DRUG ADDICTION:

The Role of Social Work in its Recognition and Treatment.

by

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Thesis Submitted in Partial Fulfilment
of the Requirements for the Degree of
MASTER OF SOCIAL WORK
in the School of Social Work

Accepted as conforming to the
standard required for the degree of
Master of Social Work

School of Social Work

1952

The University of British Columbia

ABSTRACT

For social workers, the entire problem of drug addiction is a challenge. On the one hand, it is widespread and threatening; on the other, it is dealt with much ineptness and prejudice. Because addiction involves individuals, and because problems of an emotional nature either cause or intensify the addiction, the social work profession can--or should--play a leading part in it's treatment and prevention. The thesis strives to show the addict as an individual, what his problems are, and how he can be aided by caseworkers, as well as by psychiatrists, psychologists, etc. In particular, it strives to clarify the social worker's role in a therapeutic approach.

Data for the study came from many sources: from texts and reports made by various authorities in the field, particularly, studies made at the Lexington narcotics farm. Personal visits were made to prisons, clinics, and hospitals handling addicts, and discussions were held with doctors engaged in this work. Correspondence was carried on with people in various regions who are in a position to study the problem at first hand. And finally, interviews were held with many addicts, both treated and untreated. Final impressions rendered are a product drawn and based on the composite findings.

The plan of the thesis is to review first the available information on the general incidence of addiction; then to focus what is known of the typical addict as a person, individually and socially. Treatment plans--current, discarded, and untried--are then discussed; and the final chapter attempts to describe the work that caseworkers can perform with treatable addicts.

The conclusion of the thesis is that present methods can be improved considerably, with the help of social workers among others, for work with treatable addicts, and that the number of "cured" addicts can be raised by such improvement. At the same time, the "untreatability" of many addicts has been examined, with the conclusion that a very large group of addicts cannot at present expect any real psychiatric help. Virtually no written material exists on the subject of casework with the treatable addicts, and it is hoped that this study points the way to such a development.

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INTRODUCTION

The problem of drug addiction has, in the past few years, received a great deal of attention in the press and on the radio; this publicity has, if nothing else, brought to the attention of the public the gravity of the whole matter. The almost daily recordings in the newspapers of individuals apprehended for possession or sale of drugs is indicative of the persistence of the problem; and the pleas of addicts occasionally included in these items -- pleas to have some remedial attention given them -- provides some insight into the need that exists to attempt at least some form of therapeutic approach to the problem. That this entire matter is -- or should be -- of wide community concern is indicated by both the widespread prevalence of narcotics addiction and by the deteriorating effect that this addiction has on the social structure. Narcotics addiction is not only a symptom of personal and social disorganization, but it is also, in turn, an additional stress that may cause still further disorganization in the individual and in society. Alleviation of the problem, to be consistent, would therefore rest upon correction of weaknesses in both these areas. Just what the nature of this problem is, and how it can be approached in a positive, correctional way will remain the central purpose of these chapters.

Chapter I

NATURE AND PREVALENCE OF NARCOTICS ADDICTION

The narcotics addict is often referred to in a manner which suggests that he belongs to an undifferentiated entity in society, and as part of this entity, he leads a life quite unique in most social respects. It would be helpful if the conduct of the addict, as a member of the community, could be examined more closely, so that any conclusions that may be drawn about him would be based upon observation rather than on prejudice. Specifically, it would be enlightening to know, first of all, just how many there are today, and how this total compares with, say, the number of addicts twenty years ago; it would be helpful to know how these people actually do get along in the community; are they all criminals; what sort of marital and sex life do they lead; can they manage to work, even though addicted; which group in society is most affected by drug addiction, etc. These are pertinent questions which call for substantiated answers if one is to understand, with some authority, the many ramifications of this entire problem.

HISTORICAL BACKGROUND

The use of narcotic drugs is nothing new; it is as old as recorded history itself. The Sumerians spoke of their poppy some seven to eight thousand years ago; around 4000 BC, the Assyrians had their word for the 'joy' associated with the use of the poppy. The Egyptians, Greeks, and then the Romans were all acquainted with the drug. Through

the spread of Mohammedanism by the Arabs, opium first reached Persia, and later India; and because the poppy then grew mostly in the East, addiction there became most prevalent. In the West, the renowned physician, Dr. Sydenham, in 1680, in speaking of the value of opium, made this interesting observation: "Among the remedies which it has pleased Almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium."[1] For more than two thousand years, the use of opium was employed as the major means for the alleviation of pain in human ills.

In 1804, a German chemist, Dr. Serturner, isolated morphium, and with this discovery the means was provided whereby usage, and then addiction, became prevalent in the West. In the United States, the Civil War saw the popularization in medical circles of the hypodermic needle, and also saw the almost indiscriminate use of narcotics among the wounded to reduce pain. The years following were years in which addiction in the United States reached major proportions; this, primarily as a result of the inordinate use of the drug. Both the Spanish-American War and the first World War had a similar effect, although the latter to a much lesser degree. Opiates were again used extensively for the wounded during the second World War, and because of the sharp drop in available drugs as a result of the war, prices for these drugs rose extravagantly in the illicit market. The high profits thus realizable on available

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1 E. Terry and A. Pellens, The Opium Problem Today, N. Y. C., Bureau of Social Hygiene, Inc., 1928, pp. 53-57.

drugs -- as high as 3000% in some cases -- became encouragement for the underworld to enter the market on a large scale, pushing the use of drugs wherever possible.[2]

Significantly, drug addiction during the nineteenth century, when narcotics were available at pharmacies, was not especially linked with crime, as it is today. Rather, addicts at that time were viewed much as alcoholics are at present. Before passage of the Harrison Act in the United States in 1914, which dealt with narcotic control, it was estimated that females addicted to drugs outnumbered males addicted by three to one; today, males are clearly the majority group.[3] The passage of the Harrison Act changed completely the narcotics picture. The Act was intended as a revenue and control scheme, and required all who dealt in opiates or cocaine to register with the Collector of Internal Revenue and to pay special taxes. Because the Act was not so interpreted as to allow doctors to treat addicts as patients, chronic users of drugs had to turn to surreptitious sources for their supply, and so the illicit traffic had fertile grounds in which to flourish. [4]

INCIDENCE

Because of the psychological and sociological complexity of narcotics addiction, it is virtually impossible to determine accurately

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2 A. R. Lindesmith, Opiate Addiction, Bloomington, Indiana, Principia Press, 1947, pp. 196-198.

