# Methadone--Fighting Fire With Fire

By GERTRUDE SAMUELS

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**PIONEERING PHYSICIANS**—Drs. Vincent P. Dole and Marie Nyswander, the husband-and-wife team that developed the Methadone Maintenance Research Program, in their laboratory at Rockefeller University. The program has recently been accredited by the state Narcotic Addiction Control Commission.

**MORE TREATMENT THAN TREAT**—A former heroin addict swallows his daily dosage of methadone in ersatz orange juice at an outpatient clinic in Harlem. As long as he takes his medicine, he will be impervious to heroin's narcotic effects. Some critics compare the treatment to switching an alcoholic from Scotch to bourbon.

**A report on a program that uses an addictive drug to combat drug addiction—specifically addiction to heroin—and how it works.**

FOR the past three years, two New York City doctors—the husband-and-wife team of Vincent P. Dole and Marie Nyswander—have pioneered a dramatic and controversial program to combat heroin addiction. They are, in a way, fighting fire with fire, using the addictive drug methadone to treat heroin addicts. At this writing, 540 addicts are off heroin and on a daily "maintenance dosage" of methadone, mixed in a cup of ersatz orange juice to mask its slightly bitter taste. As long as they remain on this dosage, they are able to remain free of the heroin habit that led them into crime, prostitution or prison; they are learning to lead normal lives again.

The doctors believe that they are demonstrating a medical "breakthrough" that could eventually bring many of the city's 60,000 heroin addicts under medical control. Their Methadone Maintenance Research Program, administered under rigid controls in a variety of hospitals and community clinics, is financed by the City of New York under the aegis of the Beth Israel Medical Center and is supported by the Health Research Council of New York. It has recently been accredited as an approved treatment program by the New York State Narcotic Addiction Control Commission; and starting this month, it will receive financial support from the commission. It also has the backing of the Mayor and Frank O'Connor, President of the City Council. The Council is studying a bill that would require the Commissioner of Correction to "establish a program for the treatment of heroin addicts through the use of methadone" in the city jail on Rikers Island.

Yet the methadone program has been strongly questioned and severely attacked on several counts. Some critics emphasize what they term the experimental nature of the treatment and the need for further data before it is used on a wide scale. Others point out that the program is limited to volunteers; it has not proved itself with the far larger group of addicts who are unwilling to give up heroin. Still others, particularly former addicts who have achieved freedom from narcotics by a "cold-turkey" withdrawal, criticize the very concept of the methadone program—the purposeful switching of an addict from heroin to another addictive drug; they say it is like switching an alcoholic from Scotch to bourbon.

To understand the methadone treatment program, one must understand the properties of both heroin and methadone and the different effects each has on the addict's body and mind.

Heroin is a short-acting narcotic, the product of a reaction between morphine (derived from the poppy) and other chemical substances. Its manufacture in this country is prohibited. Addicts use heroin because of its great euphoric property or "high." When the addict injects heroin intravenously with a needle, he experiences a brief feeling of immense well-being; he enters into a sleepy period, a state of limbo; finally, he starts "coming down." As the effects of the drug wear off (they last up to about four hours), he begins to feel "sick"; symptoms include restlessness, sweating, nausea, runny eyes and nose, pains in the back and legs—and a craving for another "fix." He feels he must seek more heroin from the illegal "black market," all the time trying to stay clear of the police and hoping that he won't be sold a "hot shot" (perhaps rat poison) that could kill him. And he knows that, as his body becomes tolerant to small quantities, he must find and inject an ever-larger amount of the drug.

The compulsive search for the narcotic "high" soon becomes the addict's whole life: his habit, or advanced state of addiction, leaves him functionally disabled. He generally cannot hold a job, continue with school, get enough money by legal means to obtain the heroin, support his family. He is a self-made outcast, despised by society.

