

# San Francisco Chronicle

NORTHERN CALIFORNIA'S LARGEST NEWSPAPER

## Another Look at Methadone Maintenance

By Marsha Rosenbaum

**L**AST WEEK, Supervisor Gavin Newsom called for changing federal regulations to endorse private physicians' prescribing of methadone to heroin addicts.

Newsom is right for many reasons. Endorsing private physician prescription and pharmacy dispensation would allow patients stabilized on methadone to leave the clinic setting, thus freeing up slots for addicts closer to the street who may need more supervision initially. Treatment by private physicians would be cheaper, and would allow patients to lead more normal lives.

Citing increased overdose deaths and long waiting lists for treatment, Newsom wants to 'start looking at the problem as a medical one.' It's about time. Today, less than 20 percent of the nation's heroin addicts are enrolled in methadone maintenance, largely because programs are mired in red tape and regulations, or are inaccessible because of cost or location.

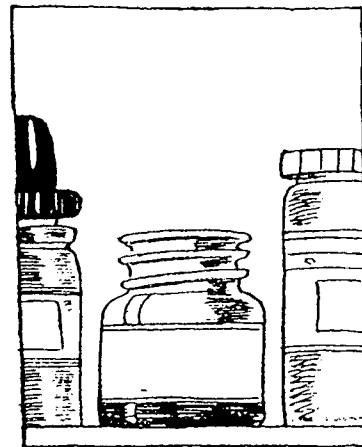
In the late 1960s, after working with heroin addicts, Drs. Vincent Dole and Marie Nyswander argued that addiction

was a physiological disease. Methadone, it was found, could lessen the physical craving for heroin, and its daily use would enable a patient to stop using heroin and become a productive member of society.

According to Dr. Robert Newman of Beth Israel Hospital in New York, the media heralded methadone as a "Cinderella drug" that could be economically applied to hundreds of thousands of addicts, and, in short order, solve the narcotics problem.

Methadone maintenance was and still is defined as a medical solution to addiction, analogous to daily insulin for diabetics. The Nixon administration adopted maintenance treatment as part of its arsenal in the war on crime and drugs. Federally funded researchers produced mounds of data showing that addicts on methadone maintenance treatment were able, some for the first

time, to begin living without hard street drug use and criminal pursuits. Methadone maintenance treatment worked, and the number of patients on it increased rapidly in the early 1970s.



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With methadone's growth, however, came calls to control its distribution. Regulations stipulated that methadone, a synthetic narcotic, could be dispensed only in licensed clinics on specific days and hours; the rules also mandated random supervised urine testing and counseling. Patients found that complying with the program often did not facilitate — but instead interfered — with work, school, and family re-

sponsibilities.

In the 1980s, scientists determined that shared IV needles help spread the AIDS virus. Nonetheless, addicts' access to oral methadone, which can eliminate the need to use needles, was diminished even further during that decade. Rea-

gan's fiscal austerity (toward the poor) meant a 30 percent decline in funding for maintenance programs between 1976 and 1987. "Treatment on demand" became anything but a reality, particularly for those who could not afford to pay clinic fees in excess of \$300 per month.

**J**ust when it is needed most as a treatment to help prevent AIDS, methadone has become almost fully demedicalized and inaccessible. Intravenous drug use has now surpassed unsafe gay sex as the leading cause of new cases of HIV disease. Study after study continues to show that methadone maintenance, because it enables addicts to stop using needles, effectively reduces drug related death, disease and crime.

Newsom was wise to call for expanding methadone treatment through increased medicalization. That is, after all, where it has succeeded.

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**Rosenbaum, Marsha. "Another Look at Methadone Maintenance."  
San Francisco Chronicle [Opinion], January 8, 1998, p.A23.**