An exploratory study of heroin addicts' perceptions of methadone treatment

Sandra Ellen Nehring

Follow this and additional works at: https://scholarworks.lib.csusb.edu/etd-project

Part of the Social Work Commons, and the Substance Abuse and Addiction Commons

Recommended Citation
https://scholarworks.lib.csusb.edu/etd-project/1237

This Project is brought to you for free and open access by the John M. Pfau Library at CSUSB ScholarWorks. It has been accepted for inclusion in Theses Digitization Project by an authorized administrator of CSUSB ScholarWorks. For more information, please contact scholarworks@csusb.edu.
AN EXPLORATORY STUDY OF HEROIN ADDICTS' PERCEPTIONS OF METHADONE TREATMENT

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Sandra Ellen Nehring
June 1996
AN EXPLORATORY STUDY OF HEROIN ADDICTS’
PERCEPTIONS OF METHADONE TREATMENT

A Project
Presented to the
Faculty of
California State University,
San Bernardino

by
Sandra Ellen Nehring
June 1996

Approved by:
Marjorie Hunt, PhD., Project Advisor, Social Work
Teresa Morris, PhD., Chair of Research Sequence
Stacy Blackstone, Program Director, Cedar House
ABSTRACT

Methadone treatment continues to be the most widely used treatment modality for heroin addiction despite continued controversy. The efficacy of methadone treatment has been determined primarily by statistical research of program outcomes. This study explored heroin addicts' perceptions of methadone treatment. Twenty heroin addicts with six to thirty-seven years of heroin addiction were interviewed about their experiences in methadone detoxification, and methadone maintenance programs. Strauss and Corbin's grounded theory approach for analyzing qualitative data was utilized within the framework of the post-positivist paradigm. Results revealed that methadone treatment did not meet many of the addicts' expectations, did not cure their addiction, and was considered by most to be more highly addictive and more dangerous than heroin.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>PROBLEM STATEMENT</td>
<td>2</td>
</tr>
<tr>
<td>PROBLEM FOCUS</td>
<td>8</td>
</tr>
<tr>
<td>RESEARCH DESIGN AND METHOD</td>
<td>9</td>
</tr>
<tr>
<td>SAMPLING</td>
<td>10</td>
</tr>
<tr>
<td>DATA COLLECTION</td>
<td>10</td>
</tr>
<tr>
<td>PROTECTION OF HUMAN SUBJECTS</td>
<td>11</td>
</tr>
<tr>
<td>DATA ANALYSIS</td>
<td>12</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>20</td>
</tr>
<tr>
<td>APPENDIX A</td>
<td>24</td>
</tr>
<tr>
<td>APPENDIX B</td>
<td>26</td>
</tr>
<tr>
<td>APPENDIX C</td>
<td>27</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>28</td>
</tr>
</tbody>
</table>
AN EXPLORATORY STUDY OF HEROIN ADDICTS' PERCEPTIONS OF METHADONE TREATMENT

Introduction:

The purpose of this study was to explore heroin addicts' perceptions of methadone treatment. The addicts' perceptions have not been given much consideration in prior studies of methadone programs. Programs have been evaluated on retention rates, reduced criminality, and social rehabilitation (Ball & Ross, 1991). Theories of addiction, and characteristics of an addictive personality have been hypothesized. Heroin addicts have been studied in regard to their: severity of addiction, their criminal behavior, their program attendance, their program completion, their program drop-out rate, their employment rates etc. Although their thoughts and feelings may not be totally discounted, they have not received the attention they deserve.

Self-report is not generally given the respect in the scientific community that statistical data is because it is thought to be too subjective. An article that reports findings that heroin addicts have an ambivalence toward methadone treatment attributes this to the personal...
heuristics that drug users draw on when making treatment decisions. The article states further that: "It is known from studies of the general population that people are quite poor at judgement and decision making under conditions of uncertainty" (Rosenblum, Magura, & Joseph, 1991). This inference is drawn from a book called "Acceptable Risk" by Fischhoff. It asks questions about how adequate people's cognitive skills are for assessing the information they receive. It states that research suggests that these skills are far from perfect. Further:

People seem to lack the intuitions and cognitive capacity for dealing with complex, probabilistic problems. As a result, they resort to rules of thumb that allow them to reduce such problems to simpler and more familiar terms. On the bright side, these strategies are quite adaptive in the sense that they always produce some answer and that answer is often moderately accurate. (Fischhoff, Lichtenstein, Slovic, Derby, & Keeney, 1983, p. 28)

However imperfect human thought processes may or may not be, who has more right to determine the effectiveness, or the acceptable or unacceptable risk of a treatment than the consumer of that service.

