

The Politics of Stigma and Racialization in the Early Years of Methadone Maintenance Regulation

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INTRODUCTION

Social science researchers have established structural racism and stigma against methadone maintenance patients as a barrier to recruitment and retention of people of color in need of treatment. Structural racism — enacted through a broad array of institutional practices and policy decisions — negatively impacts effective treatment by influencing the terms on which Black patients might gain access and successfully engage in the therapeutic process. Stigma has the deleterious effect of alienating patients and potential patients from a valuable source of help — Black patients, as Andraka-Christou has noted, suffer a “trifecta of stigmas” by virtue of being Black, having an opioid use disorder, and being a methadone patient.¹ Researchers who focus on structural barriers to access and popular stigma against methadone maintenance treatment (MMT) make the argument that in no case are matters made better by the onerous restrictions on methadone and the regimes of surveillance required by federal regulation. Even today, methadone maintenance remains one of the nation’s most closely regulated medical protocols. Perhaps not entirely by coincidence, it is also one of the most stigmatized, controversial, and misunderstood.²

* The author is responsible for the content of this article, which does not necessarily represent the views of the National Academies of Sciences, Engineering, and Medicine.

¹ Barbara Andraka-Christou, "Addressing Racial and Ethnic Disparities in the Use of Medications for Opioid Use Disorder," *Health Affairs* 40, no. 6 (2021).

² Bennett Allen, Michelle L. Nolan, and Denise Paone, "Underutilization of Medications to Treat Opioid Use Disorder: What Role Does Stigma Play?," *Substance Abuse* 40, no. 4 (2019); Holly N. Hagle et al., "Dismantling Racism against Black, Indigenous, and People of Color across the Substance Use Continuum: A Position Statement of the Association for Multidisciplinary Education and Research in Substance Use and Addiction," *Substance abuse* 42, no. 1 (2021); Anastasia Hudgins et al., "Barriers to Effective Care: Specialty Drug Treatment in Philadelphia," *Journal of substance abuse treatment* 131 (2021); Kelly Ray Knight, *Addicted.Pregnant.Poor* (Durham, NC: Duke University Press, 2015); Brendan Saloner et al., "A Public Health Strategy for the Opioid Crisis," *Public health reports (1974)* 133, no. 1S (2018); Alexander C. Tsai et al., "Stigma as a Fundamental Hindrance to the United States Opioid Overdose Crisis Response," *PLoS medicine* 16, no. 11 (2019); Tricia H. Witte et al., "Stigma Surrounding the Use of Medically Assisted Treatment for Opioid Use Disorder," *Substance Use & Misuse* 56, no. 10 (2021); Lindsay Wolfson et al., "Examining Barriers to Harm Reduction and Child Welfare Services for Pregnant Women and Mothers Who Use Substances Using a Stigma Action Framework," *Health & social care in the community* 29, no. 3 (2021); Julia Woo et al., "Don't Judge a Book by Its Cover: A Qualitative Study of Methadone Patients' Experiences of Stigma," *Substance*

In this paper, I specifically examine the historical origins of methadone stigma in the context of Black American *political culture*. In doing so, I argue that Black Americans' antimethadone attitudes, first formed in the late 1960s, emerged from methadone's political history in this country and, also, the much longer history of medical disrespect and abuse of Black Americans. For Black and White liberals in the 1960s and 1970s, issues of major concern included community control of local institutions such as school boards, medical clinics, and antipoverty programs; civil and economic rights for all Americans; youth alienation; policing reform; and the war in Vietnam. More importantly, they tended to view all of these as being closely linked and in some way causally related to another concern: the growing problem of heroin addiction among Black and Latino Americans. From this point of view, methadone maintenance appeared to address only an individual's dependence on heroin, not the broader social conditions that produced drug addiction among large groups of people. Distrust seemed warranted for another reason as well. In less than two decades, Americans had witnessed astounding revelations of government complicity in a wide range of medical abuses, including coerced sterilization of Black, Latina, and Native women of color; harassment and infiltration of prominent civil rights organizations; and, in the early 1970s, the Tuskegee syphilis study on rural, poor Black men and their sexual partners, and medical experimentation on incarcerated men in Holmesburg Prison in Pennsylvania. The capacity for abuse by a system designed to keep heavily surveilled patients indefinitely dependent on a narcotic supplied by clinics that were largely outside of community control was not simply potential, but actual. In many municipalities there were poor Black and White patients who reported having joined programs as a requirement of parole or probation or in exchange for welfare benefits.

In this light, popular distrust of MMT was lamentable, but entirely understandable. However, that distrust was in some ways misplaced, as it was *methadone policy and politics*, not anything inherent to the drug itself, which were most problematic. I focus mainly on how the era's politics helped to produce federal regulatory policy in the early 1970s, which inadvertently served to make methadone maintenance much more polarizing than it had to be. Those policies remained in place until the mid-1990s, with many aspects still existing today. The unfortunate result is that, 50 years after the first Food and Drug Administration (FDA) MMT regulations, structural barriers and popular stigma against methadone maintenance and its patients are powerful deterrents to those seeking help.

