The Institutional Treatment of the Narcotic Addict

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DRUG ADDICTION is the state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means, (2) a tendency to increase the dose, (3) a psychic (psychological and sometimes physical) dependency on the effect of the drug."[1]

This definition of drug addiction was agreed on in 1950 by the Expert Committee on Drugs Liable to Produce Addiction, now a subdivision of the World Health Organization. They labored for 20 years before there was agreement on this definition and this is an indication of the complexity of the problem with which we are dealing.

PERTINENT DEFINITIONS

In considering the subject of narcotic addiction it is well to also define several phenomena that are closely related to addiction and very much a part of it. "Tolerance is defined as a diminishing effect of repetition of the same dose of the drug, or conversely, a necessity to increase the dose to obtain an effect equivalent to the original dose when the drug is administered repeatedly over a period of time. Physical dependence refers to an altered physiological state, brought about by the repeated administration of the drug over a long period of time which necessitates the continued use of the drug to prevent the characteristic illness which is termed abstinence syndrome."[2] What this means is that when the drug is taken regularly over a period of time the body becomes dependent on the drug and if, for one reason or another, the drug is no longer available then this characteristic group of symptoms develops. This is the characteristic clinical picture presented by patients who are suddenly withdrawn from their narcotics. Not all addicting drugs produce physical dependence or demonstrate the abstinence syndrome. In cocaine or marihuana addiction physical dependence does not develop and in their abrupt withdrawal the abstinence syndrome is not produced.

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The United States Public Health Service operates two specialized hospitals for the care of drug addicts. The first is in Lexington, Ky., and opened in 1935, the second, is in Fort Worth, Texas, and opened three years later. The author discusses admission procedure for these institutions and the schedule of treatment for patients.

U. S. HOSPITALS

In the definition of drug addiction it is stated that an overpowering desire or need develops (compulsion) and the individual continues to take the drug until he suffers or society suffers. The individual is no longer able to control this compulsive need and when we recognize this loss of control it can be said that addiction is present. When the individual is no longer able to exert power of control over his use of the addicting drug, it is necessary that someone else exert such control until it is felt that the individual is once again able to assume this power himself. In the institutional treatment of the narcotic addict the institution must provide controls for the patient.

The institution that I am speaking of is a specialized hospital. The United States Public Health Service operates two such hospitals; one in Lexington, Ky., opened in 1935, the second, the United States Public Health Service Hospital in Fort Worth, Texas, opened three years later. These specialized hospitals are much the same as many large psychiatric hospitals. There are many prisoner patients at both hospitals and a majority of the addict patients are sent to the hospital for their drug addiction by Federal Courts. Voluntary patients also are admitted to both hospitals. The Lexington hospital admits voluntary male patients from east of the Mississippi River and women patients from anywhere in the United States. The Fort Worth hospital does not admit any women patients. Male patients from the area west of the Mississippi are admitted to the Fort Worth Hospital. Over 3,000 such patients are admitted to both hospitals every year. The ratio of men to women is roughly 4 or 5 to 1. About 50 per cent of the patients admitted to the hospitals are between the ages of 21 to 30. About 40 per cent of the patients are Negro and about 55 per cent are white. The racial distribution of the patients has changed a great deal in the past 20 years. In 1940, 83 per cent of the admissions to the Lexington hospital were white and 14.3 per cent were colored.

For a patient to be eligible for voluntary admission to either of the two hospitals he must be addicted to "habit forming narcotic drugs" as defined by law. The drugs included are all of the opiates, cocaine, the synthetic analgesics, such as Demerol and methadone, and marihuana. Patients cannot be admitted if they are taking sedatives, such as barbiturates or any of the tranquilizers, unless they are also taking one of the narcotic drugs.

TREATMENT PHASES

Treatment starts as soon as the patient arrives at the hospital. It can be separated into several phases: (1) Withdrawal, (2) Convalescence, (3) Rehabilitation with treatment for psychic dependence, (4) Post-hospital treatment and follow-up. A complete history of the patient's use of drugs is taken. This includes all the facts surrounding the onset of addiction, the duration of addiction, the type, amount, and method used for taking all the drugs that the patient has used. It also includes any untoward effects that any of the drugs have produced. The history must, of necessity, determine all the facts regarding the quantity and method of use of all addicting drugs. It is well to remember that it is difficult to get a precise history from each and every patient but, nonetheless, such an attempt must be made to obtain all the information possible. In addition to the drug history, a thorough medical history is recorded as on any medical patient in a general hospital. Following the history taking, a complete physical examination is performed and recorded. This gives an accurate indication of the physical state of the patient at the time of his admission.

WITHDRAWAL

Following the history and physical examination, the patient is taken to the Withdrawal Unit where he is observed for any of the characteristic symptoms of the abstinence syndrome. These signs include sweating, lacrimation, rhinorrhea, yawning, dilation of the pupils, goose flesh, muscular jerking and cramps, anorexia, vomiting, diarrhea, insomnia, and increase in blood pressure and temperature. These symptoms may be rated by a system devised by Kolb and Himmelsbach.[3] When symptoms of abstinence develop, methadone is administered orally in quantities just sufficient to keep signs of abstinence at a tolerable level, and then the dosage is progressively reduced.

