

A Mandatory Short-Term Methadone-to-Abstinence Program in New York City

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Abstract

In July 1998, Mayor Rudolph Giuliani of New York City introduced a program requiring the 2100 patients in methadone maintenance programs in selected clinics to terminate their use of methadone within 90 days. Previous short-term methadone-to-abstinence programs in California had generally been unsuccessful. Seven months of debate and controversy ensued. And several new ideas received widespread attention because of the public spotlight on this issue. In January 1999, the Mayor announced that his program had been inadequately conceptualized, was not realistic, and was being withdrawn. The wide attention given the Mayor's new program and its criticism by various authorities had led to a thoughtful examination of the whole methadone maintenance situation, with a reasonable likelihood that the situation would improve.

Key Words: Methadone, methadone maintenance.

A PROGRAM to require accelerated abstinence for methadone maintenance treatment program (MMTP) participants in some New York City clinics in 1998 led to controversy and closer scrutiny of the whole methadone treatment issue. A number of unanticipated policy changes resulted. This article examines previous short-term methadone-to-abstinence (MTA) efforts, the New York City abstinence program, and its consequences for national methadone policy.

Methadone maintenance treatment (MMT) was developed at The Rockefeller University in the 1960s, by Vincent Dole and Marie Nyswander, to deal with heroin addiction (1). They saw methadone as a medication to be used as part of a larger program that included resocialization and vocational preparation. After its approval by federal agencies and its rapid national implementation by President Nixon's Special Action Office for Drug Abuse Prevention

in the 1970s, the pharmacotherapeutic dimension became paramount and the psychosocial context less salient. When it became necessary to cut methadone maintenance budgets over the years, the counseling, job readiness, vocational dimensions and other contexts of treatment were often the first to go, in New York City and elsewhere.

Since MMT was introduced as part of a treatment for long-term metabolic dysfunction, its use was implicitly long-term. In order to satisfy government regulations, it was initially necessary for treatment programs to periodically recertify the patient's need for the medication; now, however, the recertification is no longer necessary. Patients' needs for methadone, up until recently, were assumed to be open-ended.

Studies of Methadone-to-Abstinence Programs

There are no rigorous systematic studies of MTA programs. However, some information has been reported from California, where a number of MMT programs were closed, and

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follow-up data were collected on the patients whose methadone use was terminated involuntarily.

The first experience involving the termination of methadone maintenance services probably occurred in Bakersfield, California in 1976 (2). The only MMTP clinic in the city was closed and 88 of the 99 patients were unable to join another clinic, because of the remoteness of the community. These 88 patients, whose median detoxification period was 13 weeks, were compared with 89 patients then enrolled in the MMT program in Tulare, a similar rural agricultural community 70 miles to the north. Interviews were conducted with both groups two years after the Bakersfield clinic had closed. Sixty-five percent (65%) of both groups were white; 32% of the Bakersfield patients and 35% of the Tulare patients were Chicano. The mean age of both groups was around 31 at the time of the interviews.

By that time, there were clear and statistically significant differences in what had happened to the two groups. Seventy-three percent (73%) of the Bakersfield patients had been arrested, vs. 43% of those from Tulare. Comparable figures for incarceration were 65% vs. 32%. In terms of the daily use of illegal narcotics, the figures were 55% vs. 32%. For abuse of alcohol, the figures were 64% vs. 43%. Two Bakersfield patients had died of overdoses. The authors note that the Bakersfield data would have been more negative but for the high price and poor quality of the heroin available and an especially vigorous law enforcement effort during the two-year period.

Some 27% of the Bakersfield respondents were pleased that they had been able to discontinue both methadone and heroin. However, a number of patients who had been leading stable lives on MMT were thrust back into chaotic lives as street addicts, and there was a substantial net benefit from the provision of methadone maintenance in Tulare.

A similar situation occurred in Alameda County in California in 1984 (3). The county decided to stop funding MMT for persons who had occupied publicly funded slots for two years or more, had the option of being detoxified, or were paying \$160–\$200 per month at a private program. Almost all the patients had a previous history of extensive criminal involvement, and 81% had served jail and/or prison time. About half of the county's MMTP patients were interviewed at six-month intervals over a four-year period. The 143

subjects were placed by the researchers into a typology of three general types of patients:

1. Model patients (6%) are conventional working-class and middle-class men and women, with some education and work experience. Few have criminal backgrounds. Methadone removes the issue of drugs from their lives, and they remain in treatment a relatively short time.
2. Marginal patients (25%) are often members of the "underclass," with little education or work experience. They may arrive intoxicated at the clinic, and their spouses or companions are likely to be substance abusers. They are sometimes homeless and always live a marginal life.
3. Stabilized patients (69%) fall between model and marginal and are likely to have had a long career of using heroin and other drugs. Seeing no other alternative to remaining in the program, they gradually reduced their use of street drugs and their involvement in criminal activities.

The model patients fared best with the two-year rule; most chose to detoxify successfully. Since the marginal patients were least committed to methadone for rehabilitation, they were least affected by the new rule and most opted to detoxify and fully re-enter the heroin world.