Periodically, when his habit becomes too large and expensive to maintain, he may seek to withdraw from heroin, using other analgetic drugs to relieve the withdrawal pain. He will accomplish this at a hospital or, if he can obtain withdrawal drugs, on his own. Sometimes he is withdrawn compulsorily because of a jail sentence. In any case, once he achieves withdrawal, he inevitably starts back on the addiction trail.

Methadone does not come from a natural alkaloid but is manufactured in American laboratories in much the way aspirin is manufactured. It is a long-acting narcotic, the effects of which last from 24 to 38 hours. Medical people have prescribed it as a pain reliever for 20-odd years.

There are very few addicts who use methadone in lieu of heroin to achieve a high. It can be done, by injection, but the high is considered quite unsatisfactory. Moreover, the methadone addict, like the heroin addict, must continually increase his dosage to obtain a euphoric feeling; and the black market in methadone is very small compared to that in heroin. It is virtually impossible for the average addict to maintain an escalating methadone habit, even if he wanted to. He can't get enough of the stuff.

Methadone is of considerable value, though, to the heroin addict. He uses it during a heroin "panic" (shortage) or during his periodic "drying out" phase; but he uses it in relatively small quantities, to ease the pain of heroin withdrawal, rather than in escalating doses to achieve a high.

The Methadone Maintenance Research Program as developed by Drs. Dole and Nyswander is also based upon the use of methadone as a kind of substitute for heroin; but the rationale, techniques and end result are entirely different.

DOCTORS and law-enforcement officers have long been aware that, while heroin detoxification (withdrawal) is relatively easy to achieve—it takes from a few days to a week or two—it offers no lasting cure to most addicts. Upward of 90 per cent go back to heroin as soon as they hit the street.

Most treatment programs are based on the idea that abstinence is an absolute precondition to rehabilitation. But the relapse rate shows that abstinence has proven difficult to maintain. It is on this reality of life that Drs. Dole and Nyswander have built their pioneering program.

"In the past," said Dr. Nyswander, a psychiatrist who has worked at the Federal Public Health Service prison-hospital at Lexington, Ky., and with hundreds of street addicts in her former clinic in East Harlem, "we put all our emphasis on abstinence. We tried locking up addicts for as long as 10 years. We tried intensive psychoanalysis. We tried all the rehabilitation techniques that anyone ever knew—and they would fail as soon as the addict returned to the street.

"Now we find that, in our program, abstinence is taking a backseat as a treatment goal. Normal functioning citizens are the first goal of our treatment. As with all physicians, we would hope that some day our patients would not need medication—in this case, methadone. However, from our knowledge of addictions, it is possible that addicts are not normal in the abstinent period and may require methadone or some pharmacological help for the rest of their lives."

UNDER methadone maintenance, the patient is "switched" from dependence upon heroin to dependence upon methadone. He is given a massive, fixed, daily dosage of methadone dissolved in Tang. As long as he continues to take this dosage, he will be impervious to the narcotic effects of methadone—and he will

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**GERTRUDE SAMUELS**, staff writer for The Times Magazine, is the author of "The People vs. Baby," a documentary novel about drug addiction. She took the accompanying photographs.

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be equally impervious to the narcotic effects of heroin.

The methadone patients achieve what is known as a "tolerance" to methadone and a "cross-tolerance" to heroin. The phenomenon is one familiar to people who regularly use sleeping pills; over a period of time, they must increase the number of pills they take to obtain the same sleep-inducing effect. They have become tolerant to the smaller quantity. The methadone patients are gradually, and without euphoria, brought up to a very large daily dosage of methadone; at this "optimum" dosage level, their level of tolerance for the drug is such that it cannot be overcome. The pharmacological effects of methadone, and of heroin, are effectively blocked. The daily dose acts to stabilize their drug needs; they feel no craving. Since they take the dose every 24 hours, they are never subjected to the withdrawal symptoms. And they have no reason to hunt for a heroin fix since they will get nothing from it. (Patients have told Dr. Nyswander of shooting themselves with 16 bags of heroin while on methadone maintenance, all to no avail.)