I begin by briefly outlining the early years of methadone maintenance politics and policy, from roughly 1969 to 1975, to show how the FDA responded to multiple concerns regarding addiction and drug-related crime, methadone's actual ability to rehabilitate, the possibility of street diversion, and the potential for government abuse and social control. At greater length I elaborate on the points of contention specifically from Black and White critics whose opposition was philosophical and political. I conclude with a discussion about the paths not taken during this period.

Abuse: Research and Treatment 11 (2017); Kyaïen O. Conner et al., "It's Like Night and Day. He's White. I'm Black: Shared Stigmas between Counselors and Older Adult Methadone Clients," *Best Practices in Mental Health* 6, no. 1 (2010); Kyaïen O. Conner and Daniel Rosen, "'You're Nothing but a Junkie': Multiple Experiences of Stigma in an Aging Methadone Maintenance Population," *Journal of Social Work Practice in the Addictions* 8, no. 2 (2008).

The Regulatory Mire

I have noted elsewhere methadone maintenance's convoluted regulatory history. It was in mid-1970 when MM first entered FDA regulatory purview, only weeks after the Nixon administration communicated its own support for MMT expansion. Federal guidelines before this had permitted the use of methadone only in analgesia and medically supervised withdrawal of opioid-addicted patients. Addressing the emergence of maintenance, novel guidelines promulgated by the FDA and the Federal Bureau of Narcotics and Dangerous Drugs (BNDD conferred on methadone investigational new drug (IND) status for maintenance purposes, in which practitioners were bound by requirements in licensing; maximum daily dosage; diversion prevention; strict recordkeeping; staff supervision; applicant screening; patient monitoring for abuse of other drugs (urine testing); and provision of ancillary services (e.g., counseling, psychotherapy, and vocational assistance). Excluded from treatment were minors, pregnant women, and persons suffering from psychosis or from extreme physical disability.³

Many hailed the new regulation as a major advance in addiction treatment as it would, so it was presumed, standardize treatment across the country. Yet some physicians believed the regulations tied their hands. Several had opened clinics that had thrived during the recent years of ambiguous regulation. Those who did not comply with the new regulations quickly found themselves under intense federal scrutiny.⁴ Meanwhile, Dr. Vincent Dole, who with Dr. Marie Nyswander in New York brought methadone maintenance into being, was deeply bothered that the FDA and BNDD had constructed the June 1970 model protocol "with essentially no consultation with knowledgeable people in the field." Even the provisions that most of the public would have thought reasonable were, in Dole's opinion, countertherapeutic. In excluding from the model protocol patients deemed psychotic, the FDA had deprived physicians of the opportunity to treat an otherwise unreachable population and to add other psychiatric treatments to methadone. He offered a similar argument regarding those with physical illness, arguing that, for example, before methadone maintenance, hard-core heroin users with tuberculosis "would be running off all the time without taking their medicine for tuberculosis." In the context of a methadone clinic, however, such patients could be issued both. Even the concern regarding the effects of methadone on pregnancy missed the point. Dole asserted that he had treated many women whose pregnancies were entirely normal while on methadone, but worried that these women otherwise would have continued to use heroin had they been denied the treatment.⁵

Less than a year later, in early April 1971, the FDA relaxed its regulations on methadone maintenance, upgrading its status from an "investigative new drug" to a "new drug application." Gone were those provisions of the 1970 model protocol, which excluded pregnant women, people under the age of 18 years, and those with physical or mental illness. Additionally, private physicians also were allowed to dispense methadone on a maintenance basis. Of equal importance, politically as well as therapeutically, clinics no longer had to limit daily dose to 160 milligrams. Nor were they required to stipulate for each patient an eventual goal of narcotic addiction "cure," the complete independence from any opioid at all, including methadone. With the lowering of exclusions and the elongation of treatment duration to a perhaps indefinite period of time, both the number of patients

³ Helena Hansen and Samuel Roberts, "Two Tiers of Biomedicalization: Buprenorphine, Methadone and the Biopolitics of Addiction Stigma and Race," in *Critical Perspectives on Addiction*, ed. Julie Netherland (Bingley, UK: Emerald, 2012).

⁴ David Courtwright, Herman Joseph, and Don Des Jarlais, *Addicts Who Survived: An Oral History of Narcotic Use in America, 1923-1965* (Knoxville: University of Tennessee Press, 1989).

⁵ "Methadone Plans Called Unworkable," *The Austin Statesman*, 13 July 1970.

recruited and those retained ballooned. Funded largely by President Nixon's Special Action Office on Drug Abuse Prevention, the number of methadone maintenance patients in the United States grew from 9,100 to 73,000 between 1971 and 1973. Some estimates stated a figure as high as 85,000.

