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Abstract

The institution of methadone maintenance as a treatment modality for heroin addiction in the mid-1960s was part of the growing medicalization of social problems in the United States. The definition of deviance as "sickness" rather than "badness" set the stage for America's first harm-reduction strategy. By the 1970s methadone maintenance was seen as a way to reduce drug-related crime, and federally funded programs

proliferated. Accompanying methadone's phenomenal expansion was increased regulation, bureaucratization, and criticism. The early 1980s brought the Reagan era, fiscal austerity, the new "just say no" abstinence morality, and demedicalization of methadone maintenance. By the time needle-sharing was recognized as a major contributing factor in the spread of HIV, methadone had been transformed into a largely fee-for-service, short-term, begrudgingly tolerated treatment modality. Ironically, while other countries were able to use methadone to curb the spread of AIDS, the United States refused to facilitate its expansion, and in fact impeded it. To the frustration of proponents and consumers, this original harm-reduction tool, with the potential to impact the epidemic, was demedicalized and remains marginalized.

Introduction

The institution of methadone maintenance treatment in the United States represented a culmination of the increased medicalization of social problems in American society during the first half of the twentieth century. Drug technologies had been developed that would alleviate all forms of pain, which had been defined by Americans as uniformly intolerable (Illich 1976). During the 1950s deviant behavior was redefined not as "badness" but as disease, and addiction was redefined as an illness that could be treated with advancing medical technologies (Conrad & Schneider 1980). The rehabilitative ideal became the dominating solution to the crime problem, as thousands of offenders were reformed in a myriad of programs (American Friends Service Committee 1971).

In the mid-1960s, Drs. Vincent Dole and Marie Nyswander began to report on their initial findings in their research with methadone maintenance treatment (Dole & Nyswander 1965). Their findings constitute the basic ideology behind the proliferation of methadone maintenance: methadone could relieve the metabolic disorder created by opiate addiction, and with doses high enough to block the physical craving for heroin, the individual would be immune to its euphoric effects. Thus, methadone users would be in a favorable position to break their ties with heroin and go on to become productive members of society. As such, methadone maintenance was the original form of drug harm reduction in the United States.

Although the findings of outcome of the early proponents of methadone were tentative, "the media immediately heralded it as the long-awaited 'medical breakthrough,' labeling methadone a 'Cinderella drug' which could be economically applied to hundreds of thousands of addicts, and, in short order, solve the narcotics problem" (Newman 1977:xix). With the methadone breakthrough, heroin addiction was further defined as a medical (as opposed to a social) problem, and the addict became a patient. Having transformed heroin addiction into a treatable disease, and with proclamations about its salvation to society and the addict alike, methadone maintenance spread. Programs began to open officially in 1963 with Dole and Nyswander's original two patients. In March of 1965, the expanded program moved into an open ward of Beth Israel Hospital (in New York City), with six patients; by 1968 there were 1,139 patients.

In the 1970s and 1980s, methadone providers and patients struggled with definition, implementation, and ultimately survival. This article looks at the first two decades of methadone treatment. During the 1970s the use of methadone expanded greatly. In the early 1980s, the Reagan morality and fiscal austerity

created a treatment method that was viewed largely as containment of the addict population. Finally, in the post-AIDS late 1980s methadone became almost fully demedicalized, precisely at a time when medical treatment was needed most.

The 1970s: Methadone Expands and Comes Under Attack

In the late 1960s and early 1970s, the use of methadone expanded rapidly. The spirit of rehabilitation laid the foundation for the growth of the treatment of deviant behavior, including drug abuse, using the medical model. Three other variables entered into the picture that made more efficient control of drug abuse seem imperative. First, crime statistics indicated that the growing crime rate could be accounted for in large part by drugs and drug-related activities. It was heroin addicts who were to blame for much of the burglary and petty theft that had reached epidemic proportions. Second, widespread drug addiction in Vietnam servicemen, who were becoming veterans, was alarming. Finally, the growing use of illicit substances (though, paradoxically, not opioids) by middle-class, White youths (who saw themselves as part of the "hippie" movement) redefined drug abuse as having reached epidemic proportions. Conrad and Schneider (1980:135) noted that "the late '60s and early '70s marked a rise in public concern with 'the drug problem,' especially heroin addiction. Writers in the professional and popular media were declaring a virtual 'heroin addiction epidemic' in America."