THE methadone experiment had its beginnings at Manhattan's Rockefeller Institute (now University) with two male addict patients. Drs. Nyswander and Dole accidentally stumbled on methadone, as a medication to control heroin. (In that time, Dr. Nyswander, an attractively blond and vibrant woman, married Dr. Dole, a 54-year-old senior physician and professor at the institute who specializes in metabolic research.)

The doctors' patients—one 34, the other 21—had been drug users for eight years and had served long stretches in prison for possession and theft; they had tried periodically to give up drugs and had resorted to psychotherapy without success. At first the doctors sought to relieve the drug cravings with morphine maintenance. But that left the men lethargic and craving morphine fixes several times a day.

The doctors then put them on large doses of methadone, for withdrawal from morphine. But now, instead of tapering off the methadone as the final step toward total drug abstinence (as is usual during the withdrawal period), the doctors kept the patients on these very large doses of methadone as a daily medication. The patients began to show remarkable physical and psychological changes. Their health and appetite improved; they experienced no euphoria.

Several more recruits were put in the program—and the doctors ran a series of tests to determine how safe methadone was when used in massive "maintenance dosages." A high

degree of tolerance to methadone was found. The drug, which remained effective for over 30 hours at a time, created no medical problem except for one side effect, constipation. Most importantly, patients ceased to talk about drugs and were asking about school, jobs, doing something for their families. They were freed from the disabling search for heroin and now had the time—and the desire—to start making normal lives for themselves.

How does methadone block the hunger for heroin and do its job? "We can't answer the how yet," Dr. Nyswander said. "We don't know where and how narcotics work in the body—no one has ever been able to find out in all the years of research. But we don't know how insulin works on diabetics either. We only know that the insulin is effective and allows the diabetic to live a normal life. His disease is not cured but is brought under control. Methadone *allows* a person to lead as normal a life as he can. We feel—and there's abundant evidence now—that once a person has used drugs for a long enough period of time, he is physiologically different from anyone else. Methadone works because it is an appropriate medical treatment."

TODAY there is a two-year waiting list for methadone treatment; more than 100 addicts apply each week. Not all who apply, however, are accepted for treatment.

To be admitted, the volunteer addict must have been a heroin mainliner for at least four years and must have made a number of unsuccessful attempts, voluntary or involuntary, to withdraw completely from drugs—and there must be some documentation to substantiate these facts. No adolescents are accepted. The youngest patient is 20. More than 90 per cent of those now in the methadone program have records of repeated arrests and prison terms.

At the time of admission, only about one-sixth were gainfully employed. Within six months, more than 60 per cent were working at full-time jobs ranging from posts as messengers, movers and mechanics to white-collar positions in architectural and publishing firms; the remainder are part-time workers, attend vocational or retraining schools or are on relief. Among the employed are several former heroin addicts who are on the paid staff as research assistants. They help to run the program

alongside the professional staff of doctors, nurses and social workers; their presence is most reassuring to a new patient since they talk his language and know his anxieties and problems better than anyone.

The methadone maintenance approach does not, however, require a large staff. No special centers or hospitals must be built. No one is locked up. Except for Dr. Nyswander, there are no staff psychiatrists, though psychiatric consultation is available in most of the hospitals used by the program. And the cost of the daily maintenance medication is a mere 13 cents.

The first, inpatient phase of the program lasts six weeks and is conducted in an unlocked hospital ward. (Harlem Hospital and the Morris J. Bernstein Institute, formerly Manhattan-General Hospital, are being used.)

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Here the patient gets a complete medical workup, and his family, housing and job potential are reviewed by a team of physicians, nurses and counselors. He is withdrawn from heroin and receives methadone in increasing doses until he is built up to the "stabilizing" dose, determined by the physician, of between 80 and 120 mgms. daily; some patients cannot take more than 80 mgms. without nodding from oversedation; others can take up to 120 mgms. (The latter dosage is equivalent to from four to six bags of 10 per cent-strength heroin.)