Problem Statement:

Heroin use has been a societal problem for centuries. How to "cure" heroin addiction is a matter of concern to our society because of the social costs that addiction incurs.
The cost of addiction is high for the addict, and in turn to society. Unless the addict has special skills or talents, or is rich, he will inevitably run out money, or exhaust all legal means of support. The majority of heroin addicts do not have high paying jobs, and are not rich. Many have insufficient educations, as well as other disadvantages that result from lives of poverty, and racial discrimination. They lack opportunities for meaningful, well paid, legitimate work. These problems, compounded by drug abuse prevent addicts from getting or keeping jobs. Although they may really intend to work, severe and protracted withdrawal sickness will cause them to abandon work to seek out the needed drug. Other means of supporting their habit must be found. These "other means" frequently tend to be illegal. Drug seeking becomes an all consuming occupation (Waldorf, 1973).

What may have begun with curiosity, and seemed to be a panacea for some problem becomes a "monkey on the addict's back." Addicts have reported that:

It gave me peace of mind. I could get away from reality and forget my complexes. Straight, I felt I couldn't relate to people, and when I used drugs (Heroin) I could communicate better.

I liked getting high. It was a good feeling. Heroin made me feel secure. I really felt protected. When I was high nothing could hurt me.

Heroin makes you forget about your problems; makes you feel you know everything. You feel
strong and healthy, not weak. You can work. (Waldorf, 1973, p. 37)

For the addict, heroin use becomes a way of life. What started out as a "mellow high" leads to a constant "rat-race" to get enough drug to "stay well." Instead of "fixing" to get high, the addict must fix to get well. Without the fix the addict becomes violently ill with withdrawal symptoms (Waldorf, 1973).

According to John Casey and Edward Preble's study, "Narcotic Addiction and Crime: Social Costs and Forced Transfers," addicts commit a variety of crimes to get the money they need. Typical crimes committed are shoplifting, burglary, armed robbery, hustling, prostitution, pimping, and drug dealing. Besides the criminal aspects of addiction, there are other social costs. There are the losses of the economic productivity of heroin addicts, as well as the costs to society of treatment, rehabilitation, and social welfare payments (Winick, 1974).

At the societal level heroin addiction is costly, but where the costs are the most devastating are at the personal level of the heroin addict. There are a number of hazards that are associated with heroin use. Injection of the drug may lead to contracting hepatitis or AIDS. Death may result from an overdose. There may be an overall disregard for physical health because of the focused drug seeking behavior. The addict must risk possible arrest and
incarceration for many of the activities he engages in to obtain money for the heroin (Waldorf, 1973).

Because of the costs, heroin addicts at some time in the career of their addiction may decide to "kick the habit." When an addict's tolerance develops to the extent that it is difficult to get high or to maintain him or herself without suffering withdrawal sickness, he or she may attempt withdrawal. Detoxification can be attempted on the streets using dolophines (a form of methadone), barbituates, or tranquilizers. When the addict can get into a detoxification facility he or she may take advantage of that opportunity (Waldorf, 1973).

There may be other, or additional, reasons an addict will enter a detoxification or a rehabilitation program. The addict may be experiencing other types of pressure from his or her environment. The addict may be motivated to get treatment by someone in authority. The addict may seek treatment because of a real or imagined threat from the police or the street. The addict pusher or dealer may enter treatment to avoid arrest (Waldorf, 1973).