The lowered restrictions and the dramatic expansion of the patient ranks unnerved many. Lawmakers at every level of government expressed concern about reports of loose protocols, failure to offer other kinds of therapy in conjunction with methadone, inconsistent urine testing of patients, and street diversion of methadone. Many physicians found themselves the target of popular and official allegations of medical profiteering and even intentional street diversion. Some undoubtedly were. If newspaper accounts are to be believed, before 1972 (the years of office-based prescription), in any American city with physicians prescribing methadone, there might have been as many as two or more physicians under some kind of formal or informal investigation by the Bureau of Narcotics and Dangerous Drugs, the FDA, local law enforcement, or even health officials. Most either complied with authorities or quietly closed shop. Others, in cases which often rose to the level of national attention, defended themselves against charges in the courts of law or public opinion. Dr. Thomas Moore, an African-American physician practicing in Washington, DC, denied all charges of prolific prescribing and retorted that the rising demand for street heroin was a demonstration of the need for more availability of methadone. Other physicians made similar arguments. At hearings held in late 1972 and early 1973 by the Senate Subcommittee to Investigate Juvenile Delinquency, Roger Smith, the director of a multimodality addiction treatment program in San Rafael (Marin County), CA, testified that he was not that concerned about diversion and suggested that measures to curb it could do more harm than good in that they would work against patient recruitment and retention. San Rafael is not far from San Francisco, whose Sheriff, Richard Hongisto, also questioned the assumption that diversion represented a social threat while expressing the opinion that the British system of heroin maintenance and the U.S. system of methadone maintenance were "a more humane and cheaper response than continual criminalization."⁶

Some of the April 1971 relaxations were retracted a year later, in early April 1972, when the FDA again decided that children below age 18 should not be treated with methadone. In the 1972 regulations, the FDA also restricted methadone prescription to "a closed system" of clinics in which new patients in their first 3 months would be closely supervised when administered methadone. Physicians no longer could prescribe methadone from their office for a patient to purchase at a local pharmacy, and patients, even after their 3-month probationary period, would not be allowed to take home more than a 3-day supply. To further ensure patient compliance, the FDA mandated weekly urinalysis tests to monitor polydrug use. At the same time, however, the FDA imposed a hybrid set of guidelines (combining both IND and NDA status) and approved methadone for narcotic addiction treatment, a move that further expanded the ranks of patients. These new guidelines became effective 90 days later, only to be altered again under the Narcotic Addict Treatment Act of 1974, which gave increased regulatory and investigative authority to the BNDD's successor, the Drug Enforcement Administration (DEA).⁷

⁶ *Methadone Use and Abuse -- 1972-73. Hearings before the Subcommittee to Investigate Juvenile Delinquency of the Senate Committee on the Judiciary; November 14 and 16, 1972; February 8, 13, and 14, and April 6, 1973, Second Session of the 92nd Congress and First Session of the 93rd Congress, 1973, 271-72.*

⁷ Ida Walters, "Curse or Cure?," *Wall Street Journal*, 27 July 1972; Henry L. Lennard, Leon J. Epstein, and Mitchell S. Rosenthal, "The Methadone Illusion," *Science* 176, no. 4037 (1972). On the history of FDA regulation, see Philip J. Hiltz, *Protecting America's Health: The Fda, Business, and One Hundred Years of Regulation* (New York: Alfred A. Knopf, 2003).

The Making of a Controversy

In announcing its guidelines, nothing in the FDA's language forecasted its role in the major racial controversy it helped to create. There were, of course, no provisos regarding ethnic composition of the patient base or the clinical personnel. However, in their extreme vigilance to prevent street diversion, to mandate urine testing to discourage patient "cheating" (using other drugs while on methadone), and to regulate physician practice and surveil patients, the FDA and BNDD produced a regulatory environment in which the treatment protocol was limited only to a specialized set of mainly White physicians, effectively alienating Black communities and even Black physicians. In a matter of just a few years, a fairly dominant consensus in the Black public sphere viewed methadone maintenance as anathema to the main political programs of the previous two decades.

Although in Black political culture methadone maintenance has held a generally unenviable place of distrust and derision, Black opinion on methadone or narcotic maintenance was not monolithically negative, nor was it uniformly consistent over time. As early as 1953, in answer to the question, "Should Dope Be Legalized?," the editors of the Black middle-class *Ebony* magazine gave serious consideration to proposals for private and government-run heroin and morphine maintenance clinics.⁸ In 1963, the grassroots Harlem Neighborhoods Association, Inc. (HANA) declared that it "views addiction as a *medical problem*" not to be "viewed as a moral defect, and an occasion for great shame." It also pointed to "the British system of legal availability of drugs to addicts," and called for reasoned consideration of "a limited program for the legalization of drugs," especially for those waiting to be admitted to rehabilitation programs.⁹ In response to a 1964 New York City Council resolution to explore the possibility of narcotic maintenance (methadone was not specified), Rev. Eugene Callender, a prominent Harlem clergyperson and community organizer with a history of addiction outreach, sounded much like a proto-harm reductionist. The plan, which Callender called an "excellent idea" that should be tried in a 3-year pilot program, reminded him of the British system of narcotics maintenance. "At least," he said, "he [the addicted individual] would be getting good drugs, instead of the garbage he gets in the streets and which is given to him through dirty instruments."¹⁰ Upon hearing the news of the Dole-Nyswander experiment in 1965, women's and civil rights activist Dorothy Height was cautiously optimistic: "Research on methadone is still in a very early stage, but it may lead to a new understanding and treatment of drug addicts. So far methadone has enabled some addicts, for the first time in their lives, to become self-supporting, responsible members of the community."¹¹ What changed between 1953 and the early 1970s was the political configurations surrounding narcotics maintenance, not the idea of narcotics maintenance itself.