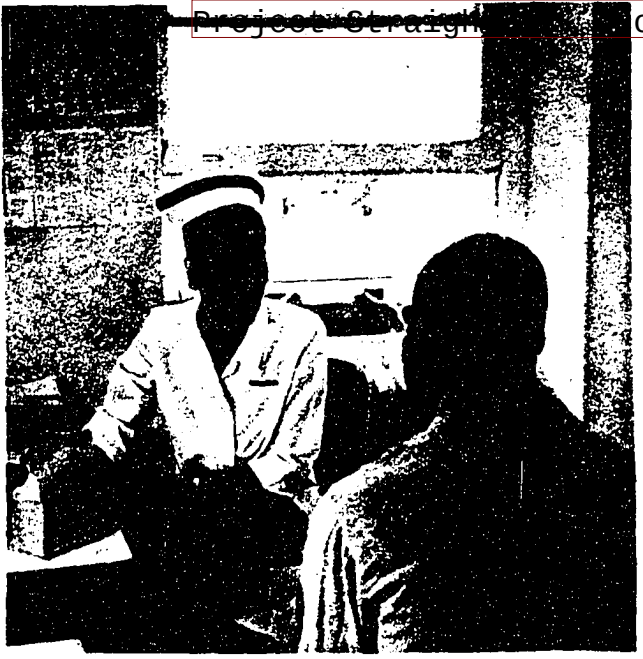
Some reach their maintenance level in four weeks, others in five. Even before being completely stabilized, patients are encouraged to leave the methadone ward for some hours each day, to seek job interviews, for recreation, to join their families. On these trips they are accompanied by a member of the staff, tangible evidence for the former convicts that at last someone is following through to help him rejoin the "square" society.

At Harlem Hospital the methadone unit for a dozen male patients comprised a spacious, self-contained arrangement of dormitories, living and recreation rooms and staff offices—homelike and clean with television and telephone and a refrigerator and coffee urn for snacks. Alec, a new patient, a tall, heavy-set Negro of 28, bewildered and tense, stood wide-eyed before Dr. James Robinson.

The white-coated Negro doctor, who taught at Stillman College in Alabama, put Alec at ease.

"Glad to see you, Alec."

"Yeah, finally made it here—after



**FRESH START**—A new patient in the Harlem Hospital methadone unit receives a gift bag (containing such necessaries as toothpaste and comb) and a briefing ("We don't treat our patients as sick people") from nurse Charlie Mae Reynolds.

six months [on the waiting list]." Alec had been on drugs for 17 years; he had been arrested six times for crimes connected with drugs, had served four years in prison, had been detoxified and had returned to drugs five times.

"All your troubles are over now," Dr. Robinson told him. "This is it. When did you have your last fix [of heroin]?"

"At 2 o'clock this morning."

"And what is your habit?"

"Three to six $5 bags."

The doctor gave Alec a routine physical examination. He also looked inside his elbows for the needle tracks and examined an old abscess on top of his right hand, made by a dirty needle. He prescribed two methadone medications a day of 10 mgms. each. For several days Alec was to stay on this initial dosage, until all the heroin was eliminated from his body. He was not being simply withdrawn from heroin; his habit was actually being "changed over" from heroin to methadone. Later, Alec would begin to get, every three or four days, an increment of 10 mgms. until he reached his "tolerance." Once his optimum dosage was established, it would remain stable.

After his medication had been prescribed, Alec was passed on to Charlie Mae Reynolds, a young registered nurse. She handed him a paper bag, lettered "Gift," containing toothpaste and toothbrush, a comb, packets of cigarettes, some shaving cream. She said briskly, without sentimentality:

"Now, you're expected to keep your own unit clean. After the first couple of days, you're expected to change into street clothes from hospital robe. We don't treat our patients as sick people, but as people who need some support to adjust to society as soon as possible. You're ex-

pected to remain on the ward for three weeks. After that, you'll get a pass to go out, and you're expected to be back at 11 P.M."