Whatever the motivation to seek treatment is, the addict does not have a wide array of treatment possibilities. The most common form of treatment, and the subject of this study, is the use of methadone, a synthetic narcotic that is reputed to inhibit the "drug hunger"
experienced by heroin addicts, and in appropriate dosage is reported to block the euphoric effects of heroin. It was originally tested at Manhattan General Hospital, and Rockefeller University in 1963 by Dr. Vincent Dole and Dr. Marie Nyswander. They wanted to determine if it was possible to rehabilitate chronic heroin users by substituting a legal narcotic for heroin, thus eliminating the need for addicts to steal large sums of money to support an illicit habit (Brill, and Lieberman, 1969).

According to Edward Senay, M.D. and Pierre Renault, M.D. in "Treatment Methods for Heroin Addicts: A Review," evaluations of Dole and Nyswander's work confirm the essential findings that methadone combined with a rehabilitation program can be effective in helping addicts:

1. To abolish or decrease greatly the use of narcotics.
2. To work at a legitimate job.
3. To abolish or decrease greatly the need for engaging in criminal behavior.
4. To relate to spouse and children in more desirable ways.
5. To experience a real increase in self esteem in which they are held by other people. (Smith, and Gay, 1972, pp. 149-150)

On the other hand a book comprised of anecdotal data from a heroin lifestyle study (HLS) questions methadone treatment. The HLS subjects voiced four principal objections to methadone maintenance:

1. Methadone maintenance is just another drug habit, perhaps even more addicting than heroin.
2. Methadone has serious physiological side effects.
3. Methadone programs are ineffective; clients continue to use drugs, including heroin.
4. Methadone maintenance programs are inadequate in meeting the real needs of people. (Hanson, Beschner, Walters, & Bovelle, 1985. p. 160)

This source states that methadone is a powerful narcotic with qualitative and quantitative effects similar to those of morphine and heroin. Methadone supplied in clinics is generally more potent than street heroin (Bellis, 1975). As a result methadone clients become more physically addicted to methadone, and their withdrawal is more severe (Hanson, Beschner, Walters, & Bovelle, 1985).

During the late 1960's and early 1970's methadone detoxification was more common than maintenance. A study at that time found a connection between methadone detoxification and severe pains in the bones. The study concluded that a too-rapid detoxification results in severe pains in the bones (Kreek, 1978).

Research also confirmed that methadone clients use the drug as "a cheap way to get high." Further some street addicts even prefer the euphoric effects of methadone over the effects of heroin (Hunt, Lipton, Douglas, Goldsmith, Douglas, & Strug, 1982).

The authors conclude by stating that the HLS subjects' perceptions of methadone maintenance raise several important issues:
What is the purpose of methadone maintenance? If the purpose is simply to reduce addiction to heroin, it may succeed. If the purpose is to reduce addiction, per se, it will not succeed. If the purpose is to render heroin users socially harmless by dispensing opiate-like drugs to them at little or no cost and keeping them off the street, methadone maintenance may benefit society. But does it really benefit the heroin user? Is it not hypocritical to treat heroin users with different, but highly potent, opiates to solve society's problems, while failing to provide significant resources to help the heroin users solve their problems? (Hanson, Beschner, Walters, & Bovelle, 1985. p.169)

**Problem Focus:**

Methadone treatment has been mainly studied with regard to outcomes. However rigorous controlled studies with statistical data may be they cannot recreate the reality of human thought and experience. The concentration on objective data and statistics leaves a lot unexplained. No matter how much we try, most of the nuances of human behavior lie beyond traditional methods of scientific study. Rather than rely solely on statistics this study examines the statements of heroin addicts to capture the essence, or flavor of their experiences.

The Post-Positivist paradigm seems the most appropriate framework in which to examine qualitative data, such as the heroin addicts' perceptions of methadone treatment. Using the "grounded theory" approach, theory building proceeds inductively by studying particular phenomena. One does not begin with a theory and then prove it. Instead, the researcher begins with an area of study
or problem focus, and what is relevant is allowed to emerge. With a set hypothesis a researcher might be forced to disregard much relevant data because it doesn't fit the hypothesis (Strauss and Corbin, 1990).

Social work is impacted by issues of drug abuse and its' treatment in virtually all areas of practice. Making the appropriate interventions to help clients depends on an updated, accurate knowledge of the efficacy of different treatment modalities. An exploratory study of methadone treatment offers to expand the knowledge base available to social workers to help make sound decisions regarding their interventions.

