National Alliance of Methadone Advocates

435 Second Avenue
New York, NY 10010
Voice/Message/Fax
(212) 595-NAMA

Education Series Number 3
March 1992

Myths About Methadone

by

Emmett Velten

Methadone has inspired an immense mythology. Perhaps it is the most extensive mythology surrounding any form of medical or psychological treatment, living or dead. Why has such a mythology developed? This question is important given the deadly stakes of the AIDS epidemic and methadone's proven efficacy in attracting opiate addicts into treatment and reducing their use of needles (Batki, 1988; Des Jarlais, Friedman, Novick et al, 1989; Joseph & Springer, 1990).

Research into psychology of rumor suggests that there are two conditions under which rumor thrives. One of them is high emotion. The other condition is lack of information. Methadone treatment amply meets these two criteria. The rumors and mythology surrounding methadone treatment may differ from normal rumors, because the emotionality surrounding methadone largely causes the lack of information about it. What causes the emotionality? Prejudice!

Prejudice toward a group of people involves judging them unfairly, as a group and negatively. Such judgments are moralistic and start with an impossible standard for the victims but one they are expected to meet to be worthy. For instance, the standard may be maleness, or whiteness, which the moralists consider the right way to be. Those who don't meet the stand, for instance females or nonwhites, are inferior. These judgments:

(1) apply different standards to the victims
(2) function to keep them in their inferior status;
(3) deny them opportunities;
(4) call upon "everybody knows" types of common knowledge to legitimize the prejudiced opinions;
(5) are often incorporated into the beliefs and self concepts of the victims, who come to believe the bigoted opinions of the majority culture.

Emmett Velten, Ph.D. is the Clinical Supervisor at the BAART Methadone Program, San Francisco, CA.

The victims of the prejudice may become prejudiced to some extent against themselves. All of these conditions exist in the case of methadone patients.

Emotion often runs high in opinions about methadone. the recipients of no other form of medical treatment are so routinely discriminated against. For instance, by custom and law, San Francisco has the reputation as one of the real citadels of freedom in America. It is one of the few places that take freedom seriously. Minorities abound, and, for the most part, opportunity and harmony reign. Except for methadone patients.

Some Examples of Routine Discrimination

Numerous drug and alcohol treatment programs in San Francisco refuse to provide services to methadone patients. The most prominent County-funded program for gays and lesbians, for instance, does not accept methadone patients into group therapy. The County-funded program to provide mental health services for medically indigent adults does not accept methadone patients. When San Francisco County has to pass along to drug and alcohol clinics a 20% cut in waiting list reduction funds, it passed alone a 100% cut to the methadone clinics, so that other treatment modalities would not have to share the burden of the cuts. At least one methadone patient, who was going to lose his treatment slot, committed suicide.

In the first competition for Ryan White emergency AIDS funds in San Francisco, largely orchestrated by the AIDS Program, no methadone clinic received funding. Yet, one of the drug-free outpatient counseling programs received funds to hire a janitor! At the second round of competition, methadone maintenance was specifically excluded as “not a priority service.”

At a meeting in San Francisco about establishment of a residential treatment facility for substance abusers who have AIDS, the question was asked, “Will patients on methadone be allow to live there?” No one knew the answer. the question could be continued,

"Or will they be forced to die on the streets because of the prejudice against methadone and against people who are on methadone?"

Not just in substance abuse, mental health, and AIDS services do methadone patients face routine discrimination. San Francisco MUNI will not allow methadone patients to drive its buses, even though an important legal ruling in New York overturned a similar policy (Beazer vs New York City Transit Authority, 1975).

Not just in those instances but in many other instances, there is discrimination against methadone patients. Providers of methadone-related treatment routinely ask whether their patients might be allow access to various services.

The prejudice stems from many sources. First, the methadone patient is still considered an addict. After all, they are still physically dependent upon a substance. It does not matter to morally righteous people that the methadone patient no longer feels like or behaves like an addict. It certainly does not matter to them that methadone may have saved the person's life and saved society thousands of dollars. The moralists view methadone patients as morally weak, morally inferior.