She handed him his first paper cup of methadone in juice. He gulped it down.

"I want to take advantage of the help," he told the nurse. "If he can look like that, I want to." He pointed to Charles, a onetime pusher and convict who had been in the methadone program for 16 months; Charles is now a paid research assistant, clean-cut, well dressed, healthy looking. Alec had known him in the street.

AT a ward meeting later in the day a dozen patients sat about informally with their doctor, counselors and nurses. Some, like Alec, were new patients in their hospital robes; others were in their street suits, ready to go out on passes for the rest of the day.

John, a large man in a gray cardigan, in his last week of phase one, was planning to look for a job and spend some time practicing on his guitar. He had been a heroin addict since high school days and in fact had earned his high school diploma in Sing Sing.

He told the writer: "Methadone makes me feel normal. I want to go to vocational school now and learn a trade. Ninety per cent of my friends are on drugs, but nothing happens to me now when I'm near them. I'm comfortable and unhurried. I can't explain it. I don't know enough about medicine."

How do his feelings differ from those he had in prison, when he was taken off drugs?

"Well, every time I came out of prison, I went back to dope within hours. Now I *know* that if I use any heroin this time, I won't feel it. I haven't tried to experiment yet, but that's what everyone tells me. I would have to use so much and it would cost so much that it would be impractical, just to see if I could get a high. And this methadone is given to you for nothing. You don't have to steal to get money for it. What's my first project now?" He smiled. "Not to look for a fix. To get a set of drums—jazz drums."

Ed Towns, the assistant unit director, a social worker with long experience with drug addicts, talked to the patients about jobs. Some firms had offered to give men in the program job training. Dr. Robinson explained methadone tolerance. Someone asked how long he should expect to remain on methadone.

"At this time," the doctor said, "it's indefinite. Maybe it's for a lifetime. But as long as you take the

medication, the action of the patient is that of the normal person."

Does methadone enhance sex? someone asked. The sex drive is usually blunted in heroin addicts, and they often joke about it; the alcoholic, they say, goes home and beats up his wife, but old dopey takes a fix, goes home and his wife beats him up. "No," Dr. Robinson replied, "but methadone does make you as normal as possible."

That evening Ed Towns took me on a tour of the area surrounding Harlem Hospital.

On the block opposite, between West 136th and 137th Streets, the dimly lit bars and taverns were infested with drug-takers and drug-sellers. In one bar a man hawked large tubes of toothpaste ("Two for 45 cents!"). A woman called out, "Men's shorts and nice bed sheets—all new!" "All stolen," Ed told me wryly. "You can bet on it! For the drugs." On a side street leading to the hospital, on a stoop next to a small church, a cluster of men included some "connections." Patients in the hospital can look down mornings and see a man accept money and pass "something" to his "clients." The methadone program takes in addicts from these streets—and the sordid streets sharply thrust their lesson home.

THE second phase of the program lasts about a year. It comes to life at an outpatient clinic in Harlem—a floor-through of brightly decorated offices in an office building at East 125th Street and Third Avenue. The program has a half-dozen such clinics in lower and upper Manhattan, in hospitals and private buildings. At some time every day—it can be before or after work, school or the various training programs—the patient comes to the hospital or one of the satellite methadone clinics to drink his methadone and leave a urine specimen, which is analyzed as a check against ingestion of other drugs.

The patient is well along on his rehabilitation, but he still must be carefully supervised to help him resist the temptation to leave methadone for heroin.

At the Harlem clinic Paul Searcy, a group counselor, a graduate in biology who is doing advanced work in psychology at Columbia University, gave me this profile of the 77 male patients reporting to his clinic:

Sixty-seven were non-whites, ranging from a 22-year-old Puerto Rican to a 43-year-old Negro. Most of them lived in the Harlem area and had spotty work records. Some came to the program direct from jail. Now 45 were working full time, holding jobs ranging from messenger ($60 a week) to film editor ($200 a week); two were working part time; eight were in school or in job training or testing; the remainder were either waiting to go to vocational school or were getting counseling help.