**Research Design And Method:**

This research project is an exploratory Post-Positivist study of heroin addicts perceptions of methadone treatment. The Post-Positivist "grounded theory" approach allows the researcher to look at and consider data without the constraint of a hypothesis. The purpose is to explore and describe phenomena not to prove a hypothesis. The phenomena that was explored here was statements made by heroin addicts during interviews.

In the discovery mode the researcher attempted to maintain an open mind as the phenomena was considered. Concepts emerged as the data was analyzed (Strauss and Corbin, 1990). Common themes presented themselves. The
goal was to gain insight into the experiences of heroin addicts with methadone treatment (Strauss and Corbin, 1990).

**Sampling:**

This research project was accomplished using a discriminate sampling of subjects. By this is meant that the subjects had to be heroin addicts who had participated in methadone treatment. Most of the subjects were clients in a drug and alcohol treatment facility. Several were peer counselors employed at the same facility. Several were referred to be interviewed by friends of the researcher. Several methadone treatment programs, one private and one public, refused to grant permission for their clients to be interviewed.

The willingness and eagerness of the majority of the subjects to share their thoughts and experiences was impressive. Several stated that they felt so strongly about the topic that they welcomed the opportunity to express their feelings.

**Data Collection:**

Data was collected through personal interviews with heroin addicts, who had participated in one or more methadone treatment programs. Many had been in both 21 day detoxification programs, and methadone maintenance
programs. Some had experiences in only one of the
treatment modalities.

An interview guide of twenty-seven questions provided
the basic structure for the interviews. (see Appendix A)
The questions were a guide only. The researcher took the
liberty to follow leads or probe more deeply when
necessary. All interviews were taped, and transcribed
verbatim at a later date.

Protection of Human Subjects:

Prior to the interviews the purpose of the study was
explained to the participants. An informed consent form
was reviewed with each participant. (see Appendix B) The
interviewer signed it indicating its completion, and
assigned an identification number.

In order to guarantee absolute confidentiality,
participants were not asked their names, nor were they
asked to sign anything. The assigned numbers identified
the informed consent forms, the tapes, and the
transcriptions of the taped interviews. This was necessary
to reassure, and protect the anonymity of the subjects. It
contributed to the candor of the participants because
disclosure was risk free. At the conclusion of each
interview the subject was given a debriefing statement.
(see Appendix C)
Data Analysis:

Twenty heroin addicts, or former heroin addicts were interviewed for this study. Thirteen (65%) were male, and seven (35%) were female. Thirteen (65%) were white, five (25%) were hispanic, and two (10%) were black. The youngest person interviewed was 30 years old, and the oldest was 64. The average age was 40.6. The youngest age that heroin was first tried was 11 years, and the average age of introduction was 17.4 years of age. The minimum number of years that interviewees had been addicted to heroin was 6 years, the maximum number of years addicted was 37 years, and the average number of years of addiction was 17.1 years.

Upon completion of all interviews the responses were analyzed according to the guidelines of the grounded theory approach described in "Basics of Qualitative Research" by Anselm Strauss, and Juliet Corbin (1990). This theory is often referred to as, "the constant comparative method of analysis" (Glaser & Strauss, 1967, pp. 101-116).

Data was coded using processes that pertain to making comparisons, and asking questions. The goals of this method is to conceptualize and categorize the data through open coding. Open coding is a process of breaking data into discrete parts so that it can be compared to determine similarities or differences. Data can be grouped according
to similarities, and concepts can be developed to describe
the phenomena.

Five questions were selected for the final analysis.
The questions were:

What was your reason for trying methadone?
What did you expect from methadone treatment?
Did methadone keep you from wanting a fix?
Do you feel like methadone helps? If so, in what way?
What criticisms do you have of methadone treatment?

There were six general categories of responses for the
question: What was your reason for trying methadone?
Seven participants stated simply that they wanted to kick
the habit. A couple of people wanted a lifestyle change.

I had begun to live a lifestyle that I refused to
live. That was one of my own boundaries. In
other words I was in the street dealing with
people I didn't want to deal with. Methadone
helped me pull out of that life, and begin
building another.