The substance abuse treatment subculture itself, and especially the 12-step approach, is probably the main source of prejudice against methadone patients. the 12-step program began as a voluntary and anonymous association of people trying to help themselves. It has become a massive moral crusade, unhesitatingly imposing its will on all others, and has almost completely cast anonymity aside. With God and the Higher Power on its side, it has no doubt about its righteous belief in the absolute necessity for abstinence and the moral superiority of abstinent people over all others.

The 12-step "abstinence uber alles" ideology is not prevalent that most people don't question its claims at all. Throughout drug and alcohol treatment programs, it is taken for granted that the 12-step program no only works, but works better than anything else. Yet, there is no proof of that in the literature. If there were such a study, it would be the most widely cited study in drug and alcohol literature. Twelve-step programs might be useful, or might not, or they might be useful for some people with some problems.

The point is that almost everyone automatically assumes 12-step programs "must" work because, they are seen as the morally superior way. Hardly anyone even thinks proof is necessary for the 12 steps. Few physicians would prescribe a medication based on testimonial support, but most of them unhesitatingly do so in the psychosocial treatment they prescribe.

Many of the myths about methadone, and must of the rampant misinformation about it are really based on the belief that people "on" substances are morally inferior. In fact, this position - the "moral weakness" vs disease model viewpoint - is what AA battled against decades ago. How ironic that the 12-step and codependency treatment subculture is at the core of the bigotry against methadone patients.

A Little History

Two New York physicians, Vincent Dole, a metabolic specialist, and his colleague, Marie Nyswander, a psychiatrist, invented methadone maintenance. They considered heroin addiction largely a metabolic defect or deficit or disorder. In other words, they believed that people who tended to become heroin addicts were different biologically from other people and that this biological difference largely contributed to their seeking heroin. Dole and Nyswander discovered, quite by chance, that methadone was good at correcting for the deficit, particularly so since methadone was so long-acting.

As a metabolic specialist Dole had studied obesity for many years. Today's theory that obesity can be attributed to a biological origin and not a "weakness of will" partly stems from his work. Dole observed that his obese patients' craving for food and relapse to overeating was "as if" they were addicted. He decided to look at heroin addiction to see if there were similarities between his obese patients and addicts.

So, initially, Dole and Nyswander were not trying to solve the American heroin problem. The study they had undertaken was to follow the metabolic pathways of morphine because they hypothesized that heroin addicts metabolized opiates differently from normal people. Two addicts were admitted to the morphine study. First they were given morphine and allowed to increase it as they pleased. Within three weeks the subjects were receiving eight injections totaling 600 mgs a day. They cooperated honestly with the barrage of tests to which they were subjected. But, much of their time was spent in front of the television set waiting for the next injection.

By law Dole had to detox his two subjects when the experiment was completed. He switched them to methadone, the approved form of treatment for detoxification. However, instead of reducing the methadone, Dole and Nyswander decided to run the same tests as they had on morphine. This way they could compare morphine to methadone.

Now something unusual began to happen. The older subject began to paint and the younger began requesting to go back to finish high school. The two subjects continued to take their methadone daily. Their behavior transformed for the better. They went from the street to stable living and better housing, from the jailhouse to the school house, from sickness unto health.

These facts were important, of course, to Dole and Nyswander, but were completely crucial in their long

battle to get government to go along with the idea of methadone maintenance. Government reflects American's practical tendency as well as its moralistic, judgmental tendency, and in this case the practical tendency can out on top. Government allowed itself to care about the fact that methadone patients are far more "cost effective" for society than are heroin addicts. There was an intention to cut costs, reduce crime, maybe to help people. Methadone maintenance had been surprisingly effective in doing those things. But the main point in Dole and Nyswander's thinking always appeared to be that heroin addiction is a medical disorder and that methadone is a use supplement to a biological deficiency (Dole & Nyswander, 1967; Dole & Nyswander, 1965; Dole, Nyswander & Kreek, 1966).

In reality, methadone treatment is barely tolerated by government. The main reason being that in out society people who are "on drugs" are considered morally inferior to others. Due to the AIDS epidemic methadone treatment has been given a temporary bit of breathing space. Still it is difficult to gain access to methadone maintenance. Staying in treatment is much, much harder than getting into treatment. The regulations and restrictions relating to methadone maintenance are so numerous that it is amazing that anyone can make it work.

