The Clients of an Unauthorized Program of Methadone Treatment

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A METHADONE "PROGRAM" of a Washington, D.C., private physician was abruptly closed by Federal authorities in February 1972 because of lack of compliance with Federal regulations controlling the use of narcotics. For several years the physician had been dispensing and writing prescriptions for methadone for a caseload of patients for whom the major criterion for acceptance for treatment allegedly was the ability to pay.

During this period the Federal Government required that all methadone maintenance programs receive authorization for use of methadone from the Food and Drug Administration (FDA). An Investigational New Drug number was issued to each maintenance program that met the requirements of the FDA.

At the time the unauthorized program was closed, it was not known exactly how many persons *(a)* had been receiving methadone from this source, *(b)* were from Maryland, *(c)* would desire long-term care in a bona fide treatment program, or *(d)* would be eligible for care under the existing criteria of the Federal Drug Administration and for admission to treatment under the criteria of the individual program. The situation was complicated because all of the authorized methadone maintenance programs, until recently, had been located in Baltimore City. These established programs had waiting lists and the few new programs, both in Baltimore City and Baltimore County, were not yet ready to accept patients. A large influx of the Washington physician's former patients undoubtedly would cause pressure on already functioning programs.

Establishment of Emergency Holding Program

The Drug Abuse Administration, the arm of the Maryland State Department of Health and Mental Hygiene that deals with drug abuse statewide, was notified of the unauthorized clinic's closing several days before the event. Thereupon plans were quickly made to offer emergency care to this unknown group of addicts so that they would not develop withdrawal symptoms while awaiting admission to established community treatment programs. To provide such care, an emergency holding program was set up. Arrangements were made to house the program at the building occupied by the State Coordinating and Counseling Center, a unit that counseled abusers of all types of drugs and referred them to treatment agencies. The program was announced in the Baltimore City newspapers on February 17; the various drug treatment programs in the area were also notified. The holding program thus soon became known both to the "street" addicts and to the various public agencies working with them.

In order to restrict treatment to the truly addicted, each applicant for the holding program was thoroughly screened before being accepted, first by a counselor at the State Coordinating and Counseling Center, then by an ex-addict counselor, and finally by a physician.

At the outset, as many as 82 percent of the persons seeking care claimed to have been patients of the Washington physician *(1)*. As the weeks progressed, however, fewer and fewer persons were making this claim. In fact, by the end of the 3½ -month period of

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the holding program's operation, it had turned into a de facto central intake facility for Baltimore City, with many referrals coming from public agencies such as social services, the criminal justice system, and drug treatment programs.

A comprehensive data collection system for the holding program was immediately instituted to produce the information needed for programmatic decision making and quantification and characterization of the population under treatment so that appropriate referral and long-range planning could be rationally undertaken *(1)*.

Study of Emergency Holding Program Participants

Using the information produced by the data collection system of the holding program, we conducted a study of the 408 patients in it during the period February 17–May 26, 1972, who reported they had participated in the Washington physician's program. We compared their characteristics with those of the 925 other patients who were in the holding program during the same period. Comparisons for age, race, and sex were also made of the 408 with the 5,578 other persons reported during fiscal year 1972 to the Maryland State Narcotics Addict Register *(2)*. This register contains data about narcotics addicts reported by treatment programs, police departments, and the Maryland State Department of Corrections. Finally, to follow the subsequent course of the 408 patients, we determined the percentage of them who had been accepted into treatment in Baltimore City and County programs and their status about 1 year after termination of the holding program.

Results of Study

Comparison of study patients with others in holding program. Before planning for and treating an unknown population, its demographic characteristics need to be cataloged. Table 1 displays the various demographic distributions of the 408 persons who claimed to have been participating in the unauthorized program and those of all other patients in the holding program during the period February 17–May 26, 1972.

The age distribution of these populations differed significantly ($P<.001$). Fewer patients from the unauthorized program were 19 years of age or under; considerably more were over 30. Although the modal age group was the same for both populations (20–24 years), more than 55 percent of the patients from the unauthorized program were 25 years of age or older; only 35 percent of the other patients were in this category.

Sixty-five percent of the persons from the unauthorized program and approximately 85 percent of the other patients in the holding program were black ($P<.001$). As can be seen in table 1, about 85 percent of the patients from the unauthorized program and more than 95 percent of the other patients in the holding program lived in Baltimore City ($P<.001$). About 55 percent of the persons from the unauthorized program were currently married or had been, as opposed to about 40 percent of the other group ($P<.001$).