Some addicts feared the withdrawal sickness. Their
responses fell into the category: to prevent withdrawal.

I was aware that it was a legal way to maintain
without having to go through withdrawal. I knew
that methadone would keep me from getting that
ill. I was terrified of the comedown from the
heroin.

A couple of the participants stated they needed a rest
from the drug lifestyle. These responses were categorized
as respite.
After I realized, in my opinion, that it was a no win situation it was more or less like a vacation. My arms would get real bad and my legs would get real bad, and I would get tired of poking myself. It was more like a break.

The next category that was formed was one called external motivation. In this category were reasons for entering methadone treatment that were external to the heroin addict such as:

I was with somebody, and I tried for their benefit, not my own. I didn't care. I cared for them caring about me. I went along with the program for their benefit. I wanted to be with this person, and she wanted me off heroin.

The final category that emerged was the legal high. A number of participants stated that methadone was a cheap, legal way to get high.

I went to the clinic, tested dirty to get into the program so I could get high. The methadone was getting me loaded, and the heroin wasn't, so I'd rather be on methadone so I could get high.

On the question about the heroin addicts' expectations of methadone treatment most of the above categories emerged. This is not surprising because of the similarity, and the close relationship of the two questions. External motivation did not come up as a category. Motivation is not relevant with regard to addicts' expectations of methadone treatment. To kick the habit was phrased more as being weaned off heroin. Two more related categories were formed from these responses. The subjects expected
methadone to be a drug substitute, and/or to kill the craving for heroin.

To the question: "Did methadone keep you from wanting a fix?", most of the participants answered "no", or gave a qualified "yes". The qualified yes answers were placed in three categories:

- **Time limited** - "Yes, for awhile."
- **High enough dosage** - "Yes, when the dose was high."
- **Maybe** - "Yes, the first time. I didn't want to use, so I drank."

The next question that was considered was: "Did methadone help you? If so, in what way?" Almost half the subjects answered "no." Out of the affirmative answers three categories emerged:

- **Helped kick the habit** - "Yes, it helps to mellow it out somewhat, so in a sense it helped me to kick."
- **Made me more functional** - "Yes. It made me more functional. Even though I used heroin while on methadone, I believe I would have used more without it."
- **Prevented heroin withdrawal** - "Yes. It kept me from getting sick."

The question that generated the greatest response was: "What criticisms do you have of methadone treatment?" The responses fit into five general categories. Methadone is considered to be: a drug substitute, a legal high, more highly addictive than heroin, and to have serious side effects, as well as having a harder withdrawal than heroin. Many of the responses had components from several categories, and some subjects included most of the
categories. The following is a sampling from some of the participants' answers:

**I know people who have been on methadone for five years. It's an addiction, but a legal one. If they get off of it they're going to go for heroin . . . I've been a heroin addict for a lot of years. When I was shooting drugs, oh yeah, it was just another drug to me, but now I'm a recovering addict, I see the things that shouldn't be. I wouldn't see it when I was out there. I'm a dope fiend. I would say, "Hey yeah, let's go get on methadone", but I never realized what it's doing to people until I sit back in here, and see on the outside now. All it's doing is killing people. I would never take it again. It keeps you loaded. That's all.

**Methadone is better than heroin, to tell the truth.

**That it's addictive. Withdrawals are worse. It's just one drug replacing another.

**It was supposed to level you off, but it's a high in itself. To me it's a high. To me it's a substitute . . . You'll go through the same things as you do with heroin . . . Kicking methadone is more prolonged than heroin.

**I have come to know there are lot of side effects. People get bone diseases. There's this huge lack of motivation. Methadone steals motivation. If anything it's more of a cunning, sick disease, because we justify it easily, because it's legal, but it's still running our lives.

