Chapter 19. The future of methadone maintenance

By December 1971, the number of American addicts on methadone maintenance was estimated at 25,000—- and may have been considerably higher. Federal, state, and local plans, public and private, in various stages of realization, moreover, called for an increase to 50,000 or more within the next year or so.

The rate of growth, interestingly enough, was nowhere limited by the availability of addicts eager to enter a methadone maintenance program. It was limited in part by the lack of funds to finance such programs, in part by the lack of trained staff to man them, and in large part by lethargy—- the lack of enough public officials and private citizens willing to invest the effort needed to get programs started or expanded.

As late as the fall of 1971, no city had reported a capacity to supply methadone to all addict applicants. All cities had waiting lists. Hence it is impossible to estimate what proportion of addicts will accept methadone maintenance voluntarily. The number of addicts eager for methadone maintenance tends to grow as the programs grow and as news of their advantages spreads. Heroin addicts, as we have noted, are not mentally retarded. They recognize a good buy when they are offered one.

Recent British experience casts some light on the proportion of addicts who can voluntarily be converted to methadone maintenance or to other alternatives to heroin. As of December 31, 1970, the 1,430 men and women receiving narcotic drugs on Britain's National Health Service were distributed as follows:

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone alone</td>
<td>732</td>
</tr>
<tr>
<td>Heroin alone</td>
<td>140</td>
</tr>
<tr>
<td>Methadone and Heroin</td>
<td>241</td>
</tr>
<tr>
<td>Morphine alone</td>
<td>91</td>
</tr>
<tr>
<td>Pethidine (known in the United States as meperidine or Demerol) alone</td>
<td>70</td>
</tr>
<tr>
<td>Dipipanone alone</td>
<td>40</td>
</tr>
<tr>
<td>Combination</td>
<td>Count</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>on dextromoramide alone</td>
<td>28</td>
</tr>
<tr>
<td>on heroin and cocaine</td>
<td>39</td>
</tr>
<tr>
<td>on other drugs or drug combinations</td>
<td>49</td>
</tr>
</tbody>
</table>

British patients on methadone, as noted earlier, can obtain injectable methadone and injection equipment. Many (not all) do in fact inject their methadone. This British policy, which seems strange and objectionable to many Americans, seems quite natural in Britain.

The fact that more than half of all the addicts known to the United Kingdom Home Office are being maintained on methadone alone is of particular significance, for any one of those 732 methadone patients can at any time decide to go back to heroin and have a legal right to get it, free of charge and of medicinal strength and purity---along with free sterile disposable injection equipment.

The British figures are significant in another respect: within the next few years, British authorities will be able to evaluate and compare the various maintenance drugs now in use there. Thus, for the first time, reliable data will be available on the relative advantages of methadone, heroin, morphine, and other maintenance drugs and drug combinations, taken orally or injected, in a country where all are legal and all are free of charge.

Within the next few years---and perhaps much sooner---at least some American cities will be offering methadone maintenance on a large enough scale to supply all voluntary applicants. At that point a further question will arise: what shall be done about addicts who stay on black-market heroin despite vacancies in a nearby methadone maintenance program?

From time to time, politicians and others who have not done their homework, and who fail to understand the narcotics problem, offer the same old answer to this question: pass another law. During the 1970 political campaign in New York State, for example, a candidate running for the office of New York State attorney general demanded a law for the "compulsory transfer of patients from dependence on heroin to dependence on methadone." 2

The laws already in effect in New York State and in the United States provide long terms of imprisonment for the mere possession of heroin indeed, for the possession of a
hypodermic needle with which heroin might be injected. Other Draconian provisions of existing law have been reviewed in earlier chapters. These laws, of course, already serve to force heroin addicts to enter methadone maintenance programs--- unless they want to risk the dire penalties specified. Adding another narcotics law and another penalty to the many already on the books will hardly increase the existing legal pressure on addicts to switch to methadone maintenance.