The 1972 regulations had been designed to strike a balance of proponents and opponents of methadone maintenance who themselves represented a broad range of public concerns. The most ardent of supporters, often physicians, saw in methadone maintenance real rehabilitative potential, especially when combined with counseling, social services, and vocational or educational assistance (historically, this combination of medically assisted treatment with supportive services has produced

⁸ "Should Dope Be Legalized? Doctors, Police and Social Workers Debate Drastic Move to Set up Legal Clinics as Step to Combat Narcotics Racket," *Ebony*, April 1953.

⁹ Joseph P. King, Lonnie MacDonald, and Harlem Neighborhoods Association Inc. (HANA), "A Preliminary Report of the Neighborhood Conference on Narcotics Addiction, Co-Sponsored by Harlem Neighborhoods Association Mental Health Committee, Harlem Hospital Department of Psychiatry," (Malcolm X Papers, Schomburg Center for Black History and Culture; Box 10, Folder 14, 1963).

¹⁰ "Clergymen Back, Hit Giving Dope to Addicts," *New York Amsterdam News* 22 February 1964.

¹¹ Dorothy Height, "A Woman's Word," *New York Amsterdam News*, 4 September 1965.

the best results). Allied with this group were those whose support for MMT emanated from concerns about escalating crime rates attributable, so they believed, to drug users. Meanwhile, methadone's critics were more diverse, united mainly in their opposition. For example, there were NIMBYist elements who worried mainly about declining property values and public safety in their neighborhoods. Similarly, by 1970 the "drug-free" (non-methadone) addiction rehabilitation industry was reaching its maturity, but few organizations in the field were so established as to not regard methadone maintenance as an ideologically and even economically competing threat.

Added to these motivations were ones that were more philosophical, sociological, and political. Unless one subscribed to the biomedicalized metabolic theory of addiction underlying the Dole–Nyswander program, the contradictions inherent in treating opioid addiction with an opioid were obvious. In the way that simplistic analogies rarely do much to illuminate the nuance of a controversy, opponents argued that methadone maintenance made as much sense as providing gin to an alcoholic to cure him of his compulsive use of whisky. Since at least the 1920s, theories of addiction ranged in emphasis from deviance and mental illness to sociological conditions of deprivation, but few if any conceived of rehabilitation as implying anything but drug abstinence.

For many Americans, the issue was a moral one. Yet for others, the questions methadone raised were social and psychological. If one believed, as did most social psychologists, sociologists, and even many psychiatrists, that the "true causes" of addiction—be they social (economic deprivation, denied opportunity, official neglect, racism) or individual (ennui, low self-esteem, anxiety, trauma, depression)—lay in one's psychic engagement with the social world, then methadone did nothing at all to address the problem. Furthermore, the metabolic theory of addiction, comparing it to diabetes, may have been a useful heuristic or analogy to offer politicians and the general public, but it, too, was demonstrably imprecise and simplistic. Few physicians could point to patients who had been able to manage their diabetes to the point where insulin was unnecessary, but stories of successful recovery from even hard-core addiction were easily found, even if not as prodigiously as everyone would have wanted.

It is one thing to believe that heroin addiction among America's youth came from ennui, or lack of meaningful work and purpose, or alienation, or, as in the case of Black and Latino Americans, structural racism. It is something almost completely different to argue that it reflected biological deficiencies in the human body. Black political leadership and racial liberals of all ethnicities generally saw heroin addiction as the result of failed economic policies that had left Black communities without viable jobs, a decent education, secure housing, appropriate health care, and effective public safety. Absent these basic rights, America's Black youth were susceptible to heroin experimentation and addiction. This certainly was a theme embedded in three of the late civil rights-era's most popular memoirs, Claude Brown's *Manchild in the Promised Land* (1965), Alex Haley's and Malcolm X's *The Autobiography of Malcolm X* (1965), and Piri Thomas's *Down These Mean Streets* (1967). If addiction was the direct result of these persisting inequities, any proposal for the provision of a narcotic to narcotics addicts would meet the rejoinder that government officials wanted merely to pacify the ghetto, not to address the deep structural problems that produced addiction. Coined in 1944, the term "genocide" found its way into the political lexicons of a global array of racialized protest movements, and in the United States framed some of the opposition's analysis of methadone policy among the Black poor.¹²

¹² See, for example, Daniel Casriel and Thomas Bratter, "Methadone Maintenance: A Questionable Procedure," *Journal of Drug Issues* 4 (1974); "Methadone a Form of Genocide: Ex-Addict," *New York Amsterdam News*, 10 May 1969; Rev. Curtis E. Burrell Jr., "Black Addiction: A Summary and Overview," *Chicago Daily Defender*, 21 October 1971; William L. Claiborne, "U.S. Methadone Role Scored," *The Washington Post*, 14 May