Myth #1
DOLOPHINE WAS NAMED AFTER ADOLF HITLER

Dolophine is the name under which Eli Lilly Company markets methadone. When methadone was first used for maintenance treatment of heroin addiction, Dolophine was the common brand name of methadone. It was dispensed as a wafer. Certain problems became apparent in the use of the wafers. It is quite difficult to dispense small increases or decreases in milligrams of methadone.

For this and other reasons, when methadone became available in a stable liquid suspension (Methadose), most clinics dropped Dolophine and went to it. Dolophine is practically history now. Some younger methadone patients and staff may have never heard of it, much less the myth about its having been named for Adolf Hitler. The connection, by the way, is that the "Dolph-" of Dolophine is supposed to be the "dolf" of Adolf.

A minor myth about methadone is that Methadose is not real methadone. All methadone is the same chemical. Methadose is just a brand name. [1]

The Germans invested in methadone during the second world war when their supplies of opium were cut off. [2] During war the Germans of course needed more painkillers than usual, so they got to work synthesizing opioids. Meperidine, its brand name is Demerol, was another analgesic they invented, along with several hundred others that didn't become famous. You'll notice that there are no myths about Demerol's having been named for Nazis. The reason methadone 'unlucked-out' has to do with the fact that methadone did emerge as a maintenance treatment for heroin addicts.

In short, the myth is that since Adolf was a bad person who wanted to control people and was against freedom of choice, "they" gave his name to a bad drug used to control people.

The myth is colorful and just happens to tie in with the prejudice against methadone, but what is the truth about Dolophine? In Latin dolor means pain, suffering. In English (look it up in an unabridged dictionary) the dol means "a unit in pain measurement" and there are such words as dolorimetry. The dol in Dolophine was from dol, dolor (Goldstein, 1992).

The "-phine" in Dolophine comes from morphine, which was from Morphin, which was its German trademark name from the early 1800's. Morphin came from Morpheus, the god of dreams of mythology, who was a son of Hypnos, who later begat hypnosis.

The Germans also invented heroin, which English word came from the German trademark, Heroisch, from their word meaning heroic. The German pharmaceutical company that manufactured heroin was named "Bayer" of aspirin fame.

Heroin's chemical name is diacetylmorphine, sometimes shortened to diamorphine. After morphine and heroin, and before methadone and Meperidine (Demerol), the Germans also invested the all-time painkiller, which we still know by the German trademark name, Aspirin!

Myth #2
METHADONE IS ADDICTING

It is not substances which addict, it is people who addict themselves to various feelings and experiences. Some of these feelings and experiences are produced by substances.

---

1. Methadone is not a brand name, it is the generic. This is another myth that many respected professionals have believed.
2. Methadone was synthesized by Max Bockmühl and Gustav Ehrhart at I.G. Farbenindustrie. They named it Hoechst 10820 or polamidon. Basically they were searching for an analgesic with a low addiction properties. The patent for methadone was not applied for until 1941 and only reasech was undertaken during this period until World War 2 was over. After the war the US controlled Hoechst the town where I.G. Farbenindustrie was located. Since the US took control of any German patents methadone became a spoil of the war along with many other substances. (See Methadone and Congeners in Education Series 5.2, The Pharmacology of Opioids, Basic Pharmacology: How Methadone Works?)

The belief that substances addict people is driven by the fact that few people have any real idea of responsibility without considering it to be equivalent to blame. The whole disease theory's main attraction is that it gets people off the hook. If their disease make them behave poorly, then they are not to blame. However, this belief leaves them powerless. Such a belief probably also helps increase the level and number of addictions in our culture.

An alternative conception is that people are responsible for their behavior themselves, but that their best chance for their behavior themselves, but that their best change comes from accepting responsibility. Many people addict themselves to relationships (AKA "love"), gambling, and shopping, and a few people in modern America are addicted to work. With these and various other addictions there is no physical substance. Substances are not addicting; some of them create a physical dependency, which means that there are withdrawal symptoms when the substance is withdrawn.