It is also frequently proposed that experimental heroin maintenance programs be set up in addition to methadone maintenance programs. These proposals are discussed in our Conclusions and Recommendations below (see Part X).

The chief peril of methadone maintenance for the future lies not in the pharmacological properties of the drug or in its abuse by addicts or others, but in the ways it may be misused by politicians and institutions. Let us explain.

The heroin addict today is a serf of the heroin black market. When he goes on methadone maintenance, he becomes a potential serf of whoever controls the methadone program. This is not the fault of methadone, of course; it is the result of his becoming addicted to heroin in the first place. Whether on heroin or methadone, the addict must dance to whatever tune the piper plays.

Most existing methadone maintenance programs play a sensible tune. They expect essentially three things of an addict: that be not get arrested, that he find and hold a job if he possibly can, and that he limit his consumption of alcohol, barbiturates, and other drugs as well as of heroin. The vast majority of patients comply. A patient is involuntarily discharged from the program, as noted earlier, only when repeated violations make it clear that methadone maintenance is doing the patient no good.

Let us suppose, however, that methadone maintenance programs drift into the hands of agencies with other goals. One example is a police department, which might use a methadone maintenance program as a recruiting center for stool pigeons, or witnesses. Leaders of the black community are particularly concerned that the power of those who control methadone maintenance may be misused to repress black organizations and aspirations. These are not idle imaginings. In at least one city, patients on methadone maintenance have already been organized to vote for a political candidate who promised to support a continuation of their supply. In a number of other cities, methadone maintenance programs are deeply enmeshed in local politics.

Probation and parole departments have been establishing or planning to establish methadone maintenance programs in several states and cities--- and police departments may be next. The patient on methadone maintenance who must placate a police officer, or a probation or parole officer empowered both to return him to prison and to cut off his methadone, is in a vise with two turn screws.

A thoughtful review of this problem was presented at the Third National Conference on Methadone Treatment (1970) by Dr. Robert G. Newman, director of the New York City
Health Department's Methadone Maintenance Treatment Program. "It is my conviction," Dr. Newman stated, "that the abuse and misuse of addiction treatment programs poses at least as great a threat to our patients as does the abuse of illicit drugs." Then he went on to explain:

Many proponents of methadone treatment dismiss as ridiculous the assertion by some militant groups that the program is a means by which the establishment can control (their word is enslave) certain communities. While I do not believe that this danger is an imminent one, I do agree that it is a very real potential threat. It is entirely conceivable to me that applicants might some day be rejected, or patients discharged, on the basis of political and/or antisocial behavior ("antisocial," of course, to be defined by those in power). The likelihood of such medical blackmail is increased by the intermingling of medical and social goals which certain programs set for themselves. We emphasize that, along with the medication which we dispense, we encourage the use of the supportive services which are offered to help the patient in his efforts to become rehabilitated, to lead a socially acceptable and productive life. Providing such assistance to those who want it is a responsibility we should accept in treating "the whole patient." On the other hand, what if the patient does not want to be rehabilitated, and does not seek to adopt what we feel is a desirable pattern of behavior? Perhaps a patient wishes to spend the rest of his life collecting welfare payments instead of working; perhaps he is a highly successful and well-adjusted numbers-runner; perhaps he is a member of an extremist group (right or left makes no difference) who feels his calling in life is to make bombs in cellars, or attack policemen, or burn synagogues. How will the professional staff relate to such a patient who, despite his antisocial life-style, abstains from all drug use, reports punctually and regularly to the clinic for his medication, and whose activities in no way pose a threat to the treatment unit itself? Even more pertinent to the topic of this paper, how much latitude will the staff be permitted in resolving the conflict when the employer is the government?