By 1972, drug abuse was proclaimed "the major domestic crisis facing the nation" by the president of the United States (Nixon 1972). In the spirit of crisis with which Nixon characterized the drug problem, treatment in various forms proliferated: the drug-free therapeutic community, outpatient detoxification, and methadone maintenance.

By 1971 the estimated number of methadone patients nationwide had jumped to 25,000 (Brecher 1972). Accompanying this expansion was increased criticism, regulation, and bureaucratization. Perhaps topping the list of criticisms was that maintenance was the equivalent of substituting one drug for another, and patients "never got off." Ironically, methadone was initially attractive because it was an opioid substitute, and maintenance was recommended for this chronic relapsing condition. Methadone also came under attack due to diversion of the drug. This was another ironic criticism, since the diverted methadone was going largely to heroin addicts and other methadone patients. The idea that novices would become addicted to their first opioid through diverted methadone (on the schoolyard) proved completely unfounded. Even patients criticized methadone, claiming that "it takes your heart" (Hunt et al. 1985), that it had a host of side effects (Rosenbaum & Murphy 1987); and that it tied them to the clinic (Rosenbaum 1981). Despite the criticism, extensive research continually found that methadone was expedient. It worked to reduce drug related criminality in patients and stabilized their drug habits. In short, as one of the early study participants stated, "methadone removes the issue of drugs from my life."

In response to methadone's criticisms came the "regulatory counterattack" in 1973 (Dole, as cited in Courtwright, Joseph & Des Jarlais 1989). Indeed, clinics had to comply with a complex set of rules governing admission to treatment, attendance, dose level, take-home doses, urinalysis, and record-keeping methods. If they did not comply with "the regs," they were out of business. From the perspective of clinic staff as well as patients, this hardly felt like traditional delivery of medical services. It became clear that the proliferation of clinics in the 1970s had much more to do with stopping crime than the well-being of heroin addicts. Indeed, increased regulation moved methadone further away from a purely medical treatment. As Zweben and Payte (1990:594) commented: "Programs quickly learned that survival depended on the condition of the records and not the patients.... There has been considerable speculation as to the motivation or purpose for the regulations that represented an unprecedented intrusion into the practice of medicine. Some think there was a sincere intention to ensure quality care, others that the process was one of political compromise, and still others that the intention was to discourage the growth of this unpopular form of treatment. Evidently some provisions were made in the absence or disregard of scientific clinical investigations and experience."

The Early 1980s: The New Morality, Fiscal Austerity and Just Say No (To Methadone)

The New Morality and fiscal austerity of the Reagan administration had major implications for methadone treatment. Nancy Reagan's "Just Say No" campaign and the emphasis on zero tolerance of illegal drugs ushered in an era (extending to the present) in which abstinence was seen as the only viable perspective and form of drug abuse treatment.

The fiscal austerity of the early 1980s meant a general scaling back, and often the elimination, of social programs that had been instituted in the 1960s and 1970s. Funding for methadone maintenance programs began to dry up, experiencing a 30% decline between 1976 and 1987 (Gerstein & Harwood 1990). As a result private, fee-for-service clinics proliferated.

The original definitions of the nature of methadone maintenance treatment were further compromised in an effort to cut costs. If there were to be time limits in treatment, a new ideology had to be

constructed. Hence there was a shift in protocol from lifelong to time-limited treatment. Methadone was seen as a means to an abstinent end rather than an end in itself.