"Some patients," Searcy said, "are not yet ready for jobs or school. They are unstable, apprehensive, fearful of facing the world realistically. With the heroin crutch gone, they have retreated into another shell. Staff is working closely with them to establish self-esteem and self-confidence."

Victor, a lean, quiet-voiced 39-year-old, is typical of those I interviewed. Using a trade he learned in prison, he has worked as a cutter in the garment district for the past six months. His employer does not know he's a former heroin addict who spent 10 years in prison for a variety of robberies. He now earns $125 a week. "I'm not on welfare," he said proudly. He was doing a term on Rikers Island when his probation officer helped him to enter the methadone program last March.

"Not out of fear, no, that's not why I came," he said. "I'm just sick and tired of using narcotics. I wanted to stop. I'd rather be addicted any day to methadone than to heroin. Why? Because I can work and live on this, instead of going out to steal every day for drugs. Drugs don't even cross my mind today."

Why does a drug addict want to give up one drug for another? Does methadone satisfy the psychological craving for the euphoria that heroin produced? In methadone's male unit at the Morris J. Bernstein Institute in lower Manhattan one patient, now in a vocational training program, spoke up bluntly:

**66The dimly lit bars near the hospital were infested with drug-takers and drug-sellers and those who sold stolen goods to get drugs.99**

"I don't really want to give up heroin, because it is a beautiful feeling in itself. It puts you in a nice state of mind, nice enough to function if you don't oversedate and make an idiot of yourself. Drug addicts like drugs—but we don't like what they do to us. They drag us down, and society spits on us. The reason why I won't go back to heroin is because I'm tired of going to jail, tired of being down. I want to get up. Even though methadone doesn't give us the same feeling, the main idea is that we're able to function *properly* on methadone—as human

beings with responsibilities." He smiled, a tired smile. "The way society wants us to conform."

When a patient becomes a functioning, self-supporting member of the community, he enters the third phase of the program. His visits to the outpatient clinic, to pick up a supply of methadone, may be as infrequent as once a week—and longer should he wish to leave town on vacation. At this stage he is considered by the doctors to have achieved stability and made a successful rehabilitation; no one who has entered the third phase has returned to heroin addiction. He is still, however, dependent upon methadone—and will remain so indefinitely.

The doctors are often asked why they do not take the next step—withdraw methadone from these advanced patients and see if they can manage without the stabilizer. "These people have long been losers in life," Dr. Dole told me, "and the removal of methadone could be socially disastrous to them. We are not yet ready to take this risk. Medically there is no difficulty in withdrawing patients from methadone. But we are concerned over the possibility that patients would revert to heroin addiction if deprived of the methadone blockade."

There have been some program failures. Three methadone patients decided to drop out of the Dole-Nyswander program and return to heroin addiction. Forty patients have been discharged by the doctors because of alcoholism or extreme emotional disturbances that had not been detected in the initial screening process.

The rest of the patients are making the adjustment to the "square" society. "Our treatment," said Dr. Dole, "has virtually eliminated criminal activity. Our patients no longer have the need to rob or prostitute to obtain the money to buy a fix."

NOTWITHSTANDING the achievements of the Dole-Nyswander program, there is a body of informed opinion that has grave doubts about methadone maintenance.

Most vehement, perhaps, are the leaders of the Synanon Foundation, nearly all of whose 850 resident-members are former drug addicts who became free of drugs by undergoing "cold-turkey" withdrawal. It was a Synanon member who compared the switch from heroin to methadone to the switching of an alcoholic from Scotch to bourbon.

