MENTAL HEALTH MONOGRAPH 2

Narcotic Drug Addiction

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

MENTAL HEALTH MONOGRAPHS

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National Institute of Mental Health
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This monograph was written by Herbert Yahraes, in cooperation with an editorial committee of the National Institute of Mental Health, which included Carl L. Anderson, Ph. D., Consultant on Drug Addiction; Joseph M. Bobbitt, Ph. D., Associate Director for Program Development; James W. Osberg, M.D., Director, Mental Health Study Center; Harris Isbell, M.D., Director, Addiction Research Center; and Stanley F. Yolles, M.D., Associate Director for Extramural Programs. James V. Lowry, M.D., Chief, Bureau of Medical Services, Public Health Service; Mabel Ross, M.D., Special Assistant in Mental Health, Bureau of State Services; and many other authorities in the field of drug addiction also provided substantial help.

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FOREWORD

Since the early 1920's, when a Public Health Service physician, Dr. Lawrence Kolb, conducted the first field studies in narcotic drug addiction in the United States, the Public Health Service has had a major and distinguished role in the field of drug addiction.

Dr. Kolb's papers, still regarded as classics in the field, brought a medical viewpoint to bear on the problem of drug addiction. He pointed out, first, that the majority of drug addicts are emotionally unstable individuals, and that drug addiction is largely a psychiatric problem. Second, and contrary to beliefs commonly held in the twenties, he showed that although criminals may use drugs, opiate addiction does not directly lead to crime, except as a means of procuring funds to support addiction.

In 1929, acting upon the conviction that drug addiction is primarily a medical and social problem and that attempts to treat addiction by imprisonment are illogical, the U.S. Congress enacted a law calling for the establishment of two medical facilities for the treatment of drug addicts.

When the Public Health Service Hospitals at Fort Worth, Tex., and Lexington, Ky., were opened in the 1930's, the program of treatment was based on the premise that addicts were patients, and that the effective treatment of drug addiction demanded that attempts be made to rehabilitate the addict, and to assist him in his return to society.

The Public Health Service has pioneered in the fields not only of medical care and rehabilitation but also of research. Investigations by PHS personnel in the Service's Addiction Research Center in Lexington have led to illuminating and highly valuable findings. Most recently, demonstration and pilot projects supported by Public Health Service funds have begun to explore possible ways of controlling drug addiction in the community.

Thus the public health approach to the problems of drug addiction involving prevention, treatment, and social rehabilitation is being introduced into our communities. If this approach is to succeed, factual knowledge about the subject of drug addiction must become common knowledge. For this reason, it is my hope that this publication will be widely read, and that the information it transmits will assist in the formation of constructive public attitudes toward the problem of drug addiction.

LUTHER L. TERRY, M.D.,
Surgeon General, Public Health Service.

PREFACE

If drug addiction is to be controlled in our society, a great deal more biological, clinical, and social research must be done on this problem. There is much we do not know about the nature of addiction. There are many clinical answers to the problem of drug addiction which we do not yet have. There are many social answers to the problem of drug addiction which we do not yet have. Answers to all aspects of the problem must be sought with increasing vigor in the coming years.

I believe that some of the missing answers to this grave problem must and will be found and developed within our communities. This can only come about, however, as sound knowledge about drug addiction becomes widespread, and as the effects of the problem of drug addiction on the social, physical, and mental health of a community are honestly faced.

I believe this publication will play a significant role in imparting such sound information about drug addiction and the problems addiction creates for the addict, his family, and his community. I further believe that armed with such knowledge, our communities will mobilize existing resources, and develop new ones, to bring the problem of drug addiction under control.

ROBERT HANNA FELIX, M.D.,
Director, National Institute of Mental Health.

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patients, set up in 1952 to care for drug users under 21 years of age.

Does this mean that treatment of the physical addiction is only successful in about 10 percent? Hardly. Any patient who stays for more than 2 weeks is over the acute illness phase. One Lexington medical officer points out that if they were then killed in an accident, they could be recorded as persons who had recovered. Instead of being killed, though, the typical addict—at least, the typical New York City addict—goes back to his same old associations and his same old troubles and eventually turns to drugs again for relief. He does well in a sheltered, drug-free environment, but away from it he finds his world too painful and himself too weak.

Doctors at Lexington can tell of patients who have stayed free of drugs for years and apparently will continue to stay free. One has become an official of his home town. Another—who telephones greetings year after year on Christmas Eve—owns a little business on the West Coast. And one founded Narcotics Anonymous after he had been to Lexington eight times.

Doctors can also cite illuminating cases of readdiction—a woman free of drugs 15 years, whose marriage broke up; a lonely, rootless man who finally found a sweetheart and lived happily for the first time, till the woman suddenly died.

