

**A HISTORY OF METHADONE TREATMENT IN  
AUSTRALIA: THE INFLUENCE OF SOCIAL  
CONTROL ARGUMENTS IN ITS DEVELOPMENT**

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## **Abstract**

Methadone treatment has been a controversial strategy used in the treatment of heroin dependent people. It has been available in Australia since 1970 and its use as a treatment option has waxed and waned until 1985 when, with the spread of HIV/AIDS, methadone was recognised as playing a major role in limiting the transmission of the virus by the unsafe practice of needle sharing.

With 25,000 people now receiving methadone treatment in Australia, it is regarded by most as a successful public health initiative. Methadone treatment also plays a significant role in controlling other ill effects of heroin use including the control of crime. This paper reconstructs the history of methadone treatment programs in Queensland and NSW. It shows how the explicit social control of heroin users was a strong argument in developing methadone treatment policy.

## **Introduction**

Drug addiction in most western industrialised countries has been conceptualised as an individual, medical, legal, and moral problem. The reliance on methadone treatment defines heroin use as a medical concern and focuses on the most manageable and easily understood of the problems of the addict, that is, his or her physiological needs (Nelkin, 1973). Currently there are over 25,000 people receiving methadone treatment in Australia and most would agree the emphasis on the use of methadone is a policy success (Ward, et al, 1992; McDonald, et al, 1988). Methadone treatment is seen as an important and effective strategy in the fight against HIV/AIDS infection. Methadone treatment is also affective in controlling other negative impacts of illegal drug use – specifically the crime associated with drug use. This paper reconstructs the history of the methadone programs in Queensland and New South Wales. It first summarises the arguments around the medicalisation of drug use and the role medicine plays in controlling drug users. The paper secondly recounts the phases of methadone treatment policy in two states in Australia – New South Wales and Queensland. Methadone treatment has been available in Australia for almost 30 years and its use as a treatment option has waxed and waned until 1985 when the program underwent a major expansion. It is argued that the history of two state programs highlights how policy makers, politicians and the media use the pragmatic and popular social control arguments to enhance a policy objective.

### **The Medicalisation of heroin use**

'Drug addiction' and the method by which the state has chosen to deal with it has, from half way through the 19th century, been regarded largely as a medical problem of individuals. Krivanek argues that:

The individualism of drug problems consists in the belief that some deficit in the individual has caused the problem. One example is the medical model: many professionals and government bureaucracies treat drug problems as an illness of individuals who are to blame for inflicting it on themselves by choosing unhealthy consumption (1988:21).

There are a number of reasons why a social problem, such as drug addiction, is constructed in a medical paradigm. One is who defines the problem. The medical profession have, through their professional authority and power, strongly influenced government and the media's agenda. Nelson (1984:17), in a discussion about the re-emergence of child abuse as a social problem, argues that one of the benefits of medicalising social problems is that governments are more likely to 'adopt and respond to issues that are constructed in this way rather than issues that confront long established power arrangements'.

Conceptualisation of social problems in this way also leads to the perception that the medical profession can offer solutions to 'treat' the person rather than punish the individual. It also results in expanded areas of influence for the medical profession which has had a vested interest in defining and constructing social problems. The medicalising of social problems also limits policy solutions. Although medicalisation undoubtedly improves the lives of some individuals it detracts from, and fails to deal with, the fundamental institutional mechanisms that may have led to the problem in the first place.

Medicine, although a less obvious control agent than, say, the criminal law, plays a pivotal role in the management of types of deviance (Edwards, 1988:143-44). Medicalising problems, changing the emphasis from criminality to illness, involves an ideological rather than an institutional rationale for social control. Conrad and Schneider (1980:241) see the definition and designation of deviance as political matters and regard the ascendancy of the medical paradigm as the most 'powerful extralegal institution of social control'.