Table 1 shows that the former patients of the Washington physician were generally better educated than others in the holding program; 39.3 percent were high school graduates or better, as opposed to 30 percent of the other patients ($P<.01$). The unauthorized program patients were also somewhat better trained, as indicated by the larger percentages with technical, skilled, and semi-skilled occupations. There was a major difference between the two groups in employment skills. Four percent of the unauthorized program patients claimed to have no trade or profession, as compared with 9.6 percent of the others ($P<.02$).

There was no statistically significant difference in the distribution of the two groups by sex, and in both groups there was a far larger percentage of males than females.

There were no statistically significant differences between the patients from the unauthorized program and the other patients treated in the holding program in respect to histories of arrests and convictions. Of the entire group of 1,333 persons, 44.2 percent had never been arrested, and 69.2 percent had no convictions. Of the patients from the unauthorized program, 31.9 percent admitted they had used cocaine during the 3 months before admission to the holding program—in addition to heroine, methadone, or synthetic opioids; 46.1 percent of the other holding program patients made this same admission. Use of barbiturates and other sedatives was 22.9 percent for unauthorized program patients and 17.0 percent for the other patients on the register. The admitted use of alcohol and amphetamines was small and approximately the same for both groups. These drug-use groupings, however, are not mutually exclusive; there was much multi-drug use. Of the 408 patients from the unauthorized program, 311 (76 percent) stated they used heroin at least several times a week; of these, 97.1 percent used it daily. Among the persons from the unauthorized program, 52.5 percent had been using heroin for 4 or more years; 32.3 percent of the other patients in the holding program had been using it this long ($P<.001$).

Comparison of study patients with others on addict register. When the patients from the unauthorized program were studied in relation to all other persons who had been reported to the Maryland State Narcotics Addict Register for 1972 *(2)*, large differences were found for the variables of age, race, and sex (table 2). A larger proportion of the females treated in the emergency holding program had attended the unauthorized program (22.7 percent) than had been entered on the narcotics addict register during fiscal year 1972 (12.9 percent)—$P<.001$. Racial differences also reached the $P<.001$ level of significance. The proportion of white persons (34.1 percent) who had attended the unauthorized program was larger than the proportion registered (26.5 percent). The persons treated in the unauthorized program were generally older than those entered on the register. More than 28 percent of the participants in the unauthorized program were 30 years of age or older; 5.3 percent were

Table 1. Selected demographic characteristics of former patients of unauthorized program of methadone treatment and of other patients treated for drug addiction in emergency holding program, Baltimore, Feb. 17—May 26, 1972

Variable	Unauthorized program patients[1]		Other patients[1]		Total	
	Number	Percent	Number	Percent	Number	Percent
Race:						
Black	263	65.9	775	86.5	1,038	80.2
White	136	34.1	121	13.5	257	19.8
Total[2]	399	100.0	896	100.0	1,295	100.0
			$\chi^2 = 79.42$, df = 1, $P < .001$			
Age group:						
19 and under	21	5.3	118	13.1	139	10.7
20-24	149	37.3	462	51.4	611	47.1
25-29	114	28.6	182	20.2	296	22.8
30-34	50	12.5	79	8.8	129	9.9
35 and over	65	16.3	58	6.5	123	9.5
Total[2]	399	100.0	899	100.0	1,298	100.0
			$\chi^2 = 69.72$, df = 4, $P < .001$			
Marital status:						
Single	181	45.5	538	61.6	719	56.5
Married	126	31.7	171	19.6	297	23.4
Separated	71	17.8	150	17.2	221	17.4
Divorced or widowed	20	5.0	14	1.6	34	2.7
Total[2]	398	100.0	873	100.0	1,271	100.0
			$\chi^2 = 48.03$, df = 3, $P < .001$			
Residence:						
Baltimore City	324	84.6	831	95.3	1,155	92.0
Maryland county	59	15.4	41	4.7	100	8.0
Total[2]	383	100.0	872	100.0	1,255	100.0
			$\chi^2 = 28.50$, df = 1, $P < .001$			
Grade level completed:						
8 or less	48	11.9	102	11.3	150	11.5
9-12	196	48.8	529	58.7	725	55.6
High School	97	24.1	184	20.4	281	21.1
More than high school	61	15.2	87	9.6	148	11.4
Total[2]	402	100.0	902	100.0	1,304	100.0
			$\chi^2 = 14.96$, df = 3, $P < .01$			
Occupation:						
Professional, official, or manager	18	5.2	35	4.6	53	4.8
Technical, sales, or clerical	46	13.2	86	11.3	132	11.9
Skilled	31	8.9	60	7.9	91	8.2
Semi-skilled	99	28.5	173	22.7	272	24.5
Unskilled	126	36.2	309	40.6	435	39.3
Housewife or student	14	4.0	25	3.3	39	3.5
No occupation	14	4.0	73	9.6	87	7.8
Total[1]	348	100.0	761	100.0	1,107	100.0
			$\chi^2 = 16.19$, df = 6, $P < .02$			
Employed:						
Yes	127	31.8	213	23.9	340	26.3
No	272	68.2	679	76.1	951	73.7
Total[2]	399	100.0	892	100.0	1,291	100.0
			$\chi^2 = 8.99$, df = 1, $P < .01$			