The medical framing of addiction as a “metabolic disorder” (as Vincent Dole frequently described it), and methadone maintenance for the addicted as analogous to insulin for the diabetic, is one of the 20th century’s most pronounced examples of what sociologist Peter Conrad critically called *medicalization*.¹³ Indeed, in offering his earliest definition of medicalization—the process of “defining [a specific] behavior as a medical problem or illness and mandating or licensing the medical profession to provide some type of treatment for it”—Conrad listed as examples “alcoholism, drug addiction, and treating violence as a genetic or brain disorder.”¹⁴ That all three were behavioral in nature pointed to the historical moment in which Conrad developed the concept. By the early 1970s, medical skepticism, like distrust of all authority, especially government, was at its height. One facet of this was the international antipsychiatry movement, which, somewhat ironically, was led largely by psychiatrists from the United Kingdom, the United States, France, and Italy. In reframing a “deviant” behavior as instead a medical condition, the process of medicalization, so the critique goes, offers the liberation of the individual from social stigma. It also, however, has the potential to turn dynamics that are imminently *social* into *individual pathologies*. Thus they are denunciations of methadone as a “false cure” and an expedient and cheap “technological fix” for issues that government policy had failed to resolve.¹⁵ Psychiatrist Thomas Szasz, one of the most polemical figures in the American antipsychiatry movement, likened the combined carceral and medical authority brought to bear on drug users to the Spanish Inquisition, and methadone to “the Medical Holy Water” designed “to counteract the Heretical Witch’s Brew of Heroin.”¹⁶ Writing in the journal *Science*, three psychiatrists argued, “If heroin use were ‘the problem,’ then methadone might well be the answer. If, however, physical, psychological, and social costs of drug use for the person and the community are ‘the problem,’ then methadone may well contribute to the problem rather than to the solution.”¹⁷ Coupled with this logical challenge was the widespread suspicion of what social critics of the time called the “medical–industrial complex.”¹⁸ This position was exemplified by social scientist Florence Heyman’s description in 1972 of methadone as “a typically American answer to a large-scale American problem,” and her prediction that rapid and vast proliferation of methadone clinics augured the emergence of a new “bureaucratic empire.”¹⁹ At a time when distrust of the government was even more widespread than distrust of organized

1972; Audrey Weaver, “From the Weaver,” *Chicago Daily Defender*, 29 April 1972; Profumo Adolfo, “Too Many Methadone Clinics = Genocide?,” *New York Amsterdam News* 1992; Frank Morales, “Methadone: Genocide of the Poor,” *The Portable Lower East Side* 1992.

¹³ Peter Conrad, “The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior,” *Social Problems* 23, no. 1 (1975); *Identifying Hyperactive Children: The Medicalization of Deviant Behavior* (Lexington, MA: Lexington Books, 1976); “Medicalization and Social Control,” *Annual Review of Sociology* 18 (1992); “Medicalizations,” (United States: American Society for the Advancement of Science, 1992); *Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (United States: The Johns Hopkins University Press, 2007); Peter Conrad and Joseph W. Schneider, “Deviance and Medicalization, from Badness to Sickness,” in *Deviance and Medicalization, from Badness to Sickness* (1980).

¹⁴ Conrad, “The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior.”

¹⁵ Dorothy Nelkin, *Methadone Maintenance: A Technological Fix* (New York: G. Braziller, 1973).

¹⁶ Thomas Szasz, *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers* (Garden City, NY: Anchor Press, 1974), 67.

¹⁷ Lennard, Epstein, and Rosenthal, “The Methadone Illusion.”

¹⁸ Barbara Ehrenreich, John Ehrenreich, and Health/PAC, *The American Health Empire: Power, Profits, and Politics* (New York: Random House, 1970).

¹⁹ Florence Heyman, “Methadone Maintenance as Law and Order,” *Society* 9, no. 8 (1972).

medicine, many feared a partnership of the two in the form of a methadone empire with an outsized capacity for social control and urban pacification.

The matter of methadone and the variety of medicalization it represented were rendered even more contentious by methadone's place in American anticrime politics and the U.S. history of racialized drug politics and law enforcement. For their own reasons, politicians, journalists, physicians, and social scientists since Emancipation frequently described Black Americans as particularly intemperate and prone to insanity and criminal activity. In the turn of the 20th-century cocaine scare, for example, as drug historian David Musto has observed, "the fear of the cocainized black coincided with the peak of lynchings, legal segregation, and voting laws all designed to remove political and social power from him."²⁰ In considering the war on crime's origins in the 1960s and 1970s, political scientists Naomi Murakawa and Vesla Weaver and legal scholar Michelle Alexander have argued that anticrime policies, especially the War on Drugs, emerged as a counter to civil rights demands.²¹ Speaking specifically of drug law enforcement in the 1950s and 1960s, historian Kathleen Frydl has noted that "African American civil rights leaders had to contend with another discursive construct of the decade, that of [B]lack criminality." Indeed, Senators and Representatives repeatedly highlighted Washington, DC, the nation's only majority Black city, as particularly crime- and drug-ridden. Those who were resistant to the civil rights movement, Frydl also notes, vigorously made "assertions of [B]lack criminality," which they "deployed regularly to counter or to stall the [B]lack freedom movement."²²