Zola (1972:487) argues that medicine as a major institution of social control has become 'the new repository of truth' where absolute and often 'final judgements are made by supposedly morally neutral and objective experts'. This has occurred, he maintains, not through any political power that doctors may hold, or influence, but through the phenomenon of the 'medicalisation of much of daily living'. The medical profession has been granted the legitimate authority to define problems in a particular way. The common theme throughout all forms of professional power is the ability to provide a technical fix. Methadone 'treatment' is a technological solution by which the state attempts to act proactively engaging the medical profession in ameliorating the effects of heroin addiction. This includes addicts' involvement in criminal activity and leads to improvement in the functioning of the individual in society with regards to health and employment. It also ensures that the addict is in contact with authorities and treatment provides a way of monitoring individuals.

As will be discussed later in the examples of two state methadone programs the social control arguments were used differently by key stakeholders in the treatment debate. Before exploring this issue a brief overview of methadone and how it is used is provided.

### **Background to Methadone**

Methadone produces similar effects to other opioids and can lead to dependence however it is dissimilar in chemical make-up to morphine or heroin (Fox and Mathews, 1992). In the United States in the 1960s it was found to have positive affects when given to heroin users. Dole and Nyswander (1968) outlined how their patients when given daily doses of methadone their behaviour and appearance significantly improved. When given higher doses they found that a substantial injection of heroin had little impact. Dole and Nyswander argued that opioid addiction was a disease that involved a metabolic deficiency. Therefore, they argued patients should be given enough methadone to stabilise this deficiency, even if they may be on methadone for the rest of their lives (not unlike diabetics having to take insulin daily). Total abstinence from drugs was not the objective in this model of treatment (Greeley and Gladstone, 1987:2).

Dole and Nyswander maintained that by providing a legal, longer acting substitute individuals had an opportunity to improve their social situation and 'take advantage of the psychotherapeutic and rehabilitative services that were an integral part of the program' (Dole and Nyswander, 1967).

Once this form of treatment was believed not only to reduce heroin use but also to lessen the need for criminal activity the program expanded very quickly in a very short period. By the early 1970s 100,000 addicts were receiving methadone in the United States as a treatment for their drug dependency. The initial attraction to this policy was the low cost of methadone treatment compared to other more expensive forms of treatment <sup>(1)</sup>. Nelkin (1973:31) argues

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(1) The relative cost of treatment in the United States in 1971 have been estimated as; Prison - \$8000 per year, Therapeutic communities - \$4,400 per year plus welfare, methadone maintenance - \$2000 per year plus welfare (Nelkin, 1973).

that another reason for methadone's adoption was that in an emergency – such as spiralling crime - new techniques are embraced with enthusiasm. 'They appeal as a potential panacea, as a means to 'wipe out' a problem'.

### **Early Australian Methadone Programs**

Methadone treatment first became available in Australia in 1970 and by the early 1970s all States were using methadone treatment to some degree. Heroin addicted clients were beginning to present themselves to services more frequently and treatment choices were limited.<sup>(2)</sup> Specialist drug and alcohol services were extremely under-developed and people with addiction problems tended to be seen by psychiatrists within mental health services or by non government, charitable organisations. However, crime related to increased heroin use was also increasing and it became apparent that there was a need to control this.

The programs in New South Wales and Queensland had similar roots and began around the same time. In New South Wales in 1970, Dr Stella Dalton, regarded as the pioneer of methadone treatment in Australia, established an in-patient unit for drug dependent patients in a western suburb of Sydney. She began prescribing methadone with a program similar to Dole and Nyswander's model involving a 6 week in-patient program which utilised high doses of methadone. It was different from the Dole and Nyswander model insofar as it aimed for total abstinence from all drugs within a three to four year period (Davies, 1986:148). Dr Dalton had previously unsuccessfully attempted to attract funding for a pilot methadone program. However, when the arrest rates for heroin use doubled in 1969 from the year before, money became available from the New South Wales State government (Davies, 1986).

The Queensland program began in a similar way. David Jenkins, the psychiatrist who started the program in Brisbane, like Dalton had also worked in England. Although Dalton and Jenkins both brought their experience back to Australia there were differences between the Queensland and New South Wales programs. The first was that Queensland doctors prescribed intravenous methadone to their clients. Secondly the major objective of the early Queensland prescribers was to ensure their clients more emotional stability which allowed the clients to take up their lives again – not necessarily an abstinence objective.