The message was clear: methadone would be begrudgingly tolerated. The government would no longer pay for it, however; nor would they allow a methadone user to remain in a program indefinitely. This message led to a further demedicalization (what other medical regimen has a built-in time limit?) and increased demoralization of treatment staff as well as patients. Clinic staff were unable to act as medical personnel. With payment of fees and the movement away from a medical definition of addiction, the nomenclature changed. "Patients" were increasingly called "clients" in an effort to upgrade their status as consumers. A well-meaning gesture, it was hollow and ultimately counterproductive. None of the regulations changed that would empower clients, and they had gained no increases in decision making vis-à-vis their own treatment. However, the shift in titles had the negative effect of moving methadone treatment even further away from the practice of medicine. As Kahn (1992:282) remarked: "It is common for counselors to interchange the terms 'client' and 'patient'. . . . This may inadvertently contribute to negative perceptions. The term 'patient' refers to someone manifesting an illness requiring expert care, and is more consistent with efforts to counteract the view of the heroin addict as a criminal with character defects"

By the mid-1980s methadone had moved, essentially, from a medical treatment to the containment of addicts, just as the criminal justice system had moved from rehabilitation to containment of "the rabble" (Irwin 1985). Methadone treatment was infused with the Reagan (abstinence) morality: dose levels were restricted despite evidence that treatment was more effective at higher levels (Ball & Ross 1991; Caplehorn & Bell 1991; Hargreaves 1983); time in treatment was limited despite research findings insisting that longer treatment stays produced better results (Hubbard et al. 1989; Simpson & Sells 1982; Cushman 1981; McGlothlin & Anglin 1981; Simpson 1981, 1979; Dole & Joseph 1978; Stimmel et al. 1978), and private fees were instituted despite evidence that addicts needing methadone could not afford to pay for it (Rosenbaum, Murphy & Beck 1987). Just as with other programs for the poor, the message was clear: it was no longer acceptable for lower-class people and their problems to be subsidized by the government.

The Mid-1980s: Enter AIDS

In the mid-1980s it was discovered that HIV could be and was being transmitted through blood by the sharing of injection equipment. Intravenous (IV) drug users became the second largest group to be infected by HIV, which causes AIDS, and their numbers were growing quickly. It became obvious that a key method to stop the spread of the virus through drug users was to (1) educate IV drug users to clean their injection equipment, (2) use clean needles, or (3) stop using needles. Regarding the latter, methadone maintenance was seen as an already-in-place method to accomplish the cessation of needle use. Indeed, methadone maintenance clients have demonstrated a lower seroprevalence rate (Siddiqui et al. 1993; Novick, Joseph & Croxson 1990; Weber et al. 1990; Hartel, Selwyn & Schoenbaum 1988; Abdul-Quadar et al. 1987). When countries all over the world expanded programs in an effort to slow the spread of AIDS, stubborn morality and fiscal shortsightedness prevented the United States from utilizing methadone maintenance as a harm-reduction strategy (Nadelmann et al. 1994).

There was an effort by providers to reinstitute the original definition of addiction as a disease that would require lifelong treatment. This effort was consistent with the "recovery" movement of the late 1980s, in which everything from alcohol problems to food abuse to gambling to relationship dependency was defined as a disease (Peele 1989). Whereas medicalization has proliferated in the form of defining so many problems and habits as diseases, the most popular solution has been the 12-Step programs. However, methadone maintenance, though a tried form of treatment for one of the oldest acknowledged diseases, has been systematically excluded as a viable option because its ultimate goal is not abstinence. Pragmatism, once again, was cast aside for morality. Funding was cut, and although providers begged for increased client access to maintenance, the continuation of defunding made methadone inaccessible at \$350 per month to the very people who needed it most (Rosenbaum, Murphy & Beck 1987).