If substances "caused" addiction, then all the service people who became heroin addicts in Vietnam would have lived out their lives upon returning to America as heroin addicts. The fact is that most of them stopped using heroin when they left Vietnam and never used it again. [3]

If "addicting" substances caused addiction, then all the complicated surgical patients who have to be maintained for prolonged periods on morphine would go on to be addicts. Practically none of them does, however. When they are withdrawn from the morphine, they feel crummy. In time the crummy feelings go away, and that's it.

Addiction is a mental state, a though process, a purpose. The addiction is the meaning of the feelings and experiences to us; it is our decisions to seek the feelings and experiences with less and less regard for overall consequences; it is the rationalizations we make up about how it's okay to keep doing what we're doing, and, sometimes, how we aren't even doing what we are doing!

Methadone patients may be maintained on methadone for years, using no heroin at all. Some of these patients, upon departing from methadone treatment, eventually relapse into drug use. What do they use? Heroin, almost every time; certainly not street methadone. They had been physically dependent upon the methadone for years, but the addiction is to the heroin. This is because the feelings produced by heroin are judged much better by most heroin addicts than the feelings produced by methadone.

3. Since the original study undertaken by D. Hunt there have been discrepancies found in the follow up methods. Many scientists now refute the findings of these studies.

Myth #3
METHADONE IS HARDER TO GET OFF THAN HEROIN

The heart of this myth is myth #2, namely that substances addict people. Instead, people addict themselves to various feelings and experiences, or highs, some of which may be related to substances, some not. Different people like different highs to differing degrees. The quality of the high influences the likelihood that various people will tend to seek it out. To day that a certain substance is powerfully addicting means mainly, "Because I like the high it gives me, I continue to choose to use it, come hell or high water, and I won't tolerate the prospect of not having it."

In studies of physical withdrawal sings from heroin and methadone, where the amounts of the two drugs are pharmacologically equivalent, withdrawal from methadone is slower and longer. None of that has anything to do with heroin or methadone "addicting" people, however. Neither one of the addicts people. We addict ourselves to various feelings and experiences. Most methadone patients report that the feeling it gives are pretty piddling compared to the feelings produced by heroin.

Much of the addictive attraction of any drug depends on the rapidity and duration of its action. Methadone is administered orally, gets into the system slowly compared to injected heroin, and is very, very long-acting. However, in studies with seasoned opiate addicts where injected drugs were compared, they could not immediately distinguish heroin from morphine from methadone. Seasoned stimulant users, similarly cannot distinguish dextroamphetamine from cocaine from methylphenidate (Ritalin) immediately upon injection. Cocaine has a greater addictive attraction (for most people) than does amphetamine, however, because of the former's much shorter duration of action.

Myth #4
PEOPLE GET ON METHADONE JUST FOR THE HIGH

Most people get on methadone because they are exhausted, fed up, desperate, can't keep a heroin addiction going and can't keep themselves together anymore. In short, they have to get on methadone. Addicts do not have to be forced to seek a high. Take a look at the people in dosing lines at methadone clinics. You won't find many who look high. They look like anyone else who has to wait in long lines in unpleasant surroundings.

Most heroin addicts will tell you the high behind methadone is quite inadequate, at least in comparison with "the real thing." You may have heard a saying, "If

God made something better than heroin, He is keeping it to Himself!"

Almost all opiate addicts like heroin better than methadone. The most seasoned staff people at methadone clinics have seen thousands of intake urinalysis results. Only a very small percentage of those results have any methadone in them (usually with morphine/codeine [heroin]). Only a tiny percentage have only methadone. Very, very few street addicts have methadone as their drug of choice.

Some recovering addicts in drug-free treatment programs, and especially some of their staff members, may wishfully (and jealously) think that methadone is a wonderful high. This is the stuff of their troubled dreams, but reality is another matter.

Myth #5
ONCE ON METHADONE,
YOU CAN'T GET OFF

This is a complex myth and would better be examined at several levels. At a purely literal level, obviously there are methadone patients who leave methadone programs. This happens all the time. So it is not true "that you can't get off methadone."

At another level this myth refers somewhat to the so-called "revolving door" of street addiction and methadone maintenance (or other forms of treatment).