The stories of methadone withdrawal were so vivid, and compelling, that six stories are recounted almost in their entirety:

***You're just replacing an illegal drug with a legal drug. The legal drug is three times more dangerous. Because when I did kick it, it was 49 days before I could sleep through the night. The last time I kicked heroin, which was the hardest
run I've ever been on, it took 14 days to be able to sleep through the night. Heroin withdrawal is not as intense. With heroin it's three to five days of hell, and it's over. With methadone your bones literally hurt. You can't stand it, you want to scream. My hair fell out in clumps. I lost a lot of weight while kicking. I couldn't eat. I had no appetite. . . . My emotions were on my shirt sleeves . . . over the 49 days I could progressively sleep a little longer. I used to sit up with this correctional officer, and she used to say, "My God, child. Don't you ever get on that ___ again. I can't believe that it's doing this to you."

***I cold turkeyed from methadone. I'd rather withdraw from heroin. I wanted to kill myself, it was so miserable. Your bones hurt so bad, you just want to lay there, and cry. People can rub your back, or your legs when you're hurting, and it doesn't help. I didn't sleep for 45 days. I kicked 45 mg. cold turkey. I went to the doctor, and he gave me some medication, and I slept for five days solid.

***I had detoxed from seven years of methadone. It was so bad, even though they detoxed me slow. The kick was so bad I started drinking a lot, doing cocaine so I could drink some more. . . . Methadone withdrawal lasts forever. You can have a two month period, and you think you're alright. Then you wake up, and you feel like _. You wake up with night sweats, your joints ache, and you feel like you're back where you were two weeks after detox. For six months, I felt I had to do something about the sick feeling. . . . These guys are talking about leaving this program, and going to a methadone program. I tell them that unless they're real serious about being habitual, and not being able to kick it by themselves, even a 21 day detox on methadone is a real hard thing. From personal experience I tell them to kick the heroin for five days, you'll be on your feet, because you have no idea what kicking methadone is like. It's 100 times worse. I believe it's intracellular. You can't get it out of you. I've always been real healthy, and exercised. It's just a real hard kick. My brother has been on methadone for 18 years, and has liver failure, but he can't get off it.
***I'd like to emphasize the withdrawal. I went through a lot, to the point of having a nervous breakdown. I had to detox cold turkey in jail. They brought a few doses to the county jail, and then I was shipped out to prison, and they don't give you any there. Intense pain for 15 days, which is twice as long as heroin. The lack of sleep. I slept one or two hours a night, and I had a breakdown from that. I ended up in the mental ward at C.I.W. Came off in January, had a nervous breakdown in May, had withdrawal symptoms after five months, anxiety attacks, out of touch with reality, a real psychological. Lost a lot of weight on methadone. Weighed 90 pounds when I went to prison. No appetite from withdrawal. I was real bad mentally, to the point they thought I was a threat to myself, or to someone else. . . . I get leg twitches even now, five years later. The withdrawal from methadone was much, much, worse, ten times worse than with heroin.

***I was on 90 mg. of methadone, and I tested dirty. Since I was on parole, my parole officer sent me to Chino for a 90 day dry out. They detoxed me in the county jail for 21 days, but they didn't bring it on weekends, so I went through hell a few weekends. They tapered me down in 21 days to 5 mg. Then they sent me to Chino. When I got off the bus I went down. They picked me up in a stretcher, and put me in the infirmary for three days. They gave me pills so I could sleep at first. When they put me in the main population, I didn't sleep for ten days. I counted the days. I'm talking nothing, no sleep. I know people who have been worse, but that was the worse one I ever had. I had the runs so bad I could hardly walk. Six days I had the runs. It was 45 days before I felt normal. . . . That's worse than heroin kicking. I'll never forget that. That's three times as bad as a heroin habit. . . . My lady tells me to get on the methadone. I tell her, you don't know what that is. Don't ever ask me to get back on that.

***Let me tell you a story first. In the twenties and thirties there were morphine addicts, and they had a big problem with morphine addicts throughout the twenties and thirties. In 1934 this German derived an opiate from the poppy called heroin. Heroin was used to withdraw morphine addicts. Morphine addicts discovered
heroin was just as good, or better than morphine, and it was a lot cheaper.