Chester Stern, East Coast director of Synanon and once a drug addict of 20 years' standing, with a long history of jail sentences, told the writer his views in very personal terms: "Had I gone into such a methadone maintenance program, I would be an addict today. Instead, because of Synanon, I am living a rather productive life, completely free of drug addiction for the last five years, and I am showing other former addicts

how to live without any chemicals whatsoever. In some cases, the methadone approach may very well be warranted—but these doctors are having to cope with the best 'con' artists on the face of the earth who can convince anyone that they are hopeless, unrehabilitable addicts who need drugs. I wonder how many people — especially young people — are caught up on this path of least resistance and will never have the opportunity now to lead a drug-free existence."

Stern's wife, Barbara, 12 years on drugs and now drug-free, was even more blunt: "Methadone is just substituting one drug for another—and I think that's criminal. Drug addicts can be cured without taking any drugs. The proof is here in Synanon.

**66'I don't really want to give up heroin,' he said. 'It's a beautiful feeling. Addicts like drugs—but we don't like what they do to us. They drag us down and society spits on us.'99**

Methadone addiction only perpetuates the drug problem, and what's so criminal is that it keeps the addict addicted."

Dr. Robert W. Rasor, medical officer-in-charge of the Federal hospital at Lexington, Ky., said: "I've never been in particular sympathy with the methadone program. I think it is an experimental tool, only one avenue of approach, and should be used only as research. I certainly would not want to see all addicts treated this way, because I would be more interested in trying to keep addicts off drugs, trying to help them find a way of life without resorting to addictive drugs like methadone. I don't see that the addict is at all comparable to the diabetic or heart patient. With the latter, one is treating a metabolic condition. With drug addicts, the total personality is involved."

And Dr. Donald B. Louria, president of the New York State Council on Drug Addiction, who helped to design the mammoth new state program that would allow judges to commit addicts for compulsory treatment for up to five years, couched his criticism in these terms: "I think methadone is an experiment that's extraordinarily interesting. But it will have to undergo rigorous evaluation. As of now it is not ready for widespread treatment of addicts. It is important to point out that all the methadone patients are voluntary patients. I feel that the program will remain an experiment until we can see how well it can deal with less motivated people—those, for example going into the program after going through the courts and being committed."

To their critics, Drs. Dole and Nyswander reply with some dry reminders: They point out that many hospitals are asking to have methadone units set up in them. They compare the cost of their medication—13 cents a day—and the modest cost of their total program with the $100-worth of goods per day that an addict must steal and fence to pay for his fixes, and with the cost of frequent hospitalizations, jailings and damage to families and communities. They compare their experiment with the multimillion-dollar cost of the state program, which calls for the building of new hospitals and centers staffed by large numbers of specialists.

Dr. Dole takes up the comparison of his program to the switching of an alcoholic from one drink to another:

"You give an alcoholic a shot of whisky, and you disable him. If a medicine did this to a heroin addict, it would be a bad medicine. This quite definitely is not the situation with methadone. Our patients pass all the psychological, neuromotor and functional tests that a team of psychologists has been able to devise. When they mix with normal people, they cannot be distinguished by any behavior. They are proving themselves in jobs and school."

Dr. Nyswander agrees that there must be voluntary patient cooperation and strong motivation to remain off drugs if an addict is to participate successfully in the methadone program. But she points out that some of her most successful patients entered the program with a cynical and doubting attitude and developed enthusiasm and motivation along the way—when they experienced the effects of methadone maintenance.

The final word on methadone maintenance is not yet in. But while many experts view the program as still in its research stage, Drs. Dole and Nyswander believe that they have passed from "research" to "proven treatment." And the New York State Narcotic Addiction Control Commission has agreed.

The two doctors do not claim that their program is a panacea for heroin addiction. For example, they are warm supporters of Synanon for those who can accept that "cold-turkey," drug-free environment. But they view their own method as another important — and successful — approach to this illness. Certainly the experience of those former heroin addicts who have become their patients tends to support this view.

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**DOSE—A nurse prepares the methadone medication. The program does not require the large staff and elaborate facilities needed for treatments based on abstinence —and a single dosage costs only 13 cents.**