Addiction is a long-lasting metabolic disorder with roots deep in human nature, personality, family, upbringing, social environment and cultural values, and it is true that it can take a long time before any particular addict decides to change, changes, and stays changed. Methadone treatment, when followed by lapses and relapses, may seem to some people to be the cause of the relapse. This is the logical error, "Post hoc, ergo propter hoc." (After this, therefore because of this.)

To some extent this myth blames the methadone for the fact that someone is on methadone, and one translation would be, "If it weren't for the methadone, I wouldn't be an addict!"

Thus, this myth is a cop-out. Most of use are prone to think that some thing outside ourselves is responsible for our undesirable behavior (but much less prone to look to the outside in explaining our desirable behavior!) This cop-out relieves us of the responsibility for putting out effort to change and it gives us something to blame for failure if and when we do try to change. Of course, it also help ensure that we will keep out problems.

This myth is a variation of another popular myth, "Once a junkie, always a junkie." Untrue. Most long-term methadone clinic staff members know a number of former heroin addicts and methadone patients who are no longer addicted. Obviously there are many people in NA, Rational Recovery, Women For Sobriety, and Secular Organizations for Sobriety who are no longer practicing addicts. People change themselves, sometimes with treatment, sometimes without. No one is born with a needle in the arm, and no one has to die with one there.

The DARP (Drug Abuse Reporting Program) study found that a substantial percentage of methadone patients has not used illicit drugs at two-year follow-up (Sells, 1974a. Sells, 1974b; Sells & Simpson, 1976a; Sells & Simpson, 1976b; Sells & Simpson, 1976c). Therapeutic community graduates were equally successful. Drug-free outpatient graduates were considerably less successful. It's really time to lot go of any delusions to the effect that drug free outpatient counseling is worth recommending for treatment of opiate addicts. Generally speaking, it isn't.

The unstated continuation of this myth is "without discomfort. Magically." Low frustration tolerance, with its associated over rebelliousness and lack of willingness to work hard to over come problems, contributes substantially to why most people keep their problems, including addictions. Most of us don't want to believe that our lack of persistence contributes to our keeping certain problems, so we perfume this by saying, "You can't get off methadone," or, "Once on methadone, 'they' keep you on it."

Myth #6
METHADONE PROLONGS
AN ADDICT'S CAREER IN DRUGS

The DARP research, which began in the early 70s for about a hundred drug abuse treatment programs that received federal funds, and originally involved about 45,000 subjects, had recently had its twelve year follow-up. What has been found over the years in the analysis of the data is that demographic variables and various personal characteristics of patients seem to be the main predictors of longevity of drug career. These factors have been found across the three treatment modalities that were in the study: methadone maintenance, therapeutic communities, and drug-free outpatient counseling.

Some findings in the research are as follows: The younger some began drug use, the longer the career. The less education, the longer the career. The more times stopped by the police but not arrested, the longer the career. The number of times the addict moved geographically to avoid the police, the longer the career. Addicts employed in square, higher status jobs tended to have longer drug careers than street addicts. (However, it was found that the square, higher status job holders had considerable better courses of treatment and treatment outcomes than did the street addicts once they did get into treatment. So much for the concept of hitting the bottom! Those people did not hit the bottom.)

Thus, length of drug career does not appear related very closely to any form of treatment in itself. It appears related to a variety of other factors.

Myth #7
METHADONE DOES NO GOOD

A former methadone patient, now a successful mother and pre-med student with several clean and sober years, was asked to comment on the idea that methadone does no good. [4] She had been on methadone several times. "The only thing being on methadone the first time did for me," she said, "was save my life."

Exposure to diseases, attack on the street, overdose, and so forth are all reduced substantially for most patients on methadone. They have a better chance to stay alive. In their pursuit of the wickedness of being "on" something, some critics of methadone seem to forget the human angle. The death rate, arrest rate, illness rate of addicts drops substantially when they enroll in methadone treatment. Their legitimate employment rate, the taxes they pay, and their immune system functioning, all rise. These factors are important and would be important even if methadone treatment were less effective than outpatient drug-free treatment, but such is not the case.

In the second edition of his monumental text on heroin addiction, Jerome Platt said,

> "Based on predictors of outcome using a multiple discriminant analysis approach, outcomes for methadone maintenance and treatment communities exceeded expectation, the drug free programs did more poorly than expected..."