Now the same process is happening again. They came out with this drug called methadone to get heroin addicts off of heroin. Heroin addicts found out, man in the long run it's cheaper, and I can get just as much of a nod out of it. It's the exact thing that happened before. It took a narcotic to contain a narcotic. I was one of the first in San Diego that was placed on methadone maintenance. That was in 1969 when it came out. They gave it out at the hospital, but at the time they didn't know what they were doing. They would give you 160 mg., and scratch their heads and wonder why no one came back for three days. They didn't know how to administrate it. It was brand new. So what they did was, the federal government paid for the whole west wing of the county hospital, and if you wanted to be on methadone, you had to be placed on this wing. That's how they learned how to dose people back then.

Well, I stayed on it. I was on 80 mg. for six years. In that six years it worked, but it was just another legal drug. It was the same as heroin was for morphine addicts. At the end of that six years, I went to prison, so I had to kick. They detoxed me in fifteen days after six years at 80 mg. That's like jumping off a bridge. The difference between heroin and methadone is when you kick heroin it comes out of your bloodstream. Methadone's base home is in your bone marrow. It seeps down into your bone marrow, and when you kick, that's the reason it's so intense, so long, and so hard. It has to come out of your bone marrow first, then out of your system. I was in the penitentiary for probably a year and a half before I was physically clean of the methadone.

The methadone nearly took my life. Three months after I stopped using, my stomach collapsed on me. A day and one half out of the infirmary my right lung collapsed on me. All behind my methadone usage. I'm very anti-methadone maintenance, but I am totally for the 21 day detox. I think it helps a person detox, but as far as maintenance, it's just a legal way to use drugs, like in London where you go to the hospital, and get a shot of heroin. Withdrawing from methadone is three times as bad as heroin. The reason is it goes into the
bone marrow. That's why it's such a long lasting drug. Heroin will last 5-8 hours. Methadone lasts you 24-36 hours. It's really a dangerous drug. You've got people on it, and even though I'm shooting dope I ask my friends a lot, "What're you going to do man. You've been on it for ten or eleven years. What if the federal government pulls out on you? What are you going to do?" And the government is pulling out of programs every day. Every day. The clinics, when I started, would run out of methadone. We had to wait in line for several hours while they would run up to Oceanside. The programs can shut down. . . .

I don't have to be spanked twice. I have gone on 21 day detox. I've done that several times. You're not on it long enough to get strung out on it. . . . They're paying $200 a month for methadone maintenance. You could't pay me $200 to get on it.

Discussion:

Heroin addicts' motivation to enter a methadone treatment program seems to coincide logically with what they expect methadone will do for them. Typically the expectations evolved out of rumors or hearsay that circulate through "the grapevine" regarding common methadone propaganda, or from other addicts' perceptions of, or experiences with methadone treatment.

The addict may want to kick the habit, and expect methadone will wean him or her off of heroin by either successfully substituting for heroin, or by killing the craving for heroin. Some addicts don't want to leave heroin alone permanently, but instead want a rest from the constant hustling, or other aspects of the heroin lifestyle they may find negative. For them methadone provides a
respite, and a cheap, or free, legal high. Others find the heroin withdrawal so aversive that they are willing to try anything to avoid it. Ironically they find out too late that methadone is even harder to withdraw from than the heroin.

All of the people interviewed agreed that methadone was more addictive, and harder to withdraw from than heroin. Thus it would seem logical that methadone could keep addicts from wanting a heroin "fix". Surprisingly enough most said it did not. Those that said methadone kept them from craving heroin stated it did so only at high enough doses, or only for a limited amount of time. Several credited other factors coupled with the methadone for conquering the craving. These factors included internal motivations, such as state of mind, and external motivations, such as other drugs or alcohol.

Half of the participants in this study did not believe that methadone helped them at all. Of those that thought methadone was helpful to them, at least one of their expectations of treatment was met. However, for many that expectation was only partially met, and all expectations were not met for any of the interviewees. This could mean that their expectations were unrealistic, or it could mean that methadone treatment is simply not designed to address the needs of the heroin addict in stopping drug abuse, in
curing drug addiction, or in learning how to lead a satisfying and productive life. Instead many of the addicts' responses seem to confirm that methadone treatment is drug substitution, and a legal high.

Some addicts want a substitute drug, and some want a legal high, but most really want to cure their addiction, and escape a self-destructive lifestyle. Methadone treatment, as experienced by the participants of this study did very little to help addicts make the changes in their thinking, or in their way of life that could help them stop using heroin.