The withdrawal treatment has been described in a number of publications by Isbell,[4] Wikler[5] and Fraser,[6] former staff members of the Addiction Research Center of the National Institute of Mental Health which is located at the Lexington Hospital. Anyone treating the narcotic addict should become familiar with their work. During this withdrawal procedure, which usually lasts for a period of from four to seven days, depending upon the extent and duration of the addiction, the patients are somewhat uncomfortable but do not experience or display the usual agonies so often associated with withdrawal and described by the patients as "kicking the habit cold turkey."

If the narcotic addiction is associated with barbiturate addiction, then the withdrawal period will be prolonged and the patient must be stabilized on barbiturates as well as on methadone with the gradual withdrawal of both medications. Hamburger[7] has shown that "more than 31 per cent of heroin addicts admitted to the hospital in 1962 and 1963 claim to have taken doses large enough to addict and 21 per cent of the heroin addicts were found to have been physically dependent to barbiturate drugs on admission." It is well to remember that about 75 per cent of the patients admitted to the Lexington Hospital are addicted to heroin. It is of the utmost importance that the pos-

sibility of barbiturate addiction associated with narcotic addiction be recognized and properly treated. This has been pointed out by Isbell.[8] Any person caring for addicts should be aware of the dangers involved in withdrawal of barbiturate drugs. If the individual is addicted to barbiturates and abrupt withdrawal is undertaken, a toxic psychosis may be precipitated which may go on to delirium, coma, and even death, if not recognized and properly treated.

CONVALESCENCE

Following the withdrawal procedure a convalescent period begins. The patient starts to regain his appetite, and his weight, and strength increases. He continues to display irritability, restlessness, and has difficulty getting his proper rest. These physical symptoms may last for several weeks. The patient remains in a convalescent unit until his physical and mental status has improved sufficiently to the point where he can be transferred to the Orientation Unit. In the Orientation Unit the patient is interviewed by various staff members representing psychiatry, educational, vocational training, occupational training, social service, psychology, religious counseling, and recreational programs. Following the evaluation that takes place in the Orientation Unit a treatment program is formulated by the staff for each patient.

REHABILITATION

From the moment of admission until discharge one aspect of the program is the same for all patients, i.e., living in a drug-free environment. The patient must once again learn to live a life without having to resort to the use of drugs. Those who display a desire and willingness to accept psychotherapy are assigned to staff psychiatrists for group psychotherapy. A limited number are assigned for individual psychotherapy.

The Psychology Service administers a battery of psychology tests to the patients to determine the patients most likely to benefit from psychotherapy. In special diagnostic problems they administer special tests helpful in establishing the diagnosis. They also, participate in individual and group therapy and are important members of the treatment team.

The Social Workers function in their liaison capacity with the patient's family and community and assist in post-discharge planning and follow-up. Attention is given to the family situation from which the patient came as there is general recognition that when addiction develops in one member of the family, the entire family constellation has to be considered in the overall treatment program if any lasting results are to be achieved.

All patients who are physically able are given a vocational assignment where an effort is made to help them learn good work habits and to work and live with others. The vocational staff members keep in close contact with the patients' physicians and discuss any problems or unusual behavioral patterns of the patients. Staff psychiatrists join in a discussion in a consulting role when patients are given vocational assignments. The vocational and educational staff assist in preparing training programs in various units throughout the hospital. Monthly reports are made on the patient's progress and indicate the degree of adaptation the patient has displayed. Any abrupt deviation from usual behavior during working hours is discussed with the patient's psychiatrist. Another activity important to the patient and his morale is the recreational program. The program not only offers the patient entertainment but an opportunity to become interested in sports and participate as a team member or simply to learn to play "by the rules."

The religious and spiritual activities of the hospital are another important part of the total treatment program. Regular Catholic, Jewish, and Protestant services are conducted for patients who attend on a voluntary basis. Counseling service is also provided by the chaplains of these three faiths. Additional religious counseling is provided for patients by graduate students participating in an approved training program in pastoral counseling conducted jointly by the hospital and a local theological seminary.

The patients themselves also conduct an Addicts Anonymous program similar to the Alcoholic Anonymous program. This program has been in operation for almost 15 years and has been proven quite effective with many patients. This group receives the support of the hospital staff, but the program is entirely their own.

FOLLOW-UP

The staff at the hospital feels that for a voluntary patient to have a reasonable chance for staying off of drugs after he leaves the hospital he should remain in this drug-free environment for a period of many months, usually about four to six months. This would mean that after the volunteer patient remains in this atmosphere for this period of time

the physical effects of addiction would have been eliminated, and the patient should be in a psychological state where he should once again be able to exert a sufficient amount of control over himself so he would not need to resort to the use of narcotics or any other addicting drug. Most of the patients, when they leave the hospital, need a great deal of help if they are going to be able to become useful citizens and resume responsibility for themselves and others. When they return to their community they will need help in obtaining employment and support in meeting some of the difficult problems in living that they are sure to encounter. Regardless of how hard the patient has worked in the hospital, the real proving ground will be in his community when he returns. A helping hand from the family physician, the employment agency, a probation officer, a minister, or social worker may go a long way in determining if the patient once again becomes re-addicted or wheth becomes a useful and productive citizen.

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TERMINAL TYRANNY

The meanest man in town was bitten by a rabid dog. Failing to respond to the Pasteur treatment, he was advised by his family physician to draft his last will and testament. As the doctor made a heroic last effort to save the patient, the man wrote furiously, using six pages of stationery.

"Isn't that a rather long will?" the physician asked.

"Will, nothing," responded the ill-disposed patient. "I'm making a list of people I intend to bite!"