Queensland had what was regarded as the most liberal program in Australia because of the use of intravenous methadone. However, with the expansion of the public program in 1977, and a decision by the Commonwealth government that it was no longer prepared to fund intravenous methadone, this part of the program was stopped.<sup>(3)</sup>

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- (2) The other treatment options available in the late 1960s included:
- a) Detoxification: where dependent people were supervised to withdraw from heroin. This occurred in a specialised detoxification unit, hospital ward or at home. The aim was to eliminate physiological dependence on heroin.
  - b) Long term psychotherapy carried out by psychiatrists either on a residential or out-patient basis.
- (3) The doctors prescribing intravenous methadone argued that it wasn't fair to just stop providing this treatment to clients overnight. The decision was made to allow no more authorisations for intravenous methadone but those clients who were receiving it should continue until they were transferred to syrup form or withdrawn from all drugs. At the time of writing there was still one client receiving methadone intravenously in Queensland.

There appears to have been little pressure to document the results of the fledgling program or to justify its direction. There were no evaluations carried out in Queensland during the 1970s to justify the continuation of the program. It was not until 1984 that any evaluations of the program were carried out. The Queensland doctors appear to have quietly developed their program attracting either little notice or little concern from politicians or the public. Ian Curtis, another of the early prescribers, says:

The incredible thing was that it crept up on them. Basically we created a de facto intravenous drug program here...So that a de facto program just crept up on them and kicked them in the head and then they really couldn't get rid of it (I. Curtis, Interview, 17th February, 1994).

Influencing the decision to introduce methadone treatment in Australia was a belief that there were very few choices for treating opiate addicted people. It was in the early 1970s very much the domain of a few psychiatrists. John Marks, discussing the British setting, argues that ..'politicians were at a loss, they reasonably supposed doctors might know better and they let the medical profession argue, debate and try out different methods of managing things' (1992:184). The same could be said of the fledgling Australian programs. Heroin use was beginning to emerge as an increasing social problem leading to a rise in crime rates. For some, including some policy makers, the idea that methadone treatment could cure heroin use must have seemed appealing. The next section examines the reasons for a change in attitude towards methadone treatment in New South Wales. The methadone treatment program in Queensland, rather than becoming restricted, actually expanded during this time.

### **Methadone Loses its Appeal**

In the 1970s the use of methadone treatment was regarded, on one level, as an experimental treatment regime and there seemed little agreement amongst the key actors as to the specific objectives of the various programs. This led to the ad hoc development of services and administrative chaos. Underpinning this confusion was an ideological debate about the role of treatment. It resulted in a policy vacuum, disillusionment with methadone in most of Australia and the imposition of restrictions in treatment. Methadone treatment failed as a 'quick fix' for the increasingly dominant abstinence objective and ceased to be regarded by many Departments of Health in Australia as a legitimate long term treatment. This process was evident in New South Wales whereas Queensland provides a contrasting picture.

The Commonwealth Government produced a policy on methadone treatment for the first time in 1977 and regarded abstinence from all drugs as only one of many goals of treatment. It was the view however that methadone should only be used in a limited way for a small group of the most hardened and chronic addicts (Commonwealth Guidelines on Methadone treatment, 1977). The guidelines also indicated that relatively high doses of methadone be prescribed (between 80-120 milligrams per day) as this had been found to be more effective in limiting or reducing illicit drug use. While the policy document clearly states that higher doses **should** be given to patients on maintenance in practice, low dosages came to be prescribed because the maintenance goal was not accepted. (McArthur, 1995). Except in Queensland the Commonwealth guidelines were not followed by clinicians except in the earliest years of the programs. Most clinicians responded to the ideological debate about addiction seeing methadone not so much as a treatment for addiction but rather as a tool for the control of addicts.