Finally in the question that addressed criticisms of methadone treatment the interviewees spoke very eloquently, and dramatically of the most damning aspect of methadone treatment, the withdrawal. The majority had such horrible experiences of withdrawal from methadone that they would never enter another methadone treatment program. In fact it seemed imperative for them to warn other addicts, to spare them the same suffering. These warnings came from people who have all experienced the perils of heroin addiction, and heroin withdrawal, yet continue to take these risks.

Some addicts stated that they believed that detoxing from heroin with methadone worked, because program participants were able to avoid withdrawal from the heroin,
but were not on methadone long enough to get "strung out" on it. This suggests that with thoughtful planning, and program development methadone detoxification treatment could be effective. Perhaps the methadone detoxification in conjunction with other rehabilitative services, or in combination with other drug treatment programs could achieve more success than current methadone treatment programs.

However, for the most part the heroin addicts interviewed felt that methadone treatment was not an acceptable risk. Their concerns point out the need for further research to find a safer, more efficient means for heroin detoxification, as well as the development of more effective rehabilitation programs.
APPENDIX A

Interview Questions:

1. How old were you when you first tried heroin?
2. Describe your first experience with heroin?
3. How many years have you used heroin?
4. Do you consider yourself addicted?
5. How often do you "fix"?
6. What is the cost of the heroin you use per day?
7. How do you get the money to pay for your heroin?
8. Have you ever been arrested for possession or use of heroin?
9. Have you been arrested for anything associated with your heroin use? If so, what?
10. What other drugs do you use, and why?
11. Have you ever tried to "kick the Habit"?
12. What have you tried to stop using?
13. What does withdrawal sickness feel like?
15. What did you expect from methadone treatment? Were your expectations met? Explain.
16. What had you heard about methadone?
17. What was your reason for trying methadone?
18. What do you feel like after taking methadone? Describe the feeling.
19. Did methadone keep you from wanting a fix?
20. Did you use heroin while using methadone?
21. Was the high from heroin as good after taking methadone?

22. Do you feel like methadone helped you? If so, in what way did methadone help you?

23. What criticisms do you have of methadone treatment?

24. What was good about the methadone treatment you received?

25. What services were offered to you in the methadone treatment program?

26. What services would you have liked that weren't offered?

27. What suggestions would you make to improve methadone treatment programs?
APPENDIX B

INFORMED CONSENT

The study in which you are being asked to participate is designed to investigate heroin addicts' perceptions of methadone treatment. It is exploratory only in nature and involves no manipulation of the individuals who participate.

You will be asked a series of questions. Your participation is completely voluntary. If you do not wish to answer, that is your prerogative. However, you can be assured that your identity will be confidential, and that your answers will be identified with a code and not your name. If you give permission your interview will be recorded on an audio tape. These will be identified with a code, and only used by this researcher to ensure accuracy on the written report.

The data collected will be used in a research project which will be printed, and kept by the researcher and Cal. State University, San Bernardino. At the conclusion of this study you may have a copy of the results upon request.

Since your participation is completely voluntary you may withdraw from the study, or request that your information be removed from the study. The researcher has no connection whatsoever with law enforcement, or any other authorities. Your privacy and the confidentiality of what you say will be protected.

Researcher Signature ___________________________ Date ___________________________

Researcher acknowledges with this signature that participant _______ has been informed of, and understands ID Code

the nature and purpose of this study, and freely consents to participate.
APPENDIX C

DEBRIEFING STATEMENT

Thank you for your participation in this research project. I do not foresee any potential harm to you that can result from your participation. Complete confidentiality is guaranteed. Your contribution is very much appreciated.

It is my hope that the information gathered through the questions will prove helpful to professionals working in the field of chemical dependency treatment. I also hope it was beneficial to you to be able to express your thoughts and feelings on this controversial subject.

If you have any questions or concerns regarding this project, please contact:

Researcher: Sandra Nehring, M.S.W. Intern
Pager (909) 608-3695

Faculty Advisor: Dr. Marge Hunt
Calif. State Univ. San Bdno.
(909) 880-5501
REFERENCES