Cognizant of the long history of the popular White association of Black Americans with crime and deviant behavior, and suspicious of methadone maintenance as a convenient technological fix to inconveniently complex social problems, many White and Black Americans therefore wondered which aspect of methadone—addiction recovery or crime reduction—was most attractive to its proponents. The suspicion was not unwarranted. New York's City Council, for example, attempted to pass a bill requiring MMT for as many as 5,000 drug users at Rikers Island jail. Vocal opposition from the City's Commissioners of Corrections, Addiction Services, and Health Services did not deter the largely Democratic council, and it was the veto of Liberal Republican Mayor John Lindsay which ultimately prevented it from becoming law. New York Governor Nelson Rockefeller's support for methadone programs throughout the state came after the political and therapeutic disaster of his coercive 1967 civil commitment program, and just before the draconian 1973 drug law, which also bore his name.²³

Officials at the federal level also expressed enthusiasm for methadone's potential crime-reductive capacities. The 1969 report of the National Commission on the Causes and Prevention of Violence gave significant space to the perceived connections between narcotic addiction and non-violent as well as violent crime, recommending that "more and better [treatment] facilities be

²⁰ David F. Musto, *The American Disease: Origins of Narcotic Control*, 3rd ed. (New York: Oxford University Press, 1999), 7.

²¹ Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (New York: New Press, 2010); Vesla M. Weaver, "Frontlash: Race and the Development of Punitive Crime Policy," *Studies in American Political Development* 21, no. 2 (2007); Naomi Murakawa, *The First Civil Right: How Liberals Built Prison America* (New York: Oxford University Press, 2014); Elizabeth Kai Hinton, *From the War on Poverty to the War on Crime: The Making of Mass Incarceration in America* (2016).

²² Kathleen Frydl, *The Drug Wars in America, 1940-1973* (New York: Cambridge University Press, 2012), 122, 211.

²³ Bennett, "Mandated Use of Methadone Assailed by 3 Big City Officials."; Hansen and Roberts, "Two Tiers of Biomedicalization: Buprenorphine, Methadone and the Biopolitics of Addiction Stigma and Race."; Fried, "State Panel Urges Care on Methadone."

established and that research and testing of treatment programs receive high priority [and that] additional research on drug maintenance programs, such as the methadone program in New York, should be encouraged."²⁴ Federal lawmakers and White House officials closely watched Washington, DC's, crime wave, which had begun in 1966. A February 1969 meeting of Washington's mayor, health department director, and forty other federal and local authorities produced the announcement that the District soon would develop its own methadone program. An influential development had been Vincent Dole's testimony that his program had proven its ability to change hard-core users "from criminals to respectable members of the society."²⁵ At the 1970 congressional hearings on crime in Washington, DC, even the Superintendent of the U.S. Public Health Service, Dr. Stephen Brown, contended, "we must be honest with ourselves in facing the fact that certainly one of the major things that concern us with opiate addiction is the crime which results from opiate addiction. . . . It is precisely this criminal activity which would come to an end if heroin addicts. . . could obtain legal narcotics, such as methadone, from a medically capable source of supply."²⁶

Indeed, President Nixon's "therapeutic presidency" (as one historian has called it) was but one side of a Janus-faced drug policy which otherwise emphasized his "War on Drugs" (declared in 1971) and escalated funding and powers directed toward law enforcement efforts.²⁷ Drug use had not been particularly high on the American public's mind in 1968 – certainly not as worrisome as the economy or the war in Southeast Asia – but Nixon had successfully bundled it into his appeal to conservative white voters whom he termed the "silent majority," and his leadership in skepticism and even outright resistance to peace movements, civil rights activism, gender and reproductive gains, and economic democracy.²⁸ Commenters at the time noted as much, and there certainly is evidence that Nixon's support for methadone, like his appeal to the silent majority and his "Southern Strategy," was an electoral gambit. Looking ahead to the next election, a 1970 internal White House Domestic Council Summary Option Paper argued that "in 1972 citizens will be looking at crime statistics across the nation in order to see whether expectations raised in 1968 have been met. The federal government has only one economical and effective technique for reducing crime in the streets—methadone maintenance."²⁹ Along with this was the administration's support of measures which were decidedly untherapeutic. In its continuing conflict with the Department of Health, Education, and Welfare regarding authority over the drug use issue, the Department of Justice and its Bureau of Narcotics and Dangerous Drugs seemed to have the support of the President and many influential senators and members of Congress on both sides of the aisle. This imbalance of power gave Justice the authority, provided by the passage of the Comprehensive Drug Abuse Prevention and Control Act of 1970, to perform "no-knock" raids on private residences. That act and the Narcotic Addict Treatment Act of 1974 also made the BNDD's successor, the

²⁴ Donald J. Mulvihill et al., *Crimes of Violence: A Staff Report Submitted to the National Commission on the Causes & Prevention of Violence*, 3 vols. (Washington, DC: Government Printing Office, 1969).