3 Ibid., p. 182.

4 J. D. Reichard, "The Narcotics Addict as a Custodial Problem." Prison World, Vol. 5, No. 2, 1943, p. 19.

just how extensive the problem is today; users of drugs can -- and do-- include doctors and nurses who have full access to the drugs and so are rarely reported; they can include many who are apprehended and put in prisons, but for offenses other than addiction. On the other hand, violators of narcotics laws include 'peddlers', contacts, handlers, etc., many of whom never touch their products, but who are nevertheless often listed together with addicts on the police blotters. Again, there are the habitual users and the casual users, though from the statistical viewpoint, failure to distinguish between the two is the rule rather than the exception. It can be seen from this how difficult it would be to obtain any really accurate count of 'addicts'. The Secretary of the Treasury, in 1918, reported over one million narcotics drug "addicts" in the United States.[5] The methods in arriving at that figure are open to question, but the total listed does indicate dramatically the seriousness of the problem at that time. In the years immediately following, addiction is believed to have decreased appreciably. In a not untypical year, 1937, the United States reported 5,386 convictions for violations of state and federal narcotic laws;[6] this figure is more or less indicative of the extent of violations during the period between the first World War and the start of the second. It has been estimated that in this period, drug addiction was four times as prevalent in urban areas as in rural.[7] In New York City, where recent investigations have spotlighted the intensity of the problem, fifty-six deaths were reported in

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5 Terry and Pellens, op. cit., p. 32.

6 L. Kolb, "The Narcotic Addict; His treatment" Federal Probation, Vol. 3, No. s, Washington, D. C. p. 20.

7. A Systematic Source Book in Rural Sociology, Minneapolis, P. Sorokin and C. Zimmerman, ed., Univ. of Minn. Press, Vol. 3, 1932, p. 75.

1950 as a result of illegal use of drugs; nine of these were among youths under twenty-one years of age. Among teen-agers, known addicts in that city rose from 329 in 1947 to 1,031 in 1950, a rise of 700%.[8, 9] The potential threat of drug addiction to the youth of any metropolis is made evident by these figures. There has been a corresponding rise in addiction in other areas (i.e. among adults, females, etc.,) as shown by recent surveys in Eastern cities.[10,11]

The picture in Canada is not so alarming, but is none the less serious. The Health Department at Ottawa reported 9,500 addicts in the country in 1924, with a steady decline to about 4,000 in 1943;[12] in the number of convictions for narcotics offenses, there has been a sharp rise since 1943.[13] There has similarly been a sharp rise in the number of females involved in this latter period. About one thousand cases are annually admitted to mental or penal institutions for drug offenses.[14] For the year 1951, it is estimated that there were about three to four thousand addicts, one third of whom could be found in the Vancouver area alone. The rate of increase in the past ten years is considered to be

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8 "Mayor's Committee Reports on Drug Addiction Among Teen-agers." N.Y.C. Spring 3100, Police Department, 1951.

9 J. Dumpson, "The Menace of Narcotics to the Children of New York.", Report of the Welfare Council of New York City, Aug. 1951.

10 "Drug Addiction Spreading", The British Columbian, Jan 9. 1951.

11 D. Carlsen, "Facts about Narcotics", Narcotics Anonymous, N. Y.

12 Statistics of Criminals and Other Offenses, Ottawa, Dominion Bureau of Statistics, 1949, King's Printer, p. 20.

13 Ibid, p. 92.

14 G. Josie, A Report on Drug Addiction in Canada, Department of Health and Welfare, 1948, pp. 9-10.

about four to one.[15] There is at present no significant addiction problem among the school children of Vancouver; and among the non-school adolescents, the reported incidence is extremely small. This is the record as known to police authorities at present. However, in a study made by H. F. Price for the Royal Canadian Mounted Police, of forty-five known addiction cases, it was determined that over half of this group, 54.5%, began using drugs at an average age of 17.4 years; 65.8% of the group were first arrested at an average age of 16.9 years.[16] It becomes apparent from these figures that, though addiction is not a major, overt problem among the youth of Vancouver (or Canada) today, it does nevertheless exist as a beginning pattern likely to be followed by many young delinquents in the years to come unless fundamental changes soon take place.

DRUG ADDICTION AND WORK ADJUSTMENT

Narcotics addiction is no respecter of race or education; there is an exceptionally high percentage of individuals in the medical profession involved as addicts,[17] and it is peculiarly prevalent among those groups having sufficient theoretical knowledge of the drugs.[18]

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15 H. F. Price, "The Criminal Addict", Royal Canadian Mounted Police Quarterly, Oct. 1946, pp. 150-154. (The author considers the rate to be the same for the years since 1946.)

16 Loc. cit.

17 A. R. Lindesmith, Opiate Addiction, p. 156.

18 A. R. Lindesmith, "A Sociological Theory of Drug Addiction", American Journal of Sociology (hereafter referred to as AJS.) Jan. 1938, p. 609

19 G. Josie, op. cit., p. 21.

Convictions under the Opium and Narcotics Act, however, are most often confined to those in the laboring, domestic service, and commercial work, -- in that order.[19] Among addicts studied at the 'Narcotics Farm' operated by the U. S. Public Health Service at Lexington, Kentucky, it was discovered that a high percentage had fairly good job records: their work was satisfactory, and their employment was reasonably long. In 172 cases studied, 88 had a good-to-fair job record; 84 had irregular or unsatisfactory records.[20] In most addicts, as a rule, a sufficient amount of the drugs produces lethargy and decreased ambition; preoccupation with obtaining the drug and association with the underworld to achieve this results in a personal and social deterioration, the outcome of which is an increasingly poor work record.[21,22,23] The addict's development of tolerance for the drug, which thus necessitates increasingly larger amounts for his comfort, plus the other harmful mental effects, decreases his productive ability significantly; a slave to the drug, always needing more, the addict soon finds himself unable to report to work.[24] It would appear from these studies that those addicts who

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20 L. Kolb, "Pleasure and Deterioration from Narcotic Addiction", Mental Hygiene, Oct. 1925, pp. 699-724.

