

## **Methadone Maintenance**

By

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For over thirty years, methadone has been hailed as one of the most effective drugs for treating people who are dependant on heroin. Drug policy groups have praised methadone as a viable alternative to incarceration, and effective treatment for those who have the ‘disease’ of heroin addiction. However, by promoting long term methadone maintenance as a panacea for opiate addiction, policy makers once again avoid addressing the fact that addiction is a choice. Also it treats methadone as a drug that has little to no side effects. However the fact is that certain people suffer from side effects that may keep them from completing treatment. Although methadone is touted as a drug that suppresses heroin withdrawal without creating euphoric feelings in users, it is increasingly being used recreationally, resulting in overdose and death. Methadone is an opiate, just like heroin and morphine. Therefore, methadone is merely just a government sanctioned narcotic to replace the use of a government banned narcotic. Although both drugs can cause the same side effects, overdose, and death, methadone is considered “good” and heroin is considered “bad”. This shows that “good” drugs are simply legal or socially accepted and “bad” drugs are usually illegal and have negative stigmas attached to them.

The Harrison Act of 1914 made certain narcotics like cocaine and morphine controlled substances, and made heroin an illegal substance. After the passing of the

Harrison Act many physicians were uncertain of how to treat heroin addiction because practicing heroin maintenance could jeopardize their careers (Goldstein 2001:164). In the 1960s Vincent Dole and Marie Nyswander studied the symptoms that heroin addicts display when they stop their drug use. After observing these symptoms of withdrawal they theorized that heroin addicts had a metabolic disease that resulted from the damage of the opioid receptors in the brain (Goldstein 2001: 164). As a result of this damage, heroin addicts differ from other individuals because they need opiates to function normally (Goldstein 2001: 164). Dole and Nyswander suggested that addicts receive regular doses of an opiate to stabilize them throughout the day. From this theory, methadone maintenance clinics were born.

Methadone is a synthetic opiate that was created in Germany during World War II as a replacement for morphine and other painkillers cut off by the Allied Forces (Goldstein, 2001, p. 164). Studies from this period showed that one dose lasted 24 hours or more, and that continual methadone use did not harm the body (Goldstein, 2001, p.164). Methadone can be administered orally and only needs to be given once a day. Methadone is stored in the fatty tissue and as a result it is released slowly into the body, and its euphoric effects are delayed (Belluck, 2003, p. 2). As a result methadone supposedly takes away cravings for other opiates without getting the user high. (Goldstein, 2001, p. 164). Therefore, it was the best legal option for maintenance programs because it only needed to be given once a day, and addicts could avoid withdrawal without getting high and theoretically restore order into their lives.

At first, this type of treatment faced opposition by those who believed that methadone maintenance was just another form of addiction. “Then the Federal

government, through the National Institute of Mental Health, expressed the opinion that methadone treatment was therapeutic in the broad sense, and with the fear of public prosecution removed, sections of the medical profession found their ethical doubts easier to resolve” (Williams, 1974, p. 173). Politicians who were under enormous pressure to find a solution to heroin addiction supported these clinics as a method for reducing the number of overdoses and the amount of crime caused by heroin addiction (Tapert et al. 1998, p. 153). By the 1970’s methadone maintenance was seen as a cost-effective way to treat heroin addicts and reduce crime (Bescher, Walters, 1985, p. 158). With increased support and funding, clinics became more widespread, and more involuntary clients began entering programs as an alternative to prison. Methadone was, and still is hailed as a drug that can help addicts reintegrate into society with very few side effects.

The original purpose of methadone maintenance was to help addicts deal with the problems of withdrawal, manage their opiate intake, and gradually stop using opiates altogether (Tapert et al. 1998,p. 153). However, as time progressed those who believe in the disease model of addiction began advocating indefinite methadone maintenance for heroin addicts. Supporters of indefinite methadone maintenance view heroin addiction as a physiological disease. Therefore, it should be treated like other diseases that are incurable. “It is noteworthy that the need for life long treatment with a drug is not questioned for diseases like diabetes or schizophrenia”(Goldstein, 2001, p. 171). As a result, many clinics discourage patients from discontinuing their use of methadone (Goldstein, 2001, p. 172). Relapse is attributed to the disease of addiction and is used as proof that methadone maintenance is the only solution for heroin addicts (Goldstein, 2001, p. 172).