[1]During the study period, 408 patients from the unauthorized program and 925 other patients were in the emergency holding program, or a total of 1,333 patients.

[2]Total patients for whom information on variable was available.

Table 2. Selected demographic characteristics of former patients of unauthorized program treated in emergency holding program and of all other persons reported to Maryland Narcotic Addict Register for fiscal year 1972

Variable	Unauthorized program patients[1]		Other patients[1]		Total	
	Number	Percent	Number	Percent	Number	Percent
Sex						
Male	314	77.3	4,857	87.1	5,171	86.4
Female	92	22.7	721	12.9	813	13.6
Total[2]	406	100.0	5,578	100.0	5,984	100.0
			$\chi^2 = 22.4$, df = 1, $P<.001$			
Race						
Black	263	65.9	4,102	73.5	4,365	73.0
White	136	34.1	1,476	26.5	1,612	27.0
Total[2]	399	100.0	5,578	100.0	5,977	100.0
			$\chi^2 = 12.18$, df = 1, $P<.001$			
Age group:						
19	21	5.3	482	8.7	503	8.5
20-24	149	37.3	2,641	47.6	2,790	46.9
25-29	114	28.6	1,389	25.0	1,503	25.3
30-34	50	12.5	609	11.0	659	11.0
35 and over	65	16.3	426	7.7	491	8.3
Total[2]	399	100.0	5,547	100.0	5,946	100.0
			$\chi^2 = 47.57$, df = 4, $P < .001$			

[1]During the study period, 408 persons from the unauthorized program and 5,578 other persons were reported to the Maryland Narcotics Addict Register, or a total of 5,986 persons.

[2]Total patients for whom information on variable was available.

19 years of age or younger. For persons on the register, the corresponding percentages are 18.7 and 8.7 ($P<.001$). It is of interest that 256 (62.3 percent) of the 408 persons who claimed to have been treated in the unauthorized program were known to the register before the holding program began. Of these, 161 (39.5 percent) had been in treatment programs.

Followup of patients from unauthorized program. Two hundred twenty-seven (55.6 percent) of the 408 persons who claimed to be from the Washington physician's program were admitted to the holding program within the first month of its operation. Seventy-five of these patients (33 percent) desired treatment and were accepted into methadone maintenance programs within 2 months of their entry into the holding program. As of March 1, 1973, 41 (54.7 percent) of the total persons admitted to methadone maintenance programs were still under treatment; 34 (45.3 percent) had been discharged because they had successfully completed treatment, they had moved, or they had been terminated for some reason not related to failure on the particular treatment regimen. The average length of stay for those who were terminated was 110 days. Of the 227 persons admitted to the holding program during the first month of operation, 152 did not get into community programs; 61 of these 152 were detoxified; 72 simply stopped appearing at the holding program clinic; followup information was not available for 19.

Discussion

The patients seen at the holding facility who claimed to have been treated in the unauthorized program appeared to differ considerably from the other patients treated in the holding program. Larger percentages of the clients of the unauthorized program than of the other patients were white, were older, were married or had been, had a good education, had received occupational training, and were employed. More of the clients of the unauthorized program lived in one of the counties of Maryland rather than in Baltimore City, and they more closely resembled a suburban population than other patients in the holding program. If the usual criteria for measuring socioeconomic level are used, that is, occupation and education, this group from the unauthorized program apparently had a higher socioeconomic status than is usually reported for addicts *(3)*. These patients also had been using heroin for a longer period than the other patients. The longer use might be accounted for by the greater age of the Washington physician's patients, although our study did not explicate the relationship. There was no significant difference between the two groups in the number of arrests and convictions.

When the clients of the unauthorized program were compared with all other persons reported to the narcotics addict register, the results for race and age were similar to those just mentioned.