Physicians now look on addiction as a chronic disease, with relapses to be expected. But they believe, too, that the periods of abstinence can be lengthened and—in many cases, at least—perhaps extended indefinitely if only the right measures can be found and applied. The Lexington followup study gives some reason for optimism because it shows that:

1. Readdiction rates were lower for persons over 30 than under it. The implication (supported by other evidence): As addicted persons grow older, there is some tendency toward giving up drugs, presumably because some of these persons are becoming emotionally more mature.

2. Readdiction rates were lower for those who had gone to the hospital as prisoners than for those who had gone voluntarily. One explanation, presumably, is that the prisoners had to stay longer, though stays beyond 30 days apparently brought no improvement in readdiction rates. Another likely reason: the involuntary patients often had someone to report to regularly upon release—a parole or probation officer.

HOSPITAL AND POSTHOSPITAL PROBLEMS

Hospital authorities would like to have some means of keeping voluntary patients under treatment as long as the doctors in charge of the treatment think necessary. They are particularly concerned about the patient who has withdrawn from treatment several times against medical advice and then applies again for admission, with nothing to indicate that he will stay beyond the time necessary for withdrawal. The answer may lie in legislation enabling a hospital staff to seek civil commitment—in the courts of the States where the hospital is located—for individuals who in the judgment of the staff require it.

From the viewpoint of the Public Health Service, the long-term answer to this and other problems presented by voluntary patients lies in the establishment of State and municipal facilities sufficient to care for all the addicted persons who now apply to Federal hospitals. Such facilities, too, of course, will need ways to keep their patients long enough.

No matter where an addicted person is treated, however, hospitalization is only the first step; posthospital supervision, or what is commonly known as aftercare, is usually just as essential. Among five measures to which the American Medical Association and the National Research Council of the National Academy of Sciences gave their support, in a joint statement in 1962 on narcotic addiction, the first three were listed as "1, after complete withdrawal, followup treatment for addicts,

New York City's master plan for narcotics control, which is under the direction of a Narcotics Coordinator appointed in 1960, calls for hospitalization in community institutions (which in 1962 had several hundred beds for addicted persons and planned additional ones) and then for aftercare to be supplied by neighborhood groups, outpatient departments of municipal hospitals, health department clinics, halfway houses (to ease the return to the community) and work camps (for long-term rehabilitation, vocational guidance, and eventual job placement). The program also calls for educational and preventive activities and for research and evaluation.

CANADA'S APPROACH

Under the new Canadian Narcotic Control Act, passed in 1961, the criminal addict—that is, the addicted person who has been arrested—is to be treated in a Federal rehabilitation center and, when released, is to be subject to the supervision of the Parole Board. This supervision lasts indefinitely. The Federal Government offered to treat *all* addicts in the same centers, but whether or not it will do so depends upon whether or not the provincial governments will provide for the committal of addicted persons who are not charged with any criminal offense.

Another important feature of the act is that Canadian physicians now may prescribe drugs for the state of addiction as well as for disease. The Narcotic Control Division keeps a watchful eye upon such cases to make sure the treatment is in good faith.

AMONG OTHER EFFORTS

Alcoholics Anonymous, founded to help people addicted to alcohol, often works also with people addicted to other drugs. Patterned on it is Narcotics Anonymous, which some authorities on addiction report has been troubled by a tendency on the part of the police to note who attends the meetings. Another authority writes: "It is too bad that Narcotics Anonymous has had so little encouragement and backing from community leaders that it must struggle along with insufficient funds. The by-passing of this group is in all probability due to the deeply ingrained and widely held belief that drug addicts cannot get together for any constructive purposes."

In the Los Angeles area an organization called Synanon has enabled a number of addicted persons to cure themselves for sizeable periods. It is a residential organization. An addicted person is accepted only if he agrees to kick his habit "cold turkey"—that is, without the use of methadone or any other drug—and to remain at Synanon a considerable time. During the first 6 months or longer, he lives and works within the building. Then he gets a job on the outside but continues to live at Synanon, contributing most of his earnings to the community. Eventually he moves to a place of his own but continues to visit Synanon frequently and take part in group sessions. In 1962 the organization reported that more than 100 of its addicted persons—most of them still residents—had been free of drugs for as long as 4 years. Residents stress the fact of motivation. As they progress they can become responsible for part of the program: they may even become members of the board of directors.

A RESEARCH CLINIC

In the early 1920's, following a Supreme Court decision holding it illegal for a physician to prescribe drugs to an addicted person merely to gratify his addiction, States and municipalities opened some 40 so-called narcotic clinics. Most of them were simply dispensaries set up to provide persons with drugs in order to prevent exploitation by drug peddlers. They were all closed by 1924. There is no clear record of their accomplishments, for good or evil.

Some authorities have argued that if an addicted person could get his drug legally,