From the mid 1970s to the mid to late 1980s methadone treatment was seen by some drug workers as the state sanctioned use of one addictive drug to replace the use of another uncontrolled addictive and illegal drug - heroin (*Connexions*, Sept/Oct, 1989:12). This view was held in reaction to those proponents who argued that clients were enabled to maintain a more stable lifestyle whilst receiving methadone. Underlying this conflict are the different views of drug dependence. This was a conflict that caused much of the difficulty experienced by early methadone programs in New South Wales. In New South Wales the methadone program was, by the mid 1970s, poorly resourced, poorly administered and ideologically unpopular, with little legitimacy as a form of treatment. The failure to come to consensus about the objectives of methadone treatment led to its demise.

In contrast, the Queensland program seemed unimpeded by an ideological debate about the benefits of methadone treatment. Alan Freed, the Queensland director of the public program in the late 1970s had a different view of treatment.

I see treatment as the lesser of two evils. They [addicts] are either going to be enslaved by a criminal system which includes the police, prisons - enslaved by that circle, criminal to court to prison back to criminal to court. Or a medical system. The difference being in the order of seven times \$400 a day. And they have to get up to much fewer tricks to survive on a methadone program than on a heroin scene (A. Freed, Interview, 16th February, 1994).

Thus in Queensland, the maintenance approach seems to have been accepted without experiencing a backlash. The Queensland program throughout the 1970s and into the 1980s embraced the wider social objectives of methadone treatment.

The early days of methadone treatment had a lack of clear policy objectives, mainly because of the strong ideological climate that surrounded drug treatment. With abstinence as the implicit objective methadone treatment could only fail. In the majority of programs in Australia, methadone treatment was regarded on paper as having a number of objectives. In reality, this was often ignored because of the ideological argument that to be 'drug free' was the major mission of treatment. Tony Vinson recounts an example of how, although there were explicit formal guidelines individual values had an impact on policy objectives.

I was saying, based on anecdotal evidence I suppose but quite strong impressions that I had been gaining, that some sort of quite deep puritanism affected the technical judgements of clinicians in this matter. For example in the Review of Health and Welfare Services in the ACT<sup>(4)</sup> I had Dr Dalton come as a consultant to the committee but local people, local medical people, were unwilling to prescribe effective levels of dosage of methadone. They conceded almost politically that something might have to be given to people but by many people's judgements, including Dr Dalton's, what they were doing was totally ineffectual because it wasn't sufficient to deter the craving for heroin (T. Vinson, Interview, 27th April, 1994).

The first formal objectives of the methadone program stated that abstinence was only one goal of treatment. The failure to accept this, after the initial liberal period, is due in part to the newness of the treatment modality, but is due primarily to discomfort with the idea of using drugs to treat drug addiction.

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(4) Australian Capital Territory

An intertwined issue that led to the disillusionment with methadone treatment was the poor administration of the program particularly in New South Wales. The problems that arose from inadequate management of the program appeared to legitimise the ideological position of its opponents. They were used as ammunition against methadone programs. The problems included the poor supervision of clients whilst on methadone and the diversion of methadone onto the black market.

In New South Wales key informants regard the administrative chaos of the early years as a reason for methadone's fall from favour. There were few clinics in New South Wales, with Stella Dalton's program the major centre for methadone treatment. However by the late 1970s, with the arrival of Jim Rankin, an overseas expert from Canada, programs other than those run by Dr Dalton began to tighten up.

New State guidelines were developed, clearer criteria were worked out and the program became more accountable. New units were established which were abstinence orientated, where patients received methadone withdrawal or low short term maintenance. It became a tight restrictive program that was used primarily as a 'last resort'. In this respect at least it was in line with the formal Commonwealth guidelines.<sup>(5)</sup>

There is no doubt that the early New South Wales programs were lax in their administration. There were no clear objectives or procedures for treatment. The belief in the abstinence objective by practitioners (other than Dr Dalton) meant low dose methadone was the norm, leading addicts to supplement their therapy with street heroin.

The lack of controls over the dispensing of methadone saw the drug finding its way in substantial quantities onto the black market (Davies, 1986:148). The security of the clinics was according to Richard Baldwin a matter of some concern.