As the popularity of methadone treatment spread, clinics changed their policies to allow involuntary patients to be admitted. Originally, doctors believed it was essential that patients be motivated and willing to give up heroin in order to receive treatment (Newman, 1977, p. 29). As the war on drugs continued, state public policy began to institute involuntary treatment for convicted drug users. One of the first examples of this was The New York State Narcotic Control Act (Newman, 1977, p. 32). These laws allowed convicts to enroll in methadone maintenance programs as an alternative to jail. Although the purpose of these policies was to establish a cost-effective alternative to jail, involuntary treatment may cost the state more because forced treatment often involves addicts that do not want help and relapse once they are through with the required treatment (Newman, 1977, p. 36).

Over the past 40 years methadone has been promoted as a drug that can stop heroin addiction without hedonistic euphoria or side effects. This excerpt from the Office of National Drug Control Policy states the U.S. government's stance on methadone:

Methadone does not impair cognitive functions. It has no adverse effects on mental capability, intelligence, or employability. It is not sedating or intoxicating, nor does it interfere with ordinary activities such as driving a car or operating machinery. Patients are able to feel pain and experience emotional reactions. Most importantly, methadone relieves the craving associated with opiate addiction. For methadone patients, typical street doses of heroin are ineffective at producing euphoria, making the use of heroin less desirable (ONDCP, 2000, p. 1).

Therefore, methadone seems like a drug that benefits everyone involved. Society benefits because methadone patients are less likely to commit crimes in order to buy heroin. Politicians benefit because they support a cost efficient solution to heroin addiction and crime. Addicts benefit because they are able to stabilize their lives and stop their illegal drug use. As a result methadone and the practice of methadone maintenance has become viewed as a modern panacea for heroin use.

One benefit of the popularity of methadone treatment is that it establishes that if a narcotic is governmentally regulated and distributed for free, crime is reduced because the methadone user does not have to “hustle” to get funds for their habit. This may be a model for heroin legalization. The street price of heroin is more expensive because of inflation within the black market. However, if heroin were government regulated and distributed, the price of the drug would drop because it would be subject to federal law and regulations. If methadone users commit less crime because the drug they are ingesting is free, then a legal heroin market would also reduce crime. Also the extensive use of methadone and morphine is proof that physicians can use opiates for treating patients with chronic pain. Since heroin is an opiate that when used properly is effective in treating pain, the use of other synthetic opiates in medicine may one day open the door for heroin to be used by doctors in clinical settings similar to what is seen in the British medical system (Williams, 1974, p. 168).

There are four major problems with methadone maintenance programs. The first is that although claims have been made that methadone does not create a euphoric rush, there has been a recent rise in methadone overdoses. The majority of these overdoses are from illicit use. For years methadone was considered to be the least likely abused narcotic

because of its inability to produce a quick euphoric high (Belluck, 2003, p. 1). Now methadone is being used recreationally like OxyContin and other painkillers. However, unlike other painkillers and opiates, methadone is stored in the fatty tissue, making it more likely that a person will overdose. “They might mix it in with a beer or with some other drug. They take it thinking it's just like any other drug and will give them a buzz, and they end up either dead or deeply unconscious” (Belluck, 2003, p. 2). In several states methadone overdoses have doubled and even tripled over a five-year period (DEWS, 2004, p. 1).