Morality Frustrates America's First Harm-Reduction Effort

The War on Drugs initiated by the Reagan administration in the 1980s has Americans even more conflicted and inconsistent about drugs than ever. Even in the face of the AIDS epidemic, harm-reduction efforts—such as needle exchange, marijuana for the relief of nausea associated with AIDS and chemotherapy, and methadone for cessation of needle use—have been met with a stubborn moralistic resistance. Despite extensive research demonstrating its efficacy, as well as its legal status, methadone has been treated as an illicit drug and caught in a moral rather than medical debate (Newman & Peyser 1991:120): "The reality is that those who reject methadone treatment have been unresponsive to intuition, empiricism, pragmatism, and scientific data. The reason seems clear . . . the controversies over methadone treatment stem almost entirely from philosophical differences—objections to the substitution of one drug for another—and not from doubts about the pharmacological safety and efficacy of methadone. . ."

Methadone maintenance has been a frustrating experience for nearly everyone concerned with it: clinic staff, clients themselves, and researchers. Staff physicians and counselors in methadone programs consistently express exasperation at attempting to treat a medical problem with extensive regulatory mechanisms that more often than not interfere with sound medical treatment (Payte 1991; Zweben & Payte 1990). It is also difficult to practice medicine with the stigma attached to methadone, since that stigma ultimately extends not only to clients, but clinic staff as well. As Newman said (as cited in Kahn 1992): "There is no other medication (methadone) ... that physicians rely on for which maximum dosages have been decreed.... Physicians in no other medical practice are constrained by law from treating more than a designated number of patients...." For this reason, some physicians have simply abandoned methadone treatment (Payte 1991).

Methadone users have been victims of the political and social maneuvering of the past 20 years. Initially they expected a medical treatment that would allow them to function without having to procure an illegal drug (heroin) on a daily basis in order to feel normal. With the introduction of extensive regulations they found that being on methadone was no picnic (Rosenbaum In press; Rosenblum, Magura & Joseph 1991). Methadone users also felt stigmatized by the negative definitions of maintenance (Rosenbaum In press; Murphy & Irwin 1992). They were in a perpetual state of identity "limbo." Ultimately, their real-life struggles are the most frustrating (Rosenbaum, Irwin & Murphy 1988). The conditions experienced by clients have been exasperated by the demedicalization of methadone treatment and its progressive marginalization.

Finally, those in the field of treatment research have learned that sometimes policy has little to do with science. Research findings largely in support of methadone maintenance as an effective harm-reduction treatment are widely acknowledged in the drug abuse field. The National Institute on Drug Abuse, now a part of the National Institutes of Health, has funded methadone research for over two decades, and instituted policy consistent with the findings of their grantees. Nonetheless, to add to the frustration of researchers, state and federal bureaucracies often ignore such policy positions. Instead, they opt for cost-cutting, politically expedient, but ultimately counterproductive means for dealing with drug abuse. Perhaps, with increasing international adoption of harm-reduction strategies and a shift in focus from a criminal justice to a public health view of drug use, methadone maintenance will become remedicalized in the United States. Some providers believe methadone maintenance has been reintroduced and is already becoming less marginalized because of the AIDS epidemic (Zweben & Sorenson 1988). Perhaps the Clinton administration's new drug control strategy emphasizing prevention and treatment will mean that methadone can once again be used as it was designed by Drs. Dole and Nyswander: as a medical tool to reduce the harms of addiction and abuse.

Notes

1. Despite its growth and seeming acceptance, there was trouble early on for methadone maintenance. A 1919 amendment to the Harrison Act allowed physicians to prescribe narcotics only for legitimate medical purposes. Since addiction was not seen as a legitimate disease, the prescription of drugs for maintenance purposes was not allowed (Joseph & Appel 1993). In this instance, precedence was set for the reticence to endorse and then support maintenance treatment.
2. Although it was believed there was a heroin epidemic, some argued that it was actually manufactured by the reaction to increasing marijuana use by "counterculture" types, such as hippies, leftist and other dissidents, including the Black Power movement (Lidz, Walker & Gould 1980). The proliferation of programs to "help" addicts and stepped up law enforcement created statistics that after-the-fact proved there was an epidemic. Numbers of people in treatment and arrests had increased drastically.

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