The other thing that turned us off methadone was we had an armed holdup. One of the nurses was held up with a knife and over one week end we had a break in and we lost 10,000 milligrams. We used to have huge bottles - but there you go - it was amazing days (R. Baldwin, Interview, 28th April 1993).

A further reason for the disenchantment with methadone treatment was the growth of alternative methods of treating drug addiction. Davies (1986: 148) points out that with a range of therapeutic options being available and aggressive marketing methods of new therapeutic communities such as Odyssey House, methadone treatment was regarded as one part of a spectrum of therapeutic options - 'and a part, moreover, sitting at the extreme edge of that spectrum'. These expanded choices of treatment were abstinence orientated and fitted more comfortably with the policy environment at the time.

The issue of methadone used as a mechanism for social control was one of the strong reasons for methadone treatment being treated with suspicion in all States in Australia during the 1970s and early 1980s. In contrast the Queensland program sold itself by espousing and highlighting the effectiveness of methadone in doing just that. Queensland did not undergo disenchantment with methadone treatment. While New South Wales and the rest of Australia were restricting treatment places, Queensland did not impose any limits at all and, in fact expanded its public sector methadone activity.

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<sup>(5)</sup> The further reason informants give to explain the move away from methadone treatment was Stella Dalton herself – (see McArthur 1995)

As stated earlier the Queensland approach to dealing with heroin had similar beginnings to that of New South Wales. Individual doctors introduced methadone based on previous clinical experience. However, Queensland, for a variety of reasons, had a different conception of treatment. Clinicians were able to successfully argue the benefits of methadone treatment in controlling and managing drug addicts and the concomitant problems of addiction like crime.

As in New South Wales, where one individual heavily influenced (in that case negatively) the direction of treatment policy, Queensland had its own major player. When key informants were asked why Queensland had an entirely different attitude to methadone treatment before 1985 all said it was primarily due to the influence of first Alan Freed and later Michael Bolton (who argues he was persuaded by Freed's views).

Alan Freed was a psychiatrist who had been employed to develop drug and alcohol services in Queensland. He had been the director of a therapeutic community in Newcastle on Tyne in the north of England. Freed conceptualised drug addiction at this time in a very different way to the medical profession in general in Australia.

I think that drug addiction is not just a personal or moral problem as they saw it then. It also has an infectious component where one person introduces one or two others, and sells to someone else, [it is] an infectious model. This was unaccepted for quite a number of years and then it was accepted. It's completely accepted world wide now that AIDS has arisen - people preferred the moral approach and the police approach and [they wanted] to sweep it under the carpet. I think the police approach can provide very easy work for policemen. They [addicts] are easy to spot and easy to arrest (A Freed, Interview, 16th April, 1994).

The implication of Freed's view is that a treatment like methadone, even if it merely replaces heroin without achieving total abstinence from drugs, would still be worthwhile in preventing further 'infection'. While New South Wales and other States in Australia were finding creative ways not to provide methadone to people, Queensland expanded their services and provided treatment for all for whom it appeared appropriate. The Queensland program even provided places for interstate clients who came to Brisbane seeking treatment. Lyn Biggs, a nurse practitioner at Bialla during the early 1980s, described the Brisbane clinic:

Those numbers escalated dramatically in the early 1980s and the majority of the people we were getting on the program were from New South Wales. We were getting them from other States but we were getting huge numbers coming up from New South Wales saying they couldn't get onto methadone down there. We literally had people arriving on trains and buses with suitcases and children and dogs coming straight in to get onto the methadone program (L. Biggs, Interview, 14th February, 1994).

In contrast to New South Wales, the staff at the Brisbane clinic believed that there should be no ceiling placed on the numbers in treatment. This did mean that a decision was made to simply provide methadone rather than restrict numbers so that counselling and other services could be offered. Lyn Biggs again:

Well it was an attitude that was talked about quite regularly in Queensland. The Director of the time (Bolton) came around and discussed with us whether we should put a ceiling on the program and the staff decided not to put a ceiling on. We decided to at least give people methadone and very little else rather than turn them away (L. Biggs, Interview, 14th February 1994).