Members of the stabilized group were hardest hit, because their income seldom permitted them to pay for treatment. Premature detoxification devastated many and convinced them that a narcotic-free life was impossible. For most of these persons, getting a job, keeping a family together, and rebuilding a life had only been possible because they were on methadone. It can be concluded that the new policy was roughest on the patients for whom methadone did the most good.

It would appear that the Alameda County policy had at least four unanticipated consequences: (1) mistrust that resulted from patients' perception of unfairness in discretionary applications of the policy; (2) damage to the clinician-patient relationship; (3) patient adjustments that were often more expensive than the MMT would have been; and (4) increases in AIDS rates as patients returned to needle use.

The research organization that conducted the Alameda investigation also compared 10

heroin users who detoxified voluntarily with 30 who detoxified involuntarily from their MMTP when funding in the San Francisco Bay area was terminated (4). This three-year study was part of a larger study of injection drug users. Four follow-up interviews were conducted with each subject and revealed that these individuals had great difficulty in paying the \$160–200 per month for treatment, and many experienced severe destabilization in all aspects of their lives, including a return to illegal activities and partial or total abandonment of work or job training, which depended on the wellness achieved by daily methadone ingestion.

None of those who participated in the voluntary detoxification program engaged in illicit activities after they left the program. All the voluntary detoxifiers felt ready to enter an opioid-free lifestyle after the voluntary (and slow) detoxification process. The researchers, after comparing the voluntary and involuntary groups, concluded that forced premature detoxification should not be advocated. The destabilizing effect of such a policy placed heroin users at greater risk for returning to daily drug use, illicit activities, HIV, arrest and incarceration. The researchers saw the defunding as a form of harm maximization and interpreted availability of MMTP as a form of harm reduction.

Twenty-seven women who had experienced defunding from subsidized MMT slots were interviewed over a three-year period in another San Francisco Bay area study (5). Severe demoralization and destabilization of their lives were the most salient results of program loss for the women, although 7% detoxified and remained opiate-free. Most of these women found it was impossible to remain heroin-free, because they could not afford the cost of private payment. Women who held conventional jobs reported that they risked dismissal if they either revealed their MMT status to employers or were absent from work too often because of withdrawal problems.

More than a quarter of the women used Aid to Families of Dependent Children (AFDC) money, intended for their family's basic survival needs, to pay for MMT after being defunded, which resulted in less money for food, clothing, and shelter. Thirteen women returned to stealing, prostitution, and other illegal activities to pay clinic bills; ten were arrested.

While they were in the funded program, most of these women had been focusing on

positive and productive goals for themselves and their families: education, work, training, a healthier lifestyle. Defunding led to participation in illicit activities, financial strains, return to heroin use, health problems, potential loss of custody of children, and other serious hazards.

The New York City Methadone-to-Abstinence Program

Despite the fact that the literature on enforced short-term methadone-to-abstinence programs is so cautionary, in July 1998, Mayor Rudolph Giuliani of New York City announced that the 2,100 methadone patients at five city hospitals would be moved to total abstinence within 90 days of the implementation of a new policy (6). The policy was a reflection of the Mayor's belief that methadone dependence is a substitute for heroin dependence and that it would be much better for the city to encourage methadone patients to take care of their own lives without medication.

Only a relatively small proportion of the 36,000 New York City methadone patients were in the hospitals controlled by the Mayor; the rest were in slots supported by federal and state funds. However, Mayor Giuliani's comments on the evils of MMT were cited by media all over America because of his fame as a very effective crime fighter and the city's pivotal role in the heroin addiction problem.

For the next seven months, the Mayor promoted and defended his policy against objections from health agencies, state and federal officials, government organizations, and researchers. The Mayor's MMT policy reflected his larger goal of removing people from welfare and placing them in jobs; about 10% of the city's welfare recipients could not work because of a substance abuse problem. In August 1998, the city clinics announced that they would henceforth only accept patients who were willing to pursue a goal of abstinence.

Nonetheless, in January 1999 the Mayor abruptly announced that he was abandoning his plan to eliminate methadone programs in city hospitals, because the short period for detoxification had proven to be too jarring and somewhat unrealistic (7). He said that he had revised his thinking on methadone after consultations with various experts. In effect, the city's abstinence goal for methadone patients was abandoned. Only 21 of the 2,100 city patients had given up methadone and five

of them had relapsed to heroin use. The three-month detoxification program had proven unfeasible for the city patients (who had typically been in MMT for an average of nine years). Seventy percent (70%) were not working, and others were mentally ill or also abused other substances.

Discussion

The New York City methadone short-term withdrawal program ended abruptly and unexpectedly. There was little or no reference, in the discussions of the program, to the several California studies summarized above, which overwhelmingly document that mandatory detoxification from MMTP over a short period of time is unproductive and destructive for the majority of people whose treatment is interrupted. Some opponents of the new program tried to prove the wisdom of long-term maintenance by citing well-known studies like that by Ball and Ross (8), who found that 82% of the patients had relapsed to intravenous drug use after having been out of MMT for ten or more months.