²⁵ Philip D. Carter, "City Test of Cheap Drug Set for Heroin Addicts," *Washington Post*, 13 February 1969.

²⁶ *Crime in the National Capital. Part 2: Narcotics-Crime Crisis in the Washington Area. Hearings before the United States Senate Committee on the District of Columbia*, 1, 25-26 March, and 9-11 April, 1969.

²⁷ Kevin Yuill, "Another Take on the Nixon Presidency: The First Therapeutic President?," *Journal of Policy History* 21, no. 02 (2009).

²⁸ David F. Musto and Pamela Korsmeyer, *The Quest for Drug Control: Politics and Federal Policy in a Period of Increasing Substance Abuse, 1963-1981* (New Haven: Yale University Press, 2002).

²⁹ Quoted in David J. Bellis, *Heroin and Politicians: The Failure of Public Policy to Control Addiction in America*, Contributions in Political Science, (Westport, CT: Greenwood Press, 1981), 59. See also Michael Massing, *The Fix* (New York: Simon & Schuster, 1998).

Drug Enforcement Administration, an equal partner with the FDA in the federal effort to control methadone treatment programs.³⁰

There were in fact aspects of the Nixon administration that hailed the first. However, many suspected that was not unconnected from his appeal on November 3, 1969, to the “silent majority” of (white, conservative) Americans who had become weary, even resentful, of the politics of antiwar mobilizations, civil rights, gender equality, and economic rights, and distrustful of the post-1933 alliance among organized labor, civil rights, and the Democratic Party.³¹

Many who were following the politics of heroin addiction and methadone understandably expressed concern at the potential abuses of the new treatment modality, and whether massive funding simply tempered a wider agenda of racial control.³² *Washington Post* columnist William Raspberry opined that “methadone is not so much a means for treating addicts as a way of fighting crime” whose effectiveness in crime reduction would obviate the need for actual treatment from “psychiatrists, social workers, placement specialists and the rest.”³³ In two days of hearings on methadone maintenance, U.S. House of Representatives Delegate Walter E. Fauntroy (District of Columbia) made clear his own distrust. So, too, did invited witness Ron Clark, the director of Washington, DC’s, RAP, Inc., who argued that MMT was not particularly beneficial to Black patients or Black communities, but was “politically expedient,” for politicians more concerned about crime than recovery.³⁴

Historical Lessons

It is tempting to attribute the methadone controversy to mere misunderstanding of the problem and of the other side’s perspectives and approaches. It is clear that proponents and opponents, respectively, harbored differing views on the “true causes” and the nature and proper treatment of addiction. By 1970, many of the “drug free” (non-methadone) programs and

³⁰ United States General Accounting Office, *More Effective Action Needed to Control Abuse and Diversion in Methadone Treatment Programs : Food and Drug Administration, Department of Health, Education, and Welfare, Drug Enforcement Administration, Department of Justice : Report to the Congress* (1976).

³¹ Mical Raz, "Treating Addiction or Reducing Crime? Methadone Maintenance and Drug Policy under the Nixon Administration," *ibid.* 29, no. 1 (2017); Hinton, *From the War on Poverty to the War on Crime : The Making of Mass Incarceration in America*; Rick Perlstein, *Nixonland: The Rise of a President and the Fracturing of America* (New York: Scribner, 2008); Michael Flamm, "Politics and Pragmatism: The Nixon Administration and Crime Control," *White House Studies* 6, no. 2 (2006); Jason Edwin Glenn, "Medicalizing Addictions, Criminalizing Addicts: Race, Politics and Profit in Narratives of Addiction" (doctoral dissertation, Harvard University, 2005); Ted Galen Carpenter, *Bad Neighbor Policy : Washington's Futile War on Drugs in Latin America*, 1st ed. (New York: Palgrave Macmillan, 2003); Musto and Korszmeier, *The Quest for Drug Control: Politics and Federal Policy in a Period of Increasing Substance Abuse, 1963-1981*; Dan Baum, *Smoke and Mirrors: The War on Drugs and the Politics of Failure*, 1st ed. (Boston: Little, Brown, 1996); Brooks Jackson, "Nixon Action Aids Capital's Crime Battle," *Los Angeles Times*, 18 November 1971.

³² Hansen and Roberts, "Two Tiers of Biomedicalization: Buprenorphine, Methadone and the Biopolitics of Addiction Stigma and Race."

³³ William Raspberry, "Holdups or Hangups?," *The Washington Post*, 25 June 1971; "Methadone Use: Another Blunder," *The Washington Post*, 11 May 1971.