Even in the early days the Queensland program seemed to reflect the broader goals of the Commonwealth government policy that regarded abstinence as only one of many goals in treating drug addicts. In 1978, in a statement prepared for the Royal Commission on Drugs, the Queensland Director of Psychiatric Services outlined the objectives of the early program.

The legitimate objectives of the methadone treatment are a combination of reduced mortality, improved physical and psycho-social well-being, diminished involvement in anti social behaviour and containment of drug abuse. Abstinence itself is only one of many goals. Success does not necessarily depend on the total achievement of all treatment goals as partial achievement must be considered a measure of success. (Dr G. Urquart: Statement submitted to Royal Commission on Drugs, 1978).

Why Queensland embraced methadone can be explained in a number of ways. The first incorporates the notion of methadone treatment as a means of controlling or managing drug addicts. As stated earlier medicine is a successful agent of social control. The Queensland experience is used to illustrate how this was an effective selling point for the continuance of the methadone program in that State in direct contrast to New South Wales. The conservative political climate of Queensland with a Premier who strongly espoused values of law and order accepted the important role methadone could play in ensuring control over drug addicts.

Freed, and subsequently Bolton, argued that methadone treatment could ameliorate the problems of illegal heroin use. These doctors were able to 'sell' methadone as a method of managing people who, by the nature of the addiction, involved themselves in crime. It was the lesser of two evils. Freed, in a memorandum to the Director of Public Health, outlines the philosophy of the program. Objective Three of the program is particularly telling:

To maintain a centralised information source so that the expansion and contraction of the drug scene, and our effectiveness in meeting the problem quantitatively, can be monitored and thought about. From society's point of view it is necessary for clinics and doctors to be accepting, as far as is possible, pliable addicts for their programme (these being the ones that are the least danger to society), it is necessary to accept all addicts onto a programme. The more active the person is in selling drugs to others, the more psychopathic he appears, the more he is tattooed, the more he should be persuaded and cajoled to remain on the programme (Memo 13th March, 1979).

In an interview with Freed carried out for the study, he highlights the benefits of monitoring drug addicts through treatment. The methadone program was sold to the politicians and bureaucrats as a way of keeping an eye on addicts:

In terms of territory I had two choices. Had I chosen to be territorial and kept the program under me then they would have killed me off so to speak and the program would have gone as well. I very carefully made sure that the monitoring side of the program was seen to be the strong point and that could be used even to police the scene. All you need was the Health Department to hand over a map of where the people lived and you'll see where the police should go. So if you mapped out the names and addresses, not the names just the addresses, and put pins in the map of all the Kenmore<sup>(6)</sup> people you'd be able to see even the routes of distribution. I did it when I was there for my own interest. I emphasised the usefulness of the data for monitoring...Ron Ram's people (Environmental Health) come under the police act as well as the Health Department. I didn't actually realise it at the time that they were under the police act but they are (A. Freed, Interview, 16th February, 1994).

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(6) Kenmore is a western suburb of Brisbane.

Individuals in Queensland not only conceptualised methadone treatment differently but appear to have strategically chosen to emphasise the control or management role that methadone treatment could deliver. In this way the program did not seem to undergo any threat. There were, however, attacks from other States who from their position felt the Queensland program was going down the wrong path. The Director of Services, Mike Bolton says:

I mean I'm not saying we got it right but I think we got it less wrong than a lot of people. In those early days in opioid related deaths we were the only State that went down. Everyone else went up. I remember using that at MCDS <sup>(7)</sup> meetings to argue the toss. At that stage we were under siege..Alex Wodak accused us of anarchy at one time (M. Bolton, Interview, 16th February, 1994).

While other States were expanding treatment options Queensland only provided methadone treatment. It was not until the early 1980s that funding was made available for a therapeutic community. Methadone remained, until the mid 1980s, an unpopular treatment regime in all States except for Queensland.

