Methadone: best hope for now

Unlike other programs for heroin addicts, methadone works. It should be used more widely till a better solution is found.

What do we mean when we say, “Let’s solve a social problem?” On the face of it, the answer is rather obvious: Make the problem go away, cure the ill, enrich the poor, cleanse the environment. But in the intricate, multifaceted, conflict-laced reality of society, problems are rarely solved in the sense of being made to vanish. Usually they are only reduced, defined as no longer problematic or “handled” in some other less than complete manner. This is true not only of our society but also of most others. One reason why most societies do so poorly is precisely because they believe they can do so much.

In reality, we are hampered by limited know-how (for example, no one has yet designed an effective education system to help a large number of people to catch up); lack of resources (it would take at least one-and-a-half times our gross national product to handle the popular list of our ten most urgent problems); and a lack of consensus, both of what we want and how to proceed (do we jail all marijuana dealers or legalize its use?). Thus, sadly but inevitably, we must limit ourselves to incomplete solutions. These, one must hope, in accumulation, over time, will lead to more encompassing and fundamental cures.

It is like looking back at the beginning of the industrial era, when children were forced to work long hours in the mines, under terrible working conditions. Should those efforts that were initially limited to getting kids out of the pits be sneered at as trivial and useless? Yes; if the goal is to redo mankind, such achievements are barely notable. But if the perspective is that each human life saved or enriched is worth a day’s work, keeping in mind that tomorrow we must do more, then each reform is quite welcome.

Only when you stop investing most of your time trying to build the “perfect” light bulb, one which will waste none of its energy by generating heat instead of light, will you find great value in the difference between a 4.5 percent light-yielding bulb and a 5.5 percent one.

Methadone is a good example of useful, incomplete, social problem-solving by means of what can be thought of as “technology.” It is a treatment in which a technological approach replaces the “human touch.” Methadone is not necessarily a good treatment, but nevertheless, for the time being, it is the best available.

First of all, and most important, methadone “works.” Only those who have tried scores of other approaches, ones which yield no improvement or serve to deepen the problem, can fully appreciate the sweet sound of this little word. The fact is that various punitive-custodial programs, half a dozen educational-informational ones, and rehabilitation-psychotherapeutic drives have all had very little positive effect on heroin addiction.

How well does methadone work? While practically all heroin addicts released from prisons return to the street to shoot and push heroin, while an overwhelming majority seem immune to psychotherapy and while most shrug off educational efforts, roughly 80 percent of those who have voluntarily joined several major methadone maintenance programs encompassing thousands of addicts stay with them.

Like all other incomplete solutions, methadone has hyperenthusiastic advocates. It has been occasionally claimed that methadone “blocks” heroin: that a person who is on methadone and shoots heroin will gain

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no euphoric effect, no "high." As far as I know, this quality of methadone has not been demonstrated. Actually, one percent of participants in the methadone programs studied are reported to use heroin regularly, and a larger number try it occasionally. Nevertheless, methadone's success in getting people off heroin in these programs is very high.

Some have argued that this success is futile because methadone is itself an addictive drug and the net effect can be compared to shifting an alcoholic from Scotch to bourbon. But there is no evidence of serious side effects from taking methadone (in prescribed dosages) over long periods of time.

As to crime reduction, while 91 percent of those involved in the programs referred to had been jailed prior to their participation in the methadone maintenance programs, and practically all had been involved in criminal activities more or less continuously, 88 percent of the participants now show arrest-free records. Only 5.6 percent have been found guilty of criminal offenses. A report by the director of the District of Columbia narcotics treatment division shows that as the number of addicts on methadone increased, the level of drug-related crimes fell almost proportionally. Thus, with about 20 percent of the addicts in such treatment, drug-related crimes in Washington, D.C., fell from 12,432 in 1969 to 11,222 in 1971.

The reasons are persuasive. Heroin involves a person in a life of crime, a deviant subculture and a desperate hunt for money to support a very expensive habit. A methadone program requires much less frequent intake for the addict, no hunt for funds and a much more stable psychic condition. While it does seem to have a mild tranquilizing effect, especially when higher dosages are used, it does not impair work, study or other social functioning.

In a group of 990 methadone-takers examined, those employed or attending school rose from 27 percent at admission to the methadone program to 65 percent after one year in the program, to 77 percent after two years and to 92 percent in the third year. This is an almost unparalleled success rate for any social effort that I know of.

The longer, more stable "high" that methadone is reported to provide seems to be caused, in part, by the different way it is administered. It is ingested, while heroin is injected. Both are rather similar products, but they are not identical. Part of the difference might well be attributed to the fact that heroin is an organic substance while methadone is synthetic. (I keep qualifying my statements—not to meet academic niceties

As part of the system of controls, an addict is photographed at a Washington methadone clinic.
which insist that "nothing is ever really known," but because often, when we must make such decisions, a good part of what we need to know, we don't, and what one authority claims to be quite true, others question most seriously.)

Second, the fact that methadone is usually ingested, while heroin is normally injected, is not accidental. In the programs discussed, methadone is provided in clinical conditions, and the street culture heroin is taken in the quest of a quick high. Methadone programs can bring heroin addicts in touch with people anxious to help them to overcome their condition, such as doctors and social workers. Heroin addicts deal with pushers anxious to feed their habit.

All these many virtues of methadone do not make it more than an incomplete, and hopefully transitional, solution. It also has several serious problems. It is itself addictive. People are maintained on methadone but, as a rule, are not weaned from it, because withdrawal from methadone seems to be about as difficult as withdrawal from heroin.

It does not follow, though, that we should forget about the use of drugs to curb drugs. Let us develop a better drug, one which would allow weaning. Indeed, such efforts are presently under way; nonaddictive heroin substitutes—cyclazocine and nalaxone—are already being tried. Meanwhile we use methadone.

Many of the startling good results cited above were achieved when methadone was made available under carefully controlled conditions. Recently, as it became more widely disbursed, the amount of abuses reported have been increasing. There is now a black market in methadone, partly a result of the fact that authorities in many parts of the country are still unwilling to provide it to all heroin addicts who wish to use it. Moreover, there has been a significant number of fatalities as a result of overdose—in a few cases as a result of hospital errors, in most because of abuse of methadone on the street. But similar problems appear whenever a program shifts from selective to mass use. When intrauterine devices were tried in a high-quality New York hospital birth-control effort, there were many fewer infections than when they were used in a mass program in India.

What is required in the case of methadone is: (a) For the time being, provide it to all confirmed heroin addicts who wish to use it, other than pregnant women (babies born addicted are reported to go through a severe withdrawal crisis); (b) keep tight control of supplies and dispensation systems to curb a black market which may make it available to nonaddicts; (c) combine the methadone maintenance with other services, from employment counseling to psychotherapy; (d) above all, search for better solutions.

Like a five-percent-effective light bulb, how one views methadone is a question of perspective, what one compares it to. To other methods available? It is vastly superior. In terms of human suffering that is alleviated—both for addicts and victims of crime—it is more than welcome. As an ultimate solution to the problem of heroin addiction, however, or as compared to methods we may have one day, even within the next five years, it is far, very far, indeed, from being perfect, ideal, or even acceptable.

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