³⁴ Peter Osnos, "Is It a Solution?: Controversy on Methadone as Heroin Solution Mounting," *ibid.*, 26 December 1972.

therapeutic communities based in Black communities connected the heroin problem to official neglect, and addiction treatment to community reconstruction. Though there were some Black methadone doctors in the early years who also connected their work with a larger address of the social structures that, they believed, produced addiction, most methadone physicians were White and by and large exhibited little evidence of doing the same, at least not in ways recognizable to their detractors. Furthermore, their view of their critics and competitors in the addiction treatment marketplace was often uncharitable, even derisive: they regarded the drug-free programs as at best dangerously misguided and, at worst, cynically manipulative. Indeed, in many cases this was true — some programs were based on theories of treatment, which made the programs ineffective, abusive in their tactics, and even cultish. Others, however, were well-run and valued institutions within the communities they served. Meanwhile, leaders of the community-based programs often maintained a caricaturist perception of methadone maintenance as being simply and only the delivery of narcotics to people with addictions. Certainly, many clinics lacked effective supportive services, but rather than critique individual clinics, methadone's most vociferous critics roundly condemned the whole treatment modality.

In fact, the problem was less a misunderstanding than a polarization of opinion as the late 1960s turned into the 1970s. Indeed, we might even posit historical hypotheticals that would illuminate options not taken. First, methadone maintenance represents but one particular form of medicalization of the addiction problem. Alternatively, one might imagine a form of medicalization in a different configuration. Largely because of fear of street diversion, the regulatory view of methadone as a dangerous drug to be heavily regulated effectively shut out the community-based groups who might have used it productively. Indeed, before the stringent regulations of the 1970s, many community-based programs in the 1960s had used methadone informally as a detoxification tool, dispensed every day in gradually decreasing doses. After methadone was taken out of their hands, two of these—the historic programs at Lincoln Detox in the South Bronx and the Blackman's Development Corporation in Washington, DC—were uncompromising in their opposition to methadone maintenance. It is true that there is a great difference between methadone detoxification and methadone maintenance, but this historical example shows that these groups were not categorically against the use of a narcotic on the way to recovery.

It is certainly imaginable that there could have been a methadone maintenance system more closely aligned with the community mental health and free clinic movements. These movements thrived during the War on Poverty years, but fell out of federal favor after 1969. In regard to methadone, in 1970 and after, federal policy was primarily concerned with keeping methadone out of the wrong hands, and less interested in ensuring that it was in the right ones. In a different but imaginable policy environment (one in which the federal government had maintained its commitment to the Great Society, one in which BNDD and DEA power did not so dramatically outmatch the influence of physicians and community-based groups), federal policy might have provided compelling incentives to methadone physicians to partner with or to lodge their practices within the local organizations that had better connections to the communities they served. A feature of nearly all of the spectrum of Black political thought, the political investment in addiction rehabilitation as community building, did not preclude the daily use of a substance in the service of positive psychic and social change. Had policy makers thought it a worthwhile policy experiment, the deliberate coupling of methadone with the therapeutic communities might have helped to reduce stigma. No such policy was ever explored, but a great deal of effort and resources were expended in policing methadone physicians in the name of preventing their inventories from being diverted to the street.

These notions are counterfactual, but not inconceivable. Indeed, some could have come to be as a matter of historical accident. However, one factor is difficult to imagine as being any different except outside of the United States' longer history of anti-Black racism and stigma against people who use substances. To speculate about what might have or might have not happened under a different presidential administration, or within a different regulatory structure, is relatively simple compared with the exercise of imagining how methadone maintenance might have emerged without the 350 years of history which preceded it. This consideration, however, is perhaps the most important in future drug policy. After all, heroin and virtually all of the drugs popularly described as "dangerous" in U.S. history were deeply racialized in politics and the policy arena. The War on Drugs, announced by President Nixon, but accelerated under Presidents Reagan, Bush, and Clinton, was, as we now understand, a deeply racialized enterprise. Methadone had nothing to say to that, while many social scientists and the highest profile Black drug-free community-based treatment centers took that history as a point of departure for theories of personality development. Many individuals realized successful and meaningful recovery under each approach, but one wonders what might have been had those seeking recovery not been forced to choose one over the other.

To be clear, I do not argue that popular stigma in Black political culture is today the primary barrier to the realization of good treatment. First, Black stigma against methadone may be distinguishable from other Americans' stigmatizing attitudes only in its political nature, not in its prevalence or intensity. Second, compared with structural impediments, stigma is much less "material." At the same time, understanding the nature of Black popular disapproval of methadone is of material concern, as the continued stigmatization of people in medically assisted treatment inevitably will prevent us from seeing them as citizens whose needs are not much different from other groups with specific health care requirements.

Unlike legal protection, educational equity, or economic opportunity, the needs and rights of people who use drugs was not a major plank in any civil rights platform of the 1950s, 1960s, 1970s, and 1980s. None of the movement's national or local leaders made this a priority in their negotiations with power. However, unlike 50-plus years ago, today we have the benefit of a widely distributed network of Black harm reductionists, many of whom began their work in the 1980s and whose principal agenda combines, among other things, accessibility to health care and a frontal attack on stigma. An imaginable future of therapeutic success certainly must include the peer counselors, volunteers, policy workers, and physicians who comprise this 21st century movement for civil and human rights.

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