21 L. Kolb, "Drug Addiction Among Women", United States Public Health Service Bulletin (hereafter referred to as USPHS), Wash. D.C.

22 A. Pfeffer and D. Ruble, "Chronic Psychosis and Addiction to Morphine", Archives of Neurology and Psychiatry, Dec. 1946, p. 670.

23 M. Pescor, "A statistical Analysis of the Clinic Records of Hospitalized Drug Addicts", USPHS Report, Supplement 143, 1943, p.2.

24 Spring 3100, (1951).

must obtain their drugs illicitly generally reveal unsatisfactory work records, particularly where procurement is quite difficult; the good work record of so many addicts -- even though this group included professional people capable of obtaining drugs without difficulty -- is surprising, in view of both the lethargic effect of the drugs and the deteriorating social effect of usage. One can only conjecture at this point, lacking intensive research into case backgrounds, as to why this significant difference exists. It would seem that, as borne out by these studies, a majority of addicts can make fairly good adjustments in employment in spite of their addiction.

MARRIAGE

The narcotics offender in Canada, in his marital relationships, has been found to be quite similar to his non-addicted, non-criminal neighbour; this is in interesting contrast to all other convicted offenders who, maritally, are quite different,[25] The addicts studied at Lexington however, show a high percentage of unsuccessful marriages as compared to the general population in the U. S.; half of all the married cases examined there can be described as uncongenial marriages, with separation or divorce a frequent consequence (39% of all cases studied fitted into this latter group). Divorced addicts frequently re-marry females who are themselves addicts.[26]

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25 G. Josie, op. cit., p. 20.

26 M. Pescor, op. cit., p. 11

This rather tenuous relationship which addicts show in this area of marriage can be traced to several factors: (a) the use of the drugs causes sexual disinterest and disintegration; (b) money needed for drugs reduces, often seriously, the amount available for family maintenance; and (c) the neurotic or psychopathic behavior which so often leads to addiction also creates the uneasy relationship between marital partners which then results in separation or divorce. The apparent difference in rates of divorce and separation among addicts between Canada and the United States can perhaps best be explained in cultural terms: the provinces of Canada, and particularly because of the inclusion of the Province of Quebec where family ties are very strong, have as a whole a more clearly defined and stronger social and family control than does the United States, such control quite likely having a more restraining influence even among addicts.

SEX

Contrary to most lay impressions regarding drugs and sexual behavior, it is an observed fact that the use of drugs curbs sex desires, and, in the male, delays the appearance of orgasm. [27] Indeed, medical authorities are convinced that it is actually physically impossible for the narcotic addict to commit violent sex crimes.[28] There is some stimulation of sexual phantasies resulting from the use of marijuana, at

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27 M. J. Pescor, op. cit., p. 11

28 D. Carlsen, op. cit.

least for those who expect such actions, but the degree of such stimulation is very small.[29]

Among females, there is a high correlation between prostitution and drug usage, (all but one of the female addicts studied by H. F. Price were prostitutes; the exception was a nurse.[30]) but the explanation for this correlation is debatable. Most female addicts, perhaps as rationalizations, insist that they have had to resort to this profession to pay for the drugs. Price has found that a great many of the prostitute-addicts use the drugs in the hope of blotting out of their minds their daily experiences, particularly because of the many perversions which they are expected to perform in their profession. For most prostitutes using drugs, it would appear that their addiction is merely another manifestation of their already disordered and anomalous lives.

CRIME AND DRUG ADDICTION

Perhaps the most controversial area in the entire narcotics addiction problem is that portion dealing with crime. In the popular mind, the drug addict is generally assumed to be somewhat of the "criminal type". Police authorities tend to regard the use of drugs as offshoots, by the addicts, of their other criminal tendencies. [31]

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29 J. Reichard, "Some myths about Marijuana", Federal Probation, Oct. - Dec., 1946, p. 19.

30 H. F. Price, op. cit., p. 151

31 H. F. Price, op. cit., p. 154. For purposes of clarification, "criminal tendency" will be used here to imply anti-social behavior and attitudes; thus, the one who violates the Opium and Narcotics Act, but who would not be described psychologically as anti-social will not, in this section, be described as criminal.

It would be convenient, for the purposes of analysis, if a sharp line could be drawn between criminals who later in their careers took to drugs, and addicts who, taking drugs, became offenders in the process. At the British Columbia Penitentiary, for example, in 1951, some twenty-five per cent of the inmates were adjudged to be users of drugs, but the most careful examination of records thus far fails to bring out the desired distinctions; the two are too closely intertwined. Price, in his studies, has found that every addict has had a previous record of criminal behavior; Sandoz, studying sixty morphine addicts, finds that forty-two of them never had been arrested prior to addiction, and that after addiction, his group showed 8.2 arrests per case;[32] at the Lexington farm, three-fourths of the patients studied had no delinquency record prior to addiction, and the biggest majority of patients were not anti-social prior to addiction.[33] The evidence, in these apparently contradictory observations, would seem to favor the latter studies if for no other reason than that the R.C.M.P. studies would quite naturally embrace those who are in sharpest contact with law enforcement (and hence with the observer), while the latter studies were made in areas where treatment of both voluntary and involuntary patients was the emphasis. A 'non-criminal' addicted nurse or lawyer, e.g., would be found in the Lexington study, but probably not in the R.C.M.P. study unless otherwise engaged in crime.

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32 E. Sutherland, Principles of Criminology, 4th. ed. N.Y. J. B. Lippincott Co., 1947, p. 115.