This study revealed that at least a percentage of the caseload of the Washington physician had consisted of

patients who were bona fide heroin addicts. The acceptance of these patients for treatment in the holding program, and subsequently in other Baltimore City and County programs, is evidence of their addiction. Furthermore, this group, whose members were demographically, geographically, and economically divergent from the known Maryland addicts, had sought treatment in an unconventional program distant from their homes. The reason may have been that when the unauthorized program began, virtually no drug treatment programs were serving the counties surrounding Baltimore City. However, before seeking treatment in Washington, many of these patients previously had received treatment in Baltimore City. They had sought treatment from the Washington physician after premature termination of their treatment in Baltimore City or after a later relapse to the use of heroin.

The differences found between the patients who were treated in the unauthorized program and those who were not are similar to the differences generally found between the clientele of private physicians and the clientele of public clinics. For general medical care, low-income families reportedly make much more use of hospital clinics than high-income families do *(4-6)*. In addition, nonwhites report more use of clinics than whites *(4,5,7)*. Robinson and co-authors have shown that families of low socioeconomic status make more use of hospital emergency services than do persons who rank higher in occupation and education *(8)*. Those persons who traveled to Washington, D.C., to seek care from a private physician seemed to resemble the persons who seek private medical care, while the other patients in the holding program seemed more like the persons who use hospital clinics.

The 1-year retention rate in the holding program for the patients from the unauthorized program was 54.7 percent; the overall rate for Maryland was 48 percent *(9)*. Further study is warranted to ascertain whether the patients from the unauthorized program will do as well as others in local long-term treatment programs. Moreover, this unique population offers an opportunity to study whether middle-class addicts do better after completion of treatment than do addicts of a lower socioeconomic status.

References

1. Nightingale, S. L., Goldberg, E. L.: The role of statistics in managing a drug emergency facility. Am. J. Public Health 64: 998-999, October 1974.
2. Summary of data reported to the narcotics addict register with special emphasis on contacts during FY 1971–1972. Maryland Department of Health and Mental Hygiene, Drug Abuse Administration, Baltimore, 1973.
3. National Commission on Marijuana and Drug Abuse: Drug use in America. Stock No. 5266-00003. U.S. Government Printing Office, Washington, D.C., 1973.
4. Alpert, J. J., et al.: Types of families that use an emergency clinic. Med. Care 7: 55–61, January–February 1969.
5. Andersen, R., and Anderson, O. W.: A decade of health services. University of Chicago Press, Chicago, 1967.
6. Richardson, W. C.: Poverty, illness and use of health services in the U.S. Hospitals 43: 34–40, July 1, 1969.
7. National Center for Health Statistics, Public Health Service: Differentials in health characteristics by color: United States—July, 1965–June, 1967. Vital and Health Statistics Series 10, No. 56. PHS Publication No. 1,000. U.S. Government Printing Office, Washington, D.C., 1971.
8. Robinson, G. C., et al.: Use of a hospital emergency service by children and adolescents for primary care. Canad Med Assoc J 101: 69–73 (1969).
9. Goldberg, E. L.: The life table concept—a first step in the evaluation of methadone maintenance programs. *In* Report of the 36th Annual Scientific Meeting of Committee on Problems of Drug Dependence. National Research Council, National Academy of Sciences, Washington, D.C., 1974, pp. 314–325.

SYNOPSIS

GOLDBERG, EVELYN L. (Johns Hopkins University School of Hygiene and Public Health), and NIGHTINGALE, STUART L.: ***The clients of an unauthorized program of methadone treatment. Public Health Reports, Vol. 90, March-April 1975, pp. 154–158.***

The Drug Abuse Administration of the State of Maryland in 1972 established an emergency holding facility in Baltimore. Its purpose was to attract into programs those addicts who had been treated by a private physician in Washington, D.C., until his office had been abruptly closed by the Federal Government for lack of compliance with Federal regulations controlling the use of narcotics. A comprehensive data collection system for the holding program was immediately instituted to produce the information needed for programmatic decision making and to provide quantification and characterization of the population under treatment so that appropriate referral and long-range planning could be rationally undertaken.

With data collected through this system, those 408 patients in the holding program from February to May 26, 1972, who reported they had participated in the Washington physician's program were compared with *(a)* the 925 other persons in the holding program during the same period and *(b)* the 5,578 other persons who were reported to the Maryland Narcotics Addict Register during fiscal year 1972. In both comparisons, larger percentages of the clients of the unauthorized program than of the other group were white and older. More of the clients of the unauthorized program than the other patients in the holding program were married or had been, had a high school education or more, had received occupational training, and were employed.

These differences are similar to those generally found between the clientele of private physicians and the clientele of public clinics. The persons who had traveled to Washington, D.C., to seek care from a private physician seemed to resemble the persons who seek private medical care; the other clients in the holding program seemed more like those who use hospital clinics.