During the seven-month period (July 1998 to January 1999) during which the Giuliani plan was being implemented, a number of important statements and studies on methadone were published. Under ordinary circumstances, these materials would probably have received little notice from the general public. But in the heated atmosphere of the time, they tended to get much media attention and public discussion. In September 1998, General Barry McCaffrey, director of the Office of National Drug Control Policy, speaking at the New York City meeting of the American Methadone Treatment Association, expressed the desire to make MMT available nationally to all who sought it and to expand "medical maintenance," so that physicians could write prescriptions for methadone as they would for any other drug (9).

McCaffrey, a four-star general who had been a hero of the Gulf War, and a dignified conservative who had previously been associated with a more hardline approach, became a leading spokesman for methadone maintenance. Although Giuliani used emotionally toned language in denouncing him, the general was very careful and professional in his comments, praised the Mayor's record in fighting crime, and referred to the larger needs of the country and New York City in dealing with the opiate problem. The mass media

implicitly contrasted the message and language of the two men, to the detriment of the Mayor.

In a journal article published in October 1998 (10), Dr. Alan I. Leshner, head of the National Institute on Drug Abuse, set forth the concept of addiction as a chronic, relapsing disease of the brain, for which the social contexts in which it both has developed and is expressed are critically important. He suggested that a reasonable standard for treatment success is managing the illness rather than curing it. In an interview, Leshner observed (11) that "probably the biggest disservice that has been done to getting effective treatment to heroin addicts is the inaccurate statement that methadone is a heroin substitute. . . . We think science should replace ideology on how we deal with treatment in this country."

In December 1998, the statement of an NIH consensus panel on the treatment of opiate addiction was published in *JAMA* (12). The report stated that opioid dependence is a medical disorder rather than a problem of motivation or willpower and most, if not all, MMT patients require continuous treatment over a period of years and perhaps for life. That is, the report stated, why the program is called methadone "maintenance" treatment.

The article by Leshner and the report of the NIH panel appeared in journals that schedule articles for publication months or years in advance, so that their appearing in the midst of the Giuliani policy debate was an extraordinary coincidence. Since the Giuliani policy had generated so much interest, the general's speech and the two scholarly journal reports were treated as major news events by the mass media and led many reporters to interview various authorities to get comments on how these materials contributed to the New York City methadone debate. Nearly all the editorials and authorities cited by the media during the half year of discussion expressed strong opposition to the Giuliani policy. The media summaries and allied comments by others clearly had some impact on the Mayor. In announcing his reversal of his policy, the Mayor said (7), "I listened to the debate I really do listen and read what people say and write." Like most of the developments in the debate over the methadone policy, the news of the Mayor's recantation was carried on the front page of the *New York Times*, the city's most influential newspaper.

The avalanche of publicity helped bring about a more realistic awareness of how

methadone maintenance might be improved, and led to actual program improvements. The half year of rigorous debate over methadone maintenance policy, in which the Mayor was presented by some media as a rigid ideologue who was taking away a major centerpiece of the life of a downtrodden group of people, probably helped to give MMT a much more sympathetic image than it had previously enjoyed. Because MMT is so heavily stigmatized, methadone patients tend to avoid publicity, and there are very few who will identify themselves as such, in contrast to celebrities who are eager to write books and give interviews about their stay at the Betty Ford Clinic, Hazelden, or other publicized residential treatment programs.

It is ironic that Mayor Giuliani was probably responsible for improving the image of, and permitting others to present the genuine merits of, methadone maintenance in a manner that had rarely been possible since the program began 35 years ago. Another unanticipated consequence is the expansion of vocational services for other methadone patients after the Mayor announced that he was providing intensive vocational rehabilitation services for the patients who would be in the short-term withdrawal programs.

The Mayor's announcement helped to call attention to the role of vocational-related training, not only in New York but also in the national approach to methadone treatment. In the first decade following the development of MMT, many patients were helped to become socially productive by programs that included job readiness, and vocational and related kinds of training. Unfortunately, the recession of the 1970s, subsequent changes in the job market, and the growing importance of information technology in the economy led to a substantial decline in the availability of jobs that did not require special training. In the last two decades, persons without such training, who represent a majority of the MMT patient population, have found it increasingly difficult to achieve successful integration into the workforce. Such considerations became significant elements in the discussions and reevaluation of methadone treatment, which followed the Giuliani debate. Subsequently, the

Mayor allocated \$5 million for social services at the methadone clinics. These services would be under the supervision of the Health and Hospital Corporation and include (for the first time) plans for lower patient-to-counselor ratios, and placing patients in different "treatment tracks" according to their needs.

The public reversal of a nationally important politician like Mayor Giuliani, and his willingness to admit that he had made an inappropriate judgment, had extraordinary impact in positively presenting the methadone maintenance modality. The general public and the various professional groups in America were made aware or reminded of the realities of a form of treatment that has so often been misrepresented. Another possible benefit of the debate could be a careful and well-designed prospective study of the outcomes obtained through implementation of the plans described above.

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