33 M. J. Pescor, USPHS Report (1943), pp. 7-8.

For the individual who starts taking drugs (the one having no previous delinquency record), the pattern is generally that of his becoming enslaved by the drugs, getting less efficient, becoming careless in his appearance, job, and sense of responsibility; he feels driven by psychological and physical needs to get more drugs, feels indifferent to all else, and slides rapidly down the social ladder. Lacking ambition, industriousness, the addict seeks the easy money found in gambling, larceny, etc.[34] It is very doubtful if the drug itself ever induces the user to engage in crime.[35] Narcotics addicts are not prone to crimes of violence; their crimes are associated with the obtaining of the drugs.[36]

As opposed to this group of addicts who engage in crime primarily to get their drugs, there is the large class of criminals to whom drug addiction is just another of their anomalies. For treatment purposes, the distinction may be important, as will be indicated later. Criminal addicts can here be regarded as anti-social and of such neurotic or psychopathic bent that, under the circumstances, treatment preferably falls, together with the anti-social criminal addict, under the aegis of penal authorities. Addicts-who-become-criminals, on the other hand, may (with important reservations) more logically be suited for treatment such as that offered in certain mental hospitals and narcotic farms. It is difficult to draw any hard, sharp line between these two groups because, as indicated earlier, addiction and criminality so often grow together as part of the same process; in the final analysis, one can only take

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34 C. K. Himmelsbach, "Comments on Drug Addiction", Hygeia, May 1947 p. 353.

35 J. D. Reichard, Fed. Probation, Vol.X (1946, pp.17-18.

36 G. Josie, op. cit., p. 39

each case on its own merits, and decide whether it is properly a penal or a treatment case, in the hospital-versus-prison sense of these terms. Where the case reveals a persistent record of criminality prior to addiction, then a hospital setting would ordinarily not be advisable; but where illegal activity follows as a result of addiction, then a hospital may be indicated. However, as will be discussed further in a later chapter, selection for treatment can not be arbitrarily based on a division into 'criminal versus non-criminal types'. The problem is far too complex to allow for such clear-cut and simple demarcations.

"Big time" criminals rarely use drugs themselves; they may handle it for re-sale, but among themselves they realize it is too risky for their profession.[37] The use of opium tends to make the user serene, lethargic; morphine and heroin produce mental and physical lethargy, loss of ambition, all of which is incompatible with the production of an aggressive thief.[38] The thief who takes cocaine is temporarily more efficient as a thief (this same drug will not enhance the criminal impulse in anyone not so predisposed); but taking it beyond a certain point brings on in him a state of fear or paranoia.[39] Among other effects, heroin and morphine in large doses will change drunken, fighting psychopaths into sober, non-aggresive idlers.[40] In general, male addicts resort to crimes against property; female addicts resort to prostitution.[41] Reference is of course being made here to those addicts convicted of

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37 D. W. Maurer, "The Argot of the Underworld Narcotic Addict", Part I, American Speech, April 1936, pp. 116-117.

38 L. Kolb, "Drug Addiction in its Relation to Crime", Mental Hygiene, Jan. 1925. p. 78.

39 Ibid., p. 88.

40 Loc. cit.

41 Spring 3100 (1951)

offenses other than narcotic violations.

ALCHOHOLISM AND NARCOTICS ADDICTION

The two forms of addiction, alchoholism and narcotics, have one major feature in common: both can be interpreted as symbolic methods of flight. The use of both forms of addiction for the same person is not uncommon; in the United States, the inebriates form a very large addict group. One-third of the patients at Lexington were chronic alchoholics prior to addiction.[42,43] The substitution of drugs for alchohol is a common occurrence, and has its basis in the same psychological motivation. (Cocaine and Marijuana, e. g., act to release depressed tendencies and to create disturbing and anti-social activity in those who are basically anti-social; the action resembles that of alchohol.[44]) There is, however, one very important difference between these two forms of addiction: one can drink steadily without becoming an alcholic, but the evidence suggests that it is virtually impossible to take 'shots' steadily without becoming addicted.[45]

CONFLICTING THEORIES ON DRUG ADDICTION

Existing theories that attempt to explain narcotics addiction are varied and many, and are, quite often, very much in direct conflict

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42 M. Pescoe, USPHS #143 (1943), p. 12.

43 G. Josie, op. cit., p. 25.

44 J. D. Reichard, "Narcotic Drug Addiction", Diseases of the Nervous System (hereafter referred to as DNS) Vol. IV, (Sept 1943), p. 278.

45 M. Moore, "The Management of the Alchoholic Probationers", N.Y.C. 1941, p. 317. Probation and Parole Progress, ed., E. M. Bell.

with one another. One leading authority in the field, Dr. Orgel, states categorically that " ... stable, well-integrated people do not become addicts, even when the drug is administered for any length of time".[46] But against this there is this statement by Lindesmith: "The 'Psychopathic basis' theory implies that personality disturbance is at the basis of almost all cases. Yet it appears that all 'normal' persons who have experimented upon themselves taking the drug, and who had, because of their stability, considered themselves immune, have, after taking the narcotics for a length of time, become addicted themselves."[47] This is but one illustration of the contradictory observations and conclusions found in studies of drug addiction.

The following theories, with some brief criticisms, may be set out as among the outstanding explanations given today in the field:

A. The "psychopathic basis" which applies to the big majority of cases. It is the nervous and mental instability in these people which pre-disposes them to addiction. (It has been shown, however, that 'normal' people can become addicts. Exponents of this theory have never used control groups, so that scientific proofs of this view are lacking.)

B. Bingham Dai theory of maladjusted personality. Drug addiction is, at bottom, a symptom of a maladjusted personality. The condition has definite connections with the childhood of those concerned, especially with the maternal relationship. Their defective attitudes towards people cause the addict to shun the demands of the culture, and so makes permanent cure almost impossible.

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46 S. Z. Orgel, Psychiatry Today and Tomorrow, N. Y. International Univ. Press, 1946, p. 206.