### **'A crime wave in New South Wales' – methadone finds favour again**

There were three reasons why the methadone program was expanded in New South Wales after 1985. The first was the recognition of the efficacy of methadone in alleviating criminal behaviour. The second reason was the huge and insistent demand from addicts for methadone treatment. Thirdly was the emergence of a national approach to drug policy and the recognition of the role methadone treatment could play in reducing the risk of HIV/AIDS infection. This section examines the first of these reasons – methadone's effectiveness in controlling criminal behaviour.

Although methadone treatment had been discredited in all states except Queensland the problems of heroin addiction were not being solved either by other treatment methods or by the legal system. Continuing strong negative views about methadone treatment held by the New South Wales Department of Health and workers in the addiction field ensured methadone treatment remained difficult to access (Capelhorn and Batey, 1992). Against this resistance the push for methadone treatment and the subsequent change in policy direction was motivated almost completely by the need to deal with the increasingly powerful arguments about the link between heroin and crime (Newman, 1987). Research, carried out in response to media attention, on the heroin-crime issue, provided some evidence about this relationship, specifically the over-representation of heroin users in gaol (Dobinson and Ward, 1985).

The media attention given to the link between drugs and crime provoked the New South Wales Bureau of Crime Statistics research carried out in 1984 by Dobinson and Ward (1985). The introduction to the research report points out that 'if the situation, as reflected in the media, is to be believed then an alarming percentage of both violent and non-violent crime is drug related' (Dobinson and Ward, 1985: 1-2). The research found that the link between drugs and crime was not a clear causal relationship. However there did seem to be strong evidence that income generating crime (property theft and drug selling) was often an economic consequence of regular heroin use (Dobinson, 1989). It is not my intention to canvass this issue but rather to focus on how methadone treatment was embraced as a strategy for controlling what was perceived to be a 'crime wave' in New South Wales in the early 1980s. The role of the media is particularly important and I have examined this previously (see McArthur, 1999).

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(7) Ministers Council on Drug Strategy.

Research carried out in 1982 by Phillip Bell found that the media by and large tended to focus on the drugs and crime/social control links. However later research found that there had been significant change in the way in which the print media viewed drugs. White (1985), in an analysis of 1984 Sydney media, found that there had been a move away from the drug/crime link into a drug/political 'solution' matrix. He argues that instead of just highlighting the issues around drugs, the media significantly shifted the emphasis towards calling for solutions. In this case, the media having discovered the link between crime and drug use some time before suddenly endorsed methadone treatment as the solution. It also gave a voice to the campaign carried out by some groups in the community for an expansion of the methadone program.

Groups such as The Wayback Committee, a group of influential citizens, made it obvious that they regarded the link between crime and heroin use as a clear relationship. They argued that:

The Government's failure to provide methadone treatment to all those who needed it had forced addicts into a life of crime. This had been highlighted by the killing of a policeman by a heroin addict on Wednesday (*Sydney Morning Herald*, April 6, 1984, p 3).

Richard Baldwin a policy worker in the Department of Health in this period recalls that:

At that time Sydney was suffering an epidemic of burglaries and there was starting to be some literature about the link between burglaries and addiction and although that stuff had been around for a long time the general public and the press had suddenly made the connection and drug dependence became a major issue. Heroin addiction had been the flavour of the month for a decade in terms of headline grabbing stuff but suddenly, methadone came into the picture and there was a lot of interest in it. I don't think it was just because I was in the midst of it. I mean I read the papers now and I don't see anything like during that time (R. Baldwin, Interview, 28th April, 1993).

In June 1984 a week long series of articles about heroin addiction in the *Sydney Morning Herald* outlined the major issues. They included the increase in crime, the debate about the benefits and disadvantages of methadone treatment and other treatment regimes and criticism of the government over the lack of treatment places for addicts. In an article titled 'Methadone a Catalyst for Controversy' a drug counsellor is quoted as saying that 'without extra resources the guide-lines are likely to be tightened' making methadone treatment more difficult to get and further 'the basic problem is that these services have to compete with others for the shrinking health dollar and services for "dirty addicts" are not a priority' (*Sydney Morning Herald*, 20th June, 1984).

The editorial that day, commenting on 'the disturbing series on heroin addiction', argued that the community could no longer ignore the impact of heroin induced crime.

