Stimpson, G.T. 1973. Heroin and Behavior. New York: Halstead Press.

Stroud, F. 30 September 1975. Letter to Mr. Richard Russo State of New Jersey Division of Narcotic and Drug Abuse Control Commission.

Szasz, T. 1985. Ceremonial Chemistry. Holmes Beach, Florida: Learning Publications, Inc.

Town Hall Meeting, Making Our Voices Heard. 24 April 1994. National Methadone Conference. Washington, D.C. Audiotape cassette.

Umbricht-Schneiter, A. 15 November 1994. Personal communication.

Umbricht-Schneiter, A., Ginn, D.H., Pabst, K.M. and Bigelow, G.E. 1994. "Providing medical care to methadone clinic patients: Referral vs on-site care." American Journal of Public Health 84(2): 208-210.

Waldorf, D. 1973. Careers in Dope. Englewood Cliffs, New Jersey: Prentice Hall.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Watters, J.A. and Price, R.H. 1985. "The relationship of treatment policy to client retention." In Appel, P. ed. Treatment Issue Report #56. New York: New York State Division of Substance Abuse Services. Unpublished internal report.

Cessation of intravenous drug use

Weber, R., Ledergerber, B., Opravil, M. and Luthy, R. 4-9 June 1990. Cessation of intravenous drug use reduces progression of HIV infection in HIV+ drug users. Presented at the VI International Conference on AIDS. San Francisco, California.

Wilde, O. 1891. The Picture of Dorian Grey. Republished 1977. London: Penguin Books.

Yablonsky, L. 13 August 1966. "Stoned on methadone." New Republic. 14-16.

Yarmolinsky, A. and Rettig, R.A. 15 January 1995. "Methadone maze." The Washington Post. Close To Home Section. Editorials/Columnists. C8.

Yih-Ing, H., Anglin, M.D. and Yin, L. 1990-91. "A survival analysis of gender and ethnic differences in responsiveness to methadone maintenance treatment." International Journal of the Addictions 25(11A): 1295-1315.

Zweben, J.E. and Sorensen, J.L. 1988. "Misunderstandings about methadone." Journal of Psychoactive Drugs (Jul-Sep) 20(3): 275-281.

Zwissler, M. 18 April 1975. Letter to Mr. Hanhardt, Director of the Whitney American Museum Film Library.

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