47 A. R. Lindesmith A J S (Jan. 1938), p. 598.

The addicts craving for opium is due to his psychological desire to re-enter the state of Nirvana. (Once addicted, the addict is not seeking Nirvana so much as he is seeking only relief of his distress caused by the addiction.)

C. Hereditary basis of addiction. In going over family backgrounds of a large number of cases studied, it is revealed that a significantly high percentage of them have histories of mental illnesses among their forbears. This theory does not pretend to cover all cases.

D. Pleasure Theory. The common belief that opiate addiction is based upon the happiness or pleasure which the drug is supposed to produce. (The very fact that addicts always appear unhappy would rule out such a hedonistic explanation. As suggested earlier, the addict, though he will get some gratification from the drug, also complains of the numerous evil upon himself.) [48]

E. Narcotic addiction is fundamentally a physiogenic phenomena. Dr. Spragg, working with chimpanzees, gave them repeated doses of morphine, and found evidence in their behavior of a desire for morphine.[49] (This projection of human attributes -- the "desire" -- is open to much debate.)

F. The criminological theory. Addiction is only another manifestation of the over-all anti-social pattern of the user. (But it has already been indicated how many addicts show no record of anti-social behavior prior to their addiction.)

It is extremely difficult to 'prove' any of these — or other -- theories on the subject. For one thing, control groups are extremely difficult to use for such purposes; and for another, only a slight percentage of the entire population has been exposed to drugs, so that

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48 A. R. Lindesmith, Opiate Addiction, pp. 145-155.

49 S. D. Spragg, "Morphine Addiction in Chimpanzees", Baltimore, Comparative Psychology Monographs, Baltimore, XV, No. 7.

those exposed and thenceforth addicted cannot fairly be regarded as representative of this entire population. Therapeutic work with addicts, nevertheless, has been going on for years, all of these doubts notwithstanding. The treatment difficulties encountered -- perhaps a direct reflection of this doubt and confusion -- is graphically portrayed by the following examples: (1) In Germany, 799 addicts who had been treated were studied for long term effects; in five years, 96.7% of them had relapsed;[50] (2) In India, Dr. Chapra remarks how "... we have treated in our hospitals a number of (opium) addicts ... and our efforts ... have been miserable failures."[51] The picture at the Lexington farm, where patients are treated for psychopathic and neurotic disorders, is fortunately, not nearly so discouraging. Because social work theory and practices fit in most closely with this latter approach, it is intended that they should receive the bulk of attention in the following pages.

THE PENAL APPROACH TO NARCOTICS ADDICTION

The Opium and Narcotics Act of Canada is a control and revenue measure, and does not concern itself with treatment. British Columbia has no legislation dealing with treatment of narcotic addicts, but only laws dealing with the mentally defective and insane. As a result, in

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50 A. R. Lindesmith, A J S (Jan. 1938), p. 594.

51 R. N. Chapra, "The Present Position of the Opium Habit in India", Indian Journal of Medical Research, XVI, p. 389.

all of Canada in recent years, only twenty-one addicts per annum, on an average, have been admitted to mental hospitals for treatment. [52] Generally, only addicts who are psychotic cases are admitted. Most convicted addicts are sent to jails for periods of one year or less; a great many are sent to penitentiaries for two years or more. About one thousand annually are sent to penal institutions in Canada for drug offenses. [53] That present penal methods do little good in helping addicts towards recovery is readily admitted by most penal authorities. Recidivism among addicts is very common. In recent years, about 50% of those convicted under the drugs Act had previously been convicted, usually of other offenses.[54] At the B. C. Penitentiary, as of Nov. 1951, 125 inmates were serving there for drug offenses. Of 44 cases studied in this group, at least 34 used the drugs themselves; 42 of this group of 44 were recidivists. The pattern seems to be monotonously the same: arrest for drug or other offense, prison, release, and re-arrest. It seems clear that the present techniques leave much to be desired; however, to view the cases studied as essentially narcotic cases would be equally faulty, for every one of the thirty-four addicts mentioned had delinquent records antedating their addiction. Although to be relieved of their drug habit would undoubtedly aid in their general rehabilitation, it can be suggested with good reason that, with such cases, rehabilitation might more appropriately fall under enlightened penal programs rather

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52 G. Josie, op. cit., p. 52

53 Ibid., p. 69

54 G. Josie, op. cit., p. 69

than in a hospital setting where their presence may have serious deleterious effects among the non-criminal patient populations. The great amount of time needed for these people would again militate against their being sent to hospitals for treatment when one considers the existing paucity of resources for such work. It does seem possible to take some positive therapeutic steps even for these hardened criminal addicts; relief of their addiction may help considerably as part of treatment for their entire difficulty. For this group, a hospital setting in a maximum security area completely separate from a treatment center for the other treatable addicts, and having at their disposal the necessary staff of trained personnel in psychiatric work, may be beneficial in eliminating or reducing the habit. That such efforts may be long and costly, and may actually do little to re-orient the criminal addict so far as his other deviancies are concerned, needs to be carefully considered in the light of available resources.

SOCIAL WORK AS RELATED TO THE PROBLEM

D. Carlsen, head of Narcotics Anonymous, speaks of addicts as maladjusted people who have fallen out of step with the rest of the world.[55] Taking the drug away from the addict is relatively simple, once he is in an institutional setting (hospital, prison, etc.); but only when he, the addict, learns to understand himself and his condition can

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55 D. Carlsen, op. cit., p. 2

56 L. Kolb, Fed. Probation, Vo. III, p. 23

he hope to permanently arrest the disorder. This is clearly an area in which social work is applicable. Regardless of what theory one follows regarding addiction, it does become evident that personality maladjustment is a complicating and intensifying factor in the huge majority of cases. Removal of this factor will most likely be of tremendous help in the road to being cured. The explanation for addiction based upon personality disorders may be only coincidentally correct -- as measured by its relative success in treatments, contrasted with other methods -- yet it is, for the present, pragmatically logical. A former U. S. Assistant Surgeon-General recently stated that " ... the addict deserves more attention from physicians and social workers, and less attention from the police...." This in brief, is the contention of this thesis: to show how and why social work can play a major role in the rehabilitation of the narcotic addict.