My questions are obviously rhetorical. I believe that medical care should not be withheld except for strictly medical reasons, or when the care of other patients is compromised. An orthopedist would not refuse to set a broken ankle even if he knew the injury was incurred in the course of a burglary, and even, though he were thoroughly convinced that, once healed, the patient would promptly return to his work. An epileptic is not refused his Dilantin because the physician disagrees with his political activities. Similarly, though we offer a comprehensive program for our methadone patients, and encourage them to utilize what is available, we should not present our services on an all-or-none basis. To do so would be analogous to a doctor withholding insulin from a diabetic because the patient refuses simultaneous help in controlling his obesity.

Hopefully, most health workers share this view, and will defend it against all pressures which might arise to compromise what they should accept as the primary role: serving their patients. ¹

No absolute protection from the abuse of methadone maintenance programs by those who control them is possible. A young man or woman who doesn't want to fall into the
clutches of a corrupt methadone maintenance program can best protect himself by staying away from heroin in the first place. Consumers Union does offer three suggestions, however, for minimizing the likelihood that future methadone maintenance programs will be misused for political, social, police, or other extraneous ends.

*First,* ultimate policy control of the programs as well as day-by-day supervision must be securely lodged in *medical* rather than political, probation, parole, or police hands. This principle is not observed today in a number of cities. Cities and states where politicians control methadone maintenance programs should begin planning now to transfer them to medical auspices—before a local political scandal threatens the whole methadone program. This is particularly true of some programs in New York City and State (but not of the Dole-Nyswander program, which is under firm medical control).

*Second,* as Dr. Newman of the New York City program has suggested, the regulations governing expulsion from a methadone maintenance program should be spelled out in specific and objective terms, so that patients are not left at the mercy of the staff or the institution. In his own program, Dr. Newman reports, "conditions for discharge unequivocally preclude the use of this medical treatment as a means of coercing social conformity among our patients." 4 In some cities, politicians are already using their influence to get patients into a crowded methadone maintenance program; in the absence of objective criteria for discharge it is only one small step further for a politician to threaten to have a patient expelled from a program—or, indeed, to have him expelled.

*Third,* every large city and every state should aim for *multiplicity* of independent and competing maintenance programs rather than one monolithic source of methadone. If one program becomes corrupt and seeks to manipulate its patients for political or other ends, patients should be free to transfer to another.

The role of the physician in private practice is also important here. Indeed, the private practitioner should play several roles in the future of methadone maintenance. For example, he is the only feasible source of supply in villages and towns where there are too few addicts to warrant a full-scale methadone maintenance program.

The physician in private practice is also essential as a safeguard against the manipulation of patients on organized programs. If the only local program in a city harbors a grudge against a patient and threatens to cut off his methadone supply because of his political views, or because he participates in protest meetings, or for any other reason, the patient's only alternatives are to surrender or find another source of supply. The availability of methadone from physicians in private practice is thus a major protection for the patient on a public program.

Dr. Newman implicitly recognized this role of the private practitioner in his statement to the Third National Conference on Methadone Treatment: "... We are already exploring ways by which private practitioners can be involved in the management of patients enrolled in the [New York City] program. In so doing, we are trying to anticipate the day when this form of therapy can be safely and effectively transferred from government to
the private sector. As the acceptability and availability of methadone maintenance becomes more widespread, its potential use in exerting social control will lessen."

There are also cogent arguments against letting physicians in private practice prescribe or dispense methadone for addicts. One objection is that they lack the ancillary services useful for rehabilitation. This is true; but as noted above, many patients do well on methadone without ancillary services.

A second objection raised is that a few physicians in private practice may abuse their privilege and prescribe methadone indiscriminately. Here a distinction must be made. One major purpose of methadone maintenance is to woo addicts away from the heroin black market. If a physician accomplishes this by prescribing methadone to addicts, he should surely be encouraged. Indeed, the prescription of methadone by easygoing physicians practicing in the slums or suburbs may attract some addicts who won't patronize an organized, regimented clinic-and may thus help solve the heroin problem. If an addict prefers to get his methadone this way, why shouldn't he? Members of minority ethnic groups, or middle class white adolescents, may be much more likely to go to a physician affiliated with their own group, or sympathetic to it, rather than to a clinic which the), perceive as hostile.