Sells, the chief DARP researcher concluded that methadone maintenance as well as therapeutic community approaches have demonstrated their worth for narcotics treatment, while outpatient drug-free programs are seen as mainly useful for youthful nonopioid and polydrug users (Sells & Simpson 1980).

Myth #8
METHADONE CAUSES PATIENTS TO TURN TO ALCOHOL

The idea in this myth is that there is a special tendency for methadone patients to turn to alcohol because they are on methadone. The DARP studies indicated that the amounts of alcohol consumed by methadone maintenance patients and therapeutic community and outpatient drug-free clients at the beginning of treatment were almost identical. At earlier follow-ups after treatment, the amounts of alcohol reported consumed has increased considerably. These increases were almost identical for each of the three treatment modalities. Therefore, it can be concluded that methadone treatment has no special relationship to people's propensity to increase their alcohol intake.

At 12-year follow-up, it was concluded that the increases in alcohol consumption reported above had leveled off within a few years of completion of treatment. It has been found in the DARP follow-ups, including the 12-year follow-up, that as time passes a larger and larger percentage of the original subject group remained free of illicit drug use. Therefore, it appears that there is no progressive tendency to substitute alcohol for heroin. some, but only some, patients may so substitute, or at any rate increase alcohol consumption.

Myth #9
METHADONE HURTS YOUR HEALTH

There have been well over 2,000,000 patient years on methadone, and thousands of babies have been born to mothers on methadone. The health status of patients on methadone has probably been studied with greater frequency and depth than that of any other medication. Mary Jeanne Kreek, M.D. Senior Research Associate and Physician, Department of biology of Addictive Disease of The Rockefeller University, concluded as follows in her encyclopedic review of the literature (Kreek, 1983).

> "The most important medical consequence of chronic methadone treatment, in fact, is the marked improvement in general health and nutritional status observed in patients as compared with their status at time of admission to treatment. Most medical complications observed in methadone maintenance patients are either related to ongoing preexisting chronic disease, especially chronic liver disease, the onset of which occurred prior to entry into methadone treatment, or to coexisting new diseases or illnesses or to ongoing polydrug or alcohol use. Clearly the most common cause of serious medical complications in methadone-maintained patients both during the methadone maintenance treatment and also during and following withdrawal is chronic alcohol abuse."

4. The use of clean is no longer acceptable and another example of the use of stigmatizing language. A diabetic that followed medical prescriptions is not referred to as clean. And this type of language infers that individuals displaying symptoms of addiction are "dirty".

References

Batki, S.L. Treatment of intravenous drug users with AIDS: The role of methadone maintenance. **Journal of Psychoactive Drugs** 1988 20: 213-216.

Legal Action Center. *Beazer vs New York City Transit Authority: A Landmark Decision on Methadone Maintenance* [Report]. New York: National Institute on Drug Abuse, 1975.

Des Jarlais, D.C.; Friedman, S.R.; Novick, D.M. et al. HIV-1 infection among intravenous drug users in Manhattan. **Journal of the American Medical Association** 1989 261: 1008-1012.

Dole, V.P.; Nyswander, M.E. Heroin addiction: Metabolic disease. **Archives of Internal Medicine** 1967 120: 19-24.

Dole, V.P.; Nyswander, M.E. A medical treatment for diacetylmorphine (heroin) addiction. **Journal of the American Medical Association** 1965 (August 23) 193(8): 646-650.

Dole, V.P.; Nyswander, M.E.; Kreek, M.J. Narcotic blockade. **Archives of Internal Medicine** 1966 (October) 118:304-309.

Goldstein, D. Personal communication, Eli Lilly Pharmaceuticals, 1992.

Joseph, H; Springer, E. Methadone maintenance treatment and the AIDS epidemic. In: **The Effectiveness of Drug Abuse Treatment: Dutch and American Perspectives**. p 261-274. Malabar, Florida: Robert E. Krieger, 1990.

Kreek, M.J. Health consequences associated with the use of methadone. In: Cooper, J.R.; Altman, F.; Brown, B.S.; Czechowicz, D. (eds), **Research on the Treatment of Narcotic Addiction: State of the Art** (NIDA Research Monograph 83-1201). Rockville, MD: National Institute on Drug Abuse, 1983.