Chapter II

THE ADDICT AS A PERSON.

It becomes more and more apparent, as one examines the lay literature on drug addicts, that a great deal of confusion, uncertainty, and misunderstanding exists about them; the type of life they lead is quite mysterious to the outsider; the drugs employed by them are not clearly differentiated as to the effects upon them; and the addicts themselves are not understood as being anything but addicts. In reality, the delineations are there, and are significant; to know and properly understand these afflicted people, to be able to work with them, it becomes necessary to know them, not as an undifferentiated mass, but as individuals, to know what they experience, the sort of daily existence they lead, the language they speak, the drugs that they use, and the various effects upon them as a result.

There are, to begin with, a number of expressions used in relation to addicts which can bear much clearer definition of meaning. To cite just a few of the more common and significant expressions, there are the terms like abstinence, which, when used in reference to drug addicts, signifies the purely voluntary aspect of their abstention from drugs. And in speaking of the abstinence syndrome, reference is being made to the symptom complex which appears when the individual with physical dependence undergoes drastic reduction in his dosage; the signs of this symptom, in order of importance, range from yawning, rhinorrhea,

and perspiration, to loss of weight, collapse, and possible death in the more severe cases.[1]

The "cured" addict remains a questionable term in this field, and most authorities feel that it would be better to speak in terms of self-control rather than of cure. Habituation refers only to acquired psychological need and dependence upon drugs; this is quite similar to speaking of the addict's habit formation, in which he seeks to avoid all discomfort or pain by taking refuge in some form of addiction. Narcotic drugs, as defined by Federal (U. S.) statute, refer to all derivatives of opium, such as morphine and heroin; also included are cocaine, marijuana, and peyote. Legally, the user of these drugs -- the addict -- is defined as one who, by his use of the drug, endangers society, or has lost self-control. The former user who has been abstinent for over eighteen months is not legally classed as addicted.[2] Physical dependence upon drugs inplies that the user no longer derives pleasure from the drug, but must take it to keep from becoming ill.[3] It seems to increase up to a certain level, with the length of time that narcotics are used regularly, and with the dosage.[4] After a drug has been used for some time, the addict finds that his tolerance for that drug has increased, that he has to increase his dosage in order to obtain the original effect.[5] Tolerance refers to the amount he needs to gain this desired effect.

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1 L. Kolb, Mental Hygiene (Oct. 1925), p. 699.

2 J. Reichard, Prison World, Vol. 5 (1943), pp. 12-13.

3 C. Himmelsbach, op. cit., p. 352

4 C. Himmelsbach and O. Mertes, "The Nursing Care of Drug Addicts", N.Y.C., The Trained Nurse and Hospital Review, Nov., 1937, p. 459.

5 C. Himmelsbach, op. cit., p. 352.

ARGOT OF THE DRUG ADDICT

Symptomatic of the clandestine and deviant sort of life led by most addicts is the extensive and secretive argot used by them. Listed below are a few of the more common expressions found among addicts in all parts of Canada and the United States. It will be noticed among these expressions how revealing of the attitudes and habits of the addicts are the feelings incorporated therein:

All lit up. Under the influence of narcotics.

Black Stuff. Opium.

Blowing. Inhaling narcotics.

Brody. A feigned spasm to elicit sympathy and perhaps dope from a doctor.

Coasting. The exhilarating sensation produced by cocaine.

Cold Turkey. The sudden, abrupt withdrawal of drugs from addicts in institutions.

Courage Pills. Heroin in tablet form.

Do Right People. Legitimate people, or those with no criminal connections.

Hoosier Fiend. A 'yokel' who has become addicted, perhaps accidentally, and does not realize he is 'hooked' until he develops withdrawal symptoms.

Joy Popper. A person, not a confirmed addict, who indulges in an occasional shot of dope.

Kick Back. The addict's almost inevitable return to narcotics after 'kicking the habit'.

Main Line. The vein, usually in the forearm near the elbow, into which the conditioned addict shoots the drug.

Mr. Fish. An addict who gives himself up and goes to prison in order to break the habit.

Pad. A party for addicts, generally given by a pusher. Tickets are issued only to trusted customers, or to potential users.

Panic Man. An addict who is desperate for narcotics.

Pusher. A narcotics peddler.

Snow. Cocaine.

A major reason for this addiction argot stems from the constant fear of betrayal that exists among addicts and 'peddlers'. For self-protection, they have their elaborate, effective underground facilities for transmitting both information and narcotics. The great degree of clannishness among addicts is certainly another cause for such an argot.[6]

DRUGS USED BY ADDICTS, AND THEIR EFFECTS

The attractiveness of the opiates, which include morphine, heroin, and codeine, lies primarily in the satisfaction they provide in the urge for peace and calm. All opiates quiet the nerves, reduce awareness of pain and discomfort, and, in addition, tend to wipe out mental conflict and the uncomfortable pathological strivings that result. The tensions produced by the strivings are relieved, and, under the drug's influence, the neurotic or psychopathic patient feels free, easy and contented, as contrasted to his usual anxious state. Continued use produces mental and physical lethargy, and loss of ambition. The only pleasure later received from the drug is the pleasure in relief from withdrawal symptoms. Frequently, the first dose of opium produces more pleasure than any subsequent indulgence.[7] Users appear to become hyper-suggestible

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6 D. Maurer, op. cit., p. 116

7 L. Kolb, U S P H S # 211 (1925), p. 4.

while addicted.[8] Those addicted are often comparatively free from signs of deterioration for years. When the addict's supply of opiates is stopped, he becomes ill with pain, suffers from cramps, vomiting, diarrhea, sleeplessness, and possible death.[9]

According to recent investigations in the United States, heroin is by far the most commonly used drug today in the illicit market. This drug, a narcotic derived from morphine, tends, like morphine, to soothe abnormal impulses of all kinds. unlike alchohol, it does not release, but rather it inhibits activity. It is decidedly the most toxic of the drugs used,[10] and its symptoms resemble those of morphine. The latter drug, morphine, is the most potent in dependence-producing properties, and, with heroin, has pain-relieving action, a tendency to quiet anxiety, and to relieve mental distress. It relieves the individual of his physiological discomfort, and decreases the urge to action. Long use of morphine may result in melancholia,[11] and increased loss of memory. Memory is one of the first faculties affected by use of the drug. Severe cases sometimes show visual hallucinations. Recent studies indicate that the use of morphine has not increased mental deterioration, and the habitual use of

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8 V. Vogel, "Suggestibility in Narcotic Addicts", Public Health Report No. 132, Washington, 1937, p. 4.