One reason for the increase of recreational methadone use is the increased availability of the drug. Doctors can now prescribe methadone for patients experiencing chronic pain. Recently, more doctors have turned to methadone as an alternative to OxyContin because of law enforcement crackdowns on doctors who are suspected of liberally prescribing the drug (Belluck 2003, p. 2). Yet even under a physician's care methadone can be dangerous because proper dosage varies by individual. “Methadone is probably one of the very few drugs that I've seen doctors almost kill patients with” (Belluck 2003, p. 2). In 2001 Federal regulations made methadone clinics more accessible, and consequently methadone more accessible to the illicit drug market (Belluck 2003, p. 3). Some clinics allow their patients to have “take-home” dosages after a period of continued attendance. These doses are meant to allow patients to continue their daily lives without the burden of waiting in a clinic for their methadone (Belluck 2003, p. 3). However, some patients use their take home dosages as an extra source of income (Belluck 2003, p. 3). The street value of methadone is much lower in inner cities

than heroin, and therefore there is an added incentive for heroin users to buy methadone illegally (Belluck 2003, p. 2).

The second problem with methadone maintenance programs is that they attribute lower crime to the drug and not to the fact that it is a legal substance free to those in public treatment clinics. “Hunt and her colleagues (1982) found that many methadone clients use the drug as another euphoriant (“a cheap way to get high”) and as a medication, simply adding it to the illicit drugs used prior to and during treatment” (Beschner et al. 1985, p. 162). Advocates for methadone maintenance claim that these clinics work because it keeps former addicts away from the drug scene because the methadone curbs their craving for heroin (Tapert et al., 1998, p. 159). However, this argument does not take into account that the fact the drug is legal and free to those in treatment may have a greater effect on the users’ participation in crime.

Also, the claims that methadone maintenance helps addicts find employment and stay away from illicit drugs is not reflected in studies of patients enrolled in these programs. In 1974 The New York Methadone Maintenance Treatment Program’s patients were studied to determine the success of methadone maintenance. The results showed that about 20% of patients enrolled in treatment were abusing other drugs while they were receiving methadone (Newman 1977, p. 160). Over one third of patients in the program, were not gainfully employed (Newman 1977, p. 160). Other studies have concluded that a significant number of clients in methadone programs use heroin in addition to methadone and other drugs to recapture the “high” they once experienced (Beschner et al. 1985, p. 162).

If heroin maintenance programs were established and free to those enrolled it could be argued that patients would have the same opportunity to stay away from illicit drugs and would no longer be compelled to commit crimes for drug money. Yet heroin maintenance programs would receive little or no support because heroin is considered a “bad” and “dangerous” drug. Heroin is considered ‘dangerous’ because it can lead to overdose and death. Yet there have been increasing rates of methadone overdose and death and since methadone has slower euphoric effects on the body, it may be easier for a first time user to overdose. Heroin is also considered “bad” because society views it as a highly addictive drug. However, methadone is created in a lab and as a result is purer than street heroin, which is often cut with other substances (Beschner et al. 1985, p. 161). So methadone has the potency to create a stronger physical dependence, meaning that if methadone users discontinue using the drug, their physical withdrawal will be more severe than that experienced by heroin users (Beschner et al. 1985, p. 161).

Heroin is also considered a “bad” drug because of the crimes committed by addicts in search of another “fix”. Yet even methadone, a legal drug is being abused and sold on the black market, which may lead to some addicts committing crimes to pay for methadone. Methadone is a synthetic opiate that can be abused and can cause death just as easily as heroin. It can also cause a greater physical dependence than street heroin, and withdrawal from methadone is more severe. Methadone is also present in the illegal drug market and those seeking to buy methadone may commit crimes to fund their habit. Yet in spite of these facts heroin has been labeled a “dangerous” and “bad” drug while methadone is considered “safe” and “good”. This shows that drugs are not good, bad, dangerous or safe. These are all labels that society gives these drugs as a result of social



teachings.