Platt, J.J. **Heroin Addiction: Theory, Research and Treatment**. Malabar, FL: Kreiger, 1988.

Sells, S.B. **Effectiveness of Drug Abuse Treatment: Volume 1 Evaluation of Treatments**. Cambridge: Ballinger, 1974a.

Sells, S.B. **Effectiveness of Drug Abuse Treatment: Volume 2 Research on Patients, Treatments, and Outcomes**. Cambridge: Ballinger, 1974b.

Sells, S.B; Simpson, D.D. Effectiveness of Drug Abuse Treatment: **Volume 3 Further Studies of Drug Users, Treatment Typologies and Assessment of Outcome During Treatment in the DARP**. Cambridge: Ballinger, 1976a.

Sells, S.B.; Simpson, D.D. **Effectiveness of Drug Abuse Treatment: Volume 4 Evaluation of Treatment Outcomes for the 1971-1972 Admission Cohort**. Cambridge: Ballinger, 1976b.

Sells, S.B.; Simpson, D.D. **Effectiveness of Drug Abuse Treatment: Volume 5 Evaluation of Treatment Outcomes for the 1972-1973 Admission Cohort**. Cambridge: Ballinger, 1976c.

Sells, S.B; Simpson, D.D. The case for drug abuse treatment effectiveness, based on the DARP research program. **British Journal of Addiction** 1980 75: 117-131.

Education Series
Cost per each $2

Number 1. Methadone Maintenance and Patient Self Advocacy by Arlene Ford. (March, 1991).

Number 2. Drug Policy in the Age of AIDS: The Philosophy of Harm Reduction by Rod Sorge (April, 1991).

Number 3. Myths About Methadone by Emmett Velten (March, 1992).

Number 4. Methadone, HIV Infection and Immune Function by Herman Joseph (August, 1994).

Number 5.1. The Basics of Pharmacology, Basic Pharmacology: How Methadone Works? by J.T. Payte, Jeffrey Smith and Joycelyn Woods (February, 2001 Revised).

Number 5.2. The Pharmacology of Opioids, Basic Pharmacology: How Methadone Works? by J.T. Payte, Jeffrey Smith and Joycelyn Woods (February, 2001 Revised).

Number 5.3. Drugs and Conditions That Impact On the Action of Methadone, Basic Pharmacology: How Methadone Works? by J.T. Payte, Jeffrey Smith and Joycelyn Woods (February, 2001 Revised).

Number 6. Starting A Patient Run Program (Not available in revision).

Number 7. Managed Care, Medicaid, Medicare and Private Insurance: Who Will Pay? (Not available in revision).

Number 8. Methadone Does Not Work Bibliography (October, 1995).

Number 9. The Methadone Maintained Patient and the Treatment of Pain by J. Thomas Payte, Elizabeth Khuri, Herman Joseph and Joycelyn Woods (January, 1999).

Membership in NAMA is $25 a year for Individual and $40 for International Membership. Additional family members may join at the cost of $10 each a year. Institutional Membership is $110 a year for U.S. and International. If you cannot afford membership dues, or can only afford a part of it, NAMA will still accept your membership request.

NAMA Manuals
Cost per each $10

Number 1 Starting a Methadone Advocacy Group (NAMA Chapter or Affiliate). The basics of starting a methadone advocacy group including history of methadone advocacy, forming a Board of Directors, meeting planning, first projects, politics of methadone, listing of state agencies and other resources.

Setting Up a 12 Step Group. A manual to help patients and professionals start a 12 step group. Includes organizing the group, meeting planning, the basics of starting a 12 step group, a generic version of 12 steps and other resources.

The price of the Education Series and Manuals are to cover the cost of duplicating and mailing.

NAMA is a not-for-profit organization.

For membership please complete & mail the coupon below with your dues.

Coupon

Name: _____

Organization: _____

_____

Address: _____

_____

City: _____ **State**: _____

Country: _____ **Postalcode**:_____

Work Phone: _____

Home Phone: _____

Fax: _____

Amount Enclosed: _____