9 A. Wikler, "Clinical Aspects of Diagnosis and Treatment of Addiction", Bulletin of the Menninger Clinic, Topeka, Kan., Sept. 1951, p. 158.

10. L. Kolb and A. DuMex, "Experimental Addiction of Animals to Narcotics", Public Health Report #1463, Washington, p. 30.

11. L. Kolb, Mental Hygiene, Vol. IX (1925), pp. 78-85.

the drug does not cause a chronic psychosis or an organic type of intellectual deterioration. The addict may suffer from ethical and social regressions, but this is not due to the direct effect of the drug.[12] There are many cases on record of very psychopathic individuals becoming fairly good, well behaved citizens after becoming addicted to morphine.[13] It would appear that withdrawal of morphine is not sufficient in itself to cause a psychosis, but it may intensify the symptoms of a psychosis that already exists.[14]

Addiction to the drug codeine is, in Canada, apparently far more serious than in either the United States or the United Kingdom. Codeine has been used as a principal ingredient in cough relieving syrups. Many individuals of unstable emotional character who originally had taken the medicine for its primary purpose, found themselves developing a craving for the drug, then seeking increased dosages of codeine, and eventually switching to morphine or heroin for their greater stimulation effect.[15]

Marijuana, obtained from a species of hemp plant, grows thoughout the world in both temperate and tropical climates. Many people with normal nervous constitutions use it,[16] as do others of less stable character. It is taken primarily for the intoxication it causes, and also

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12 Pfeffer and Ruble, op. cit., p. 670

13 J. Reichard, D N S Vol. IV (1943), p. 278.

14 A. Pfeffer, "Psychosis During Withdrawal of Morphine", Archives of Neurology and Psychiatry, Aug. 1947, p. 225.

15 L. Davenport, "The Abuse of Codeine: A Review of Codeine Addiction and a Study of Minimum Cough-relieving Does", Public Health Report #145, Washington, 1938.

16 L. Kolb, "Marijuana", U S P H S. reprint #B-2575, pp. 2-4.

for its inhibition-releasing qualities. Users of it limit themselves to a certain amount, not needing -- as with opiate users -- to increase the dosage rapidly to get the desired effect. It is more intoxicating than alchohol, and more abusive use of it would lead to insanity sooner than an abusive use of alchohol; in this respect, it is more harmful than opium.[17] When the smoke is inhaled, the user becomes hyper-active, anxious, has vague fears, may even fear death, and become panicky; this is quickly followed by feelings of ease and elation. The user then becomes talkative and is filled with a vivid sense of happiness; the sex impulse is aroused in some because the sex object appears more attractive. A loss of interest in the environment, and an inability to concentrate long on any one subject generally follows the second or third day of using the drug, after which users become more lethargic. After several weeks, users will complain of headache, fatigue, dryness of mouth, and will often be irritable. In general, the feelings of exhilaration and euphoria rendered by marijuana are followed by a general lassitude and indifference which results in carelessness in personal hygiene and lack of productive activity. The drug seems to increase cerebral activity, but has a lack of effect on body sensation (smell, touch, etc.).[18]

When used by unstable, anti-social, or inebriate persons, marjuana will release anti-social behavior as a symptom of abnormal attitudes already present. The intoxication caused by marijuana is considered

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17 Loc. cit.

18 E. Williams, B. Lloyd, and A. Wallace, "Studies on Marajuana and Pyrahexyl Compound", Public Health Report # 2732, Washington, 1946, pp. 16-21.

desirable by some musicians, although actual tests reveal that poorer performance results from its usage.[19] It produces temporary psychosis in unstable persons, but no evidence has been found of any irreversible damage to the nervous system.[20] Continued use of the drug can cause insanity, but most patients recover when use of the drug is ended. Marijuana does not cause any physical dependence; after withdrawal, however, users usually experience feelings of restlessness, sleep poorly, have poor appetite, and often report "hot flashes" in their bodies.[21]

Cocaine, a stimulant used as a local anaesthetic in medicine, when taken internally lessens fatigue and makes the user more energetic. It acts as a direct antidote to whiskey and opiates, and is used as such by drunkards and opium addicts. Cocaine and opiates are often taken together by addicts to gain the more intense pleasure afforded by the combination. The drug stimulates the mind and body, and, up to a certain point, increases confidence and courage. The immediate effects of the drug are pleasurable sensations; this pleasurable stimulation is enhanced in the feeling of some psychopaths because in them the drug also produces mental calm -- they get a blotting out of excessive worries. Sex power is increased, and appetite is decreased. Cocaine never causes confusion like whiskey, nor stupor like morphine and heroin. Excessive use of cocaine causes delirium, severe weight loss, and premature death.[22]

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19 C. Himmelsbach, op. cit., p. 353.