The third problem with methadone maintenance is that it medicates addicts without trying to discover why their patients begin their drug use. Methadone maintenance advocates believe that heroin addiction is a life long physiological disease. However this ignores the fact that some heroin addicts are able to stop their drug use without methadone. Comparing heroin addiction to diabetes or rheumatoid arthritis is inaccurate because there is no cure for these ailments, and patients cannot choose to stop being diabetic or arthritic. However there are many heroin addicts that stop using heroin and therefore stop being “diseased”. “For example, Mossberg and Anggard (p. 16) report in their study of literature in narcotics careers that ‘approximately 2/3 of all intravenous abusers are able are to break their habit on their own, i.e., they “mature out” of ‘abuse’” (Goldberg 1999, p. 58). This approach of treating addiction as a disease does not work because medication cannot erase the environmental factors that contribute to drug use. “In general, then, maintenance treatment is effective while the medication is being taken, but it usually does not cure the underlying problem, whatever that may be” (Zinberg 1984, p. 213). That is why many heroin users relapse once they are off methadone, and why this treatment is only effective if the clients stay on the drug indefinitely.

In their zealousness to increase treatment, many methadone clinics have relaxed their criteria for admitting new clients. Although the purpose is to make treatment more accessible to addicts, treatment facilities may be admitting people who are not in need of methadone maintenance, and therefore unnecessarily become subject to methadone dependence and withdrawal (Beschner et al. 1985, p.159). The desire to attract more patients may cause clinics to admit people who use heroin but have the ability to regulate

their intake to the point where it does not negatively affect their lives. As a result of a court sentence or pressure from their social circle they are admitted for unnecessary treatment. Unnecessary enrollment into treatment clinics not only costs society money, but is also dangerous for the patient who may become dependent on methadone and as a result believe that they have no control over their drug use.

The fourth problem is that methadone maintenance programs have a philosophy of complete abstinence from heroin (Tapert et al., p.153). Some patients can be expelled from their programs if they test positive for heroin while in treatment. This mentality of abstinence only teaches addicts that they cannot control their drug intake and therefore must abstain from heroin completely. Addicts are also taught that if they try heroin just one time, they will lose control and go back to committing crimes and living unstable lives. However these teaching completely reject the scientific findings from studies of Vietnam veterans that returned to America addicted to heroin (Schaler, 2000, p. 30). After the Vietnam war, the U.S. Department of Defense conducted a study to determine whether veterans were using heroin upon their return (Schaler, 2000, p. 30) Out of all of the veterans that came back with heroin in their system, only 14 percent returned to heroin use once they were back home (Schaler, 2000, p.30). This is proof that addiction is not an incurable disease because the majority of heroin users were able to stop use once their environment changed. Environment has a greater influence over addicts than the drug itself, and many addicts abuse drugs to avoid coping with their environment (Schaler, 2000, p. 30). However, instead of trying to create policies that deal with the poverty and environmental factors that many addicts face policy makers instead turn to methadone. They subscribe to the disease model because it allows them to say that the

problem of addiction is biological and avoid dealing with the deeper social problems of poverty and unemployment. However, to say that addicts cannot regulate their drug use is not only untrue but also dangerous because it takes away the individual's sense of empowerment to regulate and even stop drug use on their own.

Methadone is a synthetic opiate that can be used to help patients gradually stop their opiate use completely. However, treatment clinics are now favoring indefinite methadone maintenance that is not only costly to society but has also been shown to be ineffective at reducing substance abuse. By treating methadone as a panacea, public policy makers avoid addressing the underlying problems addicts have and instead promote a short-term solution for the problem of addiction. These policies also label methadone as a safe drug with medicinal value, while proclaiming heroin to be a dangerous and deadly substance. However these social labels do not reflect the fact that both drugs are opiates with similar effects on the body. In actuality neither drug is good or bad, because these are not part of their chemical makeup. They can only produce physical effects that society views as good or bad. When the effects of both drugs are the same, it is even clearer that the social label of the drug has more to do with politics and subjective opinions rather than fact. Based on this, methadone maintenance is a dangerous concept because it treats heroin addiction as a disease that requires lifelong treatment. However, addicts that have been able to stop their use "cold turkey" or who "mature out" of drug abuse prove that heroin users do not need lifelong methadone maintenance. They also do not need to abstain completely from heroin. Programs that emphasize abstinence and believe addiction is a disease are harmful to addicts because it strips them of their sense of self-efficacy in stopping drug use on their own.

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