The possibility that a corrupt physician might prescribe addicting doses of methadone to a nonaddict, of course, raises a different problem—but not a particularly frightening one. Such a physician can today prescribe addicting doses of morphine to a nonaddict, if he wants to run the risk of imprisonment. No new hazard is introduced by permitting him to prescribe methadone instead, subject to the same risk of imprisonment. Any physician found to be overprescribing or prescribing to nonaddicts, whether the drug is morphine or methadone, should of course be promptly called to account.

In sum, Consumers Union recommends that the major burden of supplying methadone maintenance to heroin addicts be borne by a multiplicity of organized clinics, under firm medical rather than political control, offering a wide range of medical, legal, employment, and counseling services along with the methadone-and with explicitly stated regulations governing discharge from the program. It also recommends, however, that physicians in private practice be authorized to prescribe methadone for maintenance purposes— in part to meet the needs of addicts who cannot conveniently get to the organized clinics, or who perceive the local clinics as alien and hostile, and in part to serve as standby sources of methadone maintenance for patients who may be improperly manipulated or discriminated against in the organized clinic setting.

Finally, a word about perspective. As methadone maintenance programs continue to expand, we can expect all kinds of unfortunate methadone "incidents" to occur and to fill newspaper headlines. If methadone is left lying around carelessly some children may get hold of it, and they will die of it—just as children get hold of aspirin left lying around, and die of it. Some methadone patients may share their methadone with friends or sell some on the black market. Some methadone patients, like other people, may commit murder, theft, and prostitution, and all manner of other offenses—and when caught, they are going
to be identified in the press as methadone patients. Every once in a while a newspaper reporter is going to disguise himself as an addict and get drugs from a clinic (as reporters did in 1920, and as a *New York Times* reporter did in 1971 ⁶). Editorial writers, politicians, and others, in the future as in the past, are going to seize on such incidents to urge an end to methadone maintenance. Or they are going to demand unreasonable restraints on methadone maintenance programs-restraints that will in effect sabotage the programs and diminish their usefulness.*

* A simple example, among many, is the rule governing how often a patient must come personally to the clinic for his methadone, often at great cost in time and inconvenience. Clinics uniformly require that patients come in daily at first, until their reliability has been established, and drink their whole glassful with a nurse watching to make sure they don't take some of it home with them to give away or sell. After a while, patients come in every other day, and those who demonstrate their trustworthiness are in some clinics eventually permitted to take home a whole week's supply. The rule usually works because addicts who must come in daily know that when they prove reliable, they will be permitted to come in at less frequent intervals. Occasionally, however, a patient with a week's supply may take pity on some heroin addict who is currently broke and suffering the torture of withdrawal, and who still has months ahead on the waiting list before he will be admitted to the methadone program himself. Or the patient may be broke and sell a little methadone to an addict. If the addict happens to be a stool pigeon, the methadone patient may be arrested for violating the narcotics laws, and the newspapers may demand that other patients no longer be allowed to take methadone home with them. This in effect sabotages the maintenance program and further buttresses the heroin black market.

It was attacks like these which discredited the opiate-dispensing clinics in the 1920s (see Chapter 13). A repetition of that experience, with methadone maintenance discredited as the result of a series of trivial but sensational scandals, is still a possibility in some cities.

When incidents discrediting methadone maintenance generate headlines in your community, as they almost certainly will, we suggest that you ask yourself a simple question. Whatever the shortcomings of methadone maintenance, and whatever the mistakes made by your local maintenance programs, do you really prefer the old-fashioned American black-market system of heroin distribution?

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**Footnotes**

**Chapter 19**


4. Ibid., p. 124.

5. Ibid.