20 J. Reichard, Fed. Probation, Vol. X (Oct.-Dec. 1946), p. 16.

21 Williams, Lloyd, and Wallace, op. cit., pp. 16-21.

22 C. Himmelsbach, op. cit., p. 303.

Beyond the point of maximum stimulation, it produces uncertainty, fear, and anxiety, which often develops into persecutory delusions. Cocaine addiction produces marked personality changes; when a psychosis develops, hallucinations of bugs crawling under the skin become characteristic.[23] Most users of cocaine eventually switch to opiates to counterbalance the excessively stimulating effects of the drug. Withdrawal of the drug produces gastric disturbances, and oftentimes fearful hallucinations; however, no significant physiological changes have yet been demonstrated during abstinence following abrupt withdrawal.[24]

Among other drugs which, thus far, have not been seriously abused are the barbiturates which may, however, be habit-forming; if used abusively, they may give rise to psychotic reactions which are usually temporary and recoverable. Addicted users often are confused, irritable, and react and speak slowly. Withdrawal of the drug may cause grand mal seizures, or bizarre, involuntary movements of all extremities.[25] Methadon, one of the new drugs developed during the war, has proven more effective for relieving most kinds of pain, and also produces less physical dependence. Its danger lies in this very fact, and users of it, many of whom regard it as more pleasant than morphine, are likely to develop stronger habituation for it as a result. Neurotic and psychopathic persons are most liable to abuse the drug, taking to it because of

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23 L. Lowrey, Psychiatry for Social Workers, N. Y. C., Columbia Univ. Press, 1947, p. 141.

24 Wikler, op. cit., p. 157

25 Ibid., p. 164-165.

the long, sustained type of euphoria it offers.[26] Another new drug, Demerol, acts like the opiates, causing physical and emotional dependence. Abuse of it can lead to delirious reactions and convulsions.[27]

CLASSIFICATION OF ADDICTS

The very heterogeneous composition of the group known as drug addicts has already been suggested. The entire group can arbitrarily be subdivided into as many classifications as there are foci of study. Inasmuch as treatment is the consideration here, the classification will be considered from that angle only, and the one that follows is based on treatment arrangements at the Lexington Hospital. Following each classification, a brief description is included of the typical inmate of that group -- as determined by studies made at the hospital -- the relative proportion of inmates in that classification, and finally, where feasible, the prognosis of each sub-group.[28]

1. Normal individuals accidentally addicted. These are persons of normal nervous constitutions accidentally or necessarily addicted through medication in the course of illness. They comprise 3.8% of all patients. The typical case in this group was past the age of forty

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26 H. Isbell and V. Vogel, "The Addiction Liability of Methadon", American Journal of Psychiatry, June, 1949, p. 913.

27 Vogel, Fed. Probation, (June 1948), p. 10.

28 M. Pescor, "The Kolb Classification of Drug Addicts", Supplement #155 to the Public Health Reports, Washington. All descriptions given are of Lexington Hospital patients covered in this study. Patients included are male and female, young and old, prisoner and volunteer.

when first addicted; he used morphine to alleviate pains, and continues to use it. He is a voluntary patient, with no anti-social record. He had a normal childhood adjustment, is happily married, and has an acceptable social adjustment despite his addiction. His parents were comfortably off, and provided average discipline at home. The prognosis of this group is above average.

2. Psychoneurotics. These comprise 6.3% of all patients. The typical case tried twice to break his habit, but relapses because he feels that he needs it for therapeutic reasons. He is a volunteer at the hospital. As a child, he was shut-in, studious, and obedient. He went to college, has a good income, and is congenially married. No anti-social record is evident, and he has an acceptable social adjustment. His parental home was intact during the developmental years; his father's income was moderate. The patient had some neurotic disorders as a child, and probably had a nervous breakdown as an adult. He is uncooperative at the hospital, always demanding his release, and is unpopular with the other patients.

(The uncooperativeness of patients in this group is somewhat surprising in the light of the fact that, ordinarily, this group in a mental hospital does lend itself rather readily to attention and treatment. It may be possible that methods of handling this group at the hospital are at fault. A common irritation to patients at mental hospitals who are not too seriously disturbed, is the physical arrangement whereby individual movement and liberties are severely restricted in the buildings. Such aggravation can conceivably interfere with receptiveness to treatment, and

so leave the patient with a strong desire to leave rather than to stay for further care. A less restrictive atmosphere -- perhaps one in which only the external limits of the institutional grounds (a high wall, e.g., appropriately disguised) to serve as a restraint, with free movement within this area at a practical maximum -- would likely be more conducive to treatment for patients bothered seriously by existing restrictions.)

3. Psychopathic diathesis. 54.5% of all patients fall in this group. The group consists of individuals who show psychopathic dispositions or tendencies; it is characterized by behavior resulting from mis-interpretation of environmental settings or situations, but it is not a well crystallized personality defect. The typical case is a male prisoner who is 35 years old. His parents lived marginally and enforced average discipline at home; family relationships at home were congenial. He had normal childhood adjustment. As an adult, he tends to live in poor city areas. He employs illegal means to support his habit. He is married, but not for long. He indulges in all forms of vice at times, and became addicted through the influence of his friends, and through curiosity. He was addicted for ten years when reporting to the hospital, and showed a history of one enforced prison treatment, but relapsed within two years because of association and desire to recapture the pleasant sensation produced by drugs. He had no delinquencies prior to his addiction; after that, his offenses were confined to drug violations. His prognosis: he will probably relapse.

4. Psychopathic personality without psychosis. This group comprises 13.4% of all patients. The typical case rationalizes his

addiction on the basis of curiosity and association. He has never tried voluntary treatment, but had several enforced attempts, each of which met with later relapse. He has a history of juvenile delinquency, is anti-social, and is single. His parents were of marginal circumstances, and his home life was uncongenial; family ties were loose. He was anti-social as a child, and as an adult, lives by gambling and other extra-legal pursuits. His social adjustment was poor before addiction and remains so after it. His prognosis is poor.

It would appear that the two classifications above, psychopath and psychopathic diathesis, are more or less continuations of the same process; that is, both can be included under psychopathy, with the latter group forming the less severe cases of a continuum, and the former group (4, above) comprising the more severe ones. In gauging prognosis, then, it might be feasible to use the same continuum as a scale of reference, with position on that scale -- the relative severity of the case -- serving as possible indication of treatability. The relatively low degree of success with this psychopathic group corresponds in general with similar difficulties encountered at other mental hospitals treating psychopaths.

5. Inebriates. These individuals, comprising 21.9% of all patients, were persons in whom alchoholic indulgence played a significant role as a precipitating factor in their addiction. The typical case takes to drugs