Status of Methadone Maintenance Treatment and Research in the United States

Methadone maintenance treatment was established in New York City in 1964 by Drs. Vincent Dole and Marie Nyswander. The original treatment regimen implemented by Drs. Dole and Nyswander with their staff provided comprehensive medical and rehabilitative services to intravenous heroin addicts. Criteria for admission included: 4 years of heroin addiction, a history of prior treatment failure, voluntary desire for treatment, age over 19, primary dependence upon opiates, and absence of psychosis or major medical complications. In the initial studies, addicts were evaluated and stabilized on a daily oral dose of methadone on an inpatient service before transfer to an outpatient clinic for continued treatment. With further experience, it was found feasible to eliminate the inpatient phase of treatment and start with the outpatient clinic.

Outcome studies from these first years of methadone maintenance treatment reported favorable results. There were high rates of patient retention, reduced criminality, and improved social rehabilitation. These early programs, then, were found to be effective in rehabilitating intravenous heroin addicts who remained in outpatient treatment on a long-term basis. In this regard, it should be noted that the treatment staff in these first clinics were highly qualified and, in particular, that a high standard of medical treatment and supervision was provided.

During the 1970s methadone maintenance treatment was greatly expanded in New York City and established in large cities throughout much of the United States. As this expansion occurred, a number of programmatic changes took place. One change of pervasive significance was that federal, state, and local governments became involved in the operation of the new or expanded clinics. Thus in 1972 the Food and Drug Administration promulgated regulations which specified the types and amount of treatment services to be provided. * At the same time, state or local juris-

* By 1980 there were 12 pages of regulations pertaining to mandated services at methadone programs (Federal Register, September 19, 1980, pp 1–12).
dictions established bureaucracies to administer, fund, and audit these treatment facilities. As a consequence of this expansion, methadone maintenance changed from a medically supervised treatment for a designated population of heroin addicts to a more diversified form of treatment and rehabilitation provided to unselected addict patients. The extent of change that occurred from the Dole-Nyswander methadone maintenance model varied by locale, city, state, and other considerations. In this last regard, methadone maintenance programs were also established by the federal government, e.g., at Veterans Administration hospitals.

One consequence of this expansion and change of auspices (from medical to governmental) was that variation among the programs developed. They differed in the number of patients treated (from a few dozen to almost a thousand in one clinic); the qualifications of the director (social worker, ex-addict, physician, administrator); type and qualifications of staff; the amount and type of counseling and medical services provided; methadone dose commonly prescribed (from less than 30 mg to over 100 mg); and policies about urine testing, take-home methadone, and many other aspects of treatment. By the end of the 1970s, methadone maintenance was far from being a uniform entity. This change, as is discussed later, had both advantages and disadvantages.

By the 1980s, the great expansion of methadone maintenance treatment had ceased. No new treatment facilities were opened in New York City during a 10-year period. There was some expansion or contraction of treatment programs in other cities or states, but it was primarily of local significance.

The 1980s were, then, a period of stability or retrenchment for methadone maintenance treatment in the United States. Although the programs that developed from the Dole-Nyswander model were generally underfunded, during the 1980s even this level of financial support was reduced. As a consequence, programs were forced to curtail treatment and rehabilitative services, staff turnover was high, and the quality of care declined. At the same time, many programs were beset with community opposition, lack of administrative support, and general public apathy or hostility. Despite these considerations, methadone maintenance treatment endured.

Current Status of Methadone Maintenance Treatment

As of January 1, 1989 there were 667 methadone maintenance programs in the United States, with a census of approximately 80,000 addicts. Most of these programs are located in large cities, with the highest concentration of heroin addicts and methadone maintenance clinics in East Coast cities. For example, there are 35,000 patients in New York State methadone programs, and most of these are residents of New York City.