It costs \$85.5 million a year to treat and police the State's estimated 10,000 addicts. Last year 87 people died from heroin overdoses, some of them found with needles still in their arms. New South Wales' hospitals treat about 500 morphine and heroin addicts a year for their addiction, and so on. Statistics like these finally become frighteningly vivid when as is happening with increasing frequency these days, people find their houses ransacked by addicts frantically trying to find something to sell to get money for another 'hit' (*Sydney Morning Herald*, editorial 20th June, 1984:12)

The media, particularly in New South Wales, underwent a shift in the mid 1980s. It played an important role in emphasising- the drug-crime link and how methadone treatment could ameliorate this problem. Certain pro-treatment groups effectively highlighted the harm created by restricted treatment services and successfully harnessed the media's influence. Politicians on both sides of politics were pressing for an expanded methadone program. Ted Pickering, the then leader of the Opposition in the Upper House used the available evidence to criticise the government's handling of the 'alarming increase in property crime'. He went on to describe what he regarded as the benefits of methadone treatment, pointing out that the 'major aim of methadone treatment programme is to reduce the use of illegal drugs and related crime' (*Hansard*, 12th September, 1984).

As Richard Balwin notes 'If by 1983 methadone was becoming a major political problem certainly by 1984 it had become a very hot item' (Interview, 28th April, 1993). The media, pro- treatment groups, doctors wanting permission to prescribe all with strong arguments were finally successful in gaining promises of more money and treatment places. Added to this was the national policy environment that emphasised methadone treatment in the changing ideological environment of 'harm minimisation' (See McArthur, 1999). Methadone treatment places were expanded and with the assistance of the private for-profit sector expanded at a great rate.

## **Conclusions**

The use of methadone treatment to treat heroin addicts has had an extremely contentious history in Australia and internationally. Although methadone treatment has been available in Australia since 1970 there was disenchantment with its effectiveness to 'cure' addiction at least until 1985. The reasons for the disillusionment are debatable. For the critics of the methadone program, the contraction of services simply reflected the failure of methadone treatment to fulfil the promises of its supporters. Lack of clear policy objectives and agreement on policy goals led to problems with the program. Methadone advocates, generally adopting wider social objectives, argue that methadone maintenance programs were never implemented in the appropriate form promoted by Dole and Nyswander (Ward et al, 1992). In New South Wales, Stella Dalton's enthusiasm for methadone treatment and the lax administration of the program were used to discredit the use of methadone. The Queensland program has a different history with influential individuals able to 'sell' the efficacy of methadone treatment in managing addicts and decreasing their need for criminal activity. Whereas the rest of Australia was primarily driven by the moral objections of continued drug use, Queensland had from the early days of program developed a more 'modern' concept of treatment which had broader objectives including improved health and decreased crime.

In New South Wales, the political pressure to expand the methadone program in the 1980s came in the form of a concerted campaign from particular individuals and pressure groups. The media, a key player in the policy process, helped to ensure methadone treatment was regarded as a solution by focusing on the social problems linked to heroin addiction. This campaign kept pressure on the government of the time to find an answer to the spiralling 'crime wave' caused by addicts. Methadone might not cure addiction but it was seen as fulfilling the social objectives of limiting the need for junkies to hit 'little old ladies' over the head for their purses. Added to this, the Commonwealth government acting largely on the basis of the views and observations of key Ministers had injected large amounts of money as part of NCADA and were supportive of the expansion of the methadone program. Armed with money, and further evidence of the effectiveness of methadone treatment on crime rates,

the New South Wales Department of Health looked for ways of expanding to meet the ever-increasing need for services. The changing policy context that recycled an old idea is not an uncommon story. The history of two state methadone programs show that the policy process is fluid and interactive in nature. As problems are reconceptualised over time, so too the possible solutions. Advocates and opponents of methadone treatment used the social control arguments to further their position. This disagreement seems no longer obvious on a policy level as support for methadone treatment is maintained - re-conceptualised not so much as a mechanism for social control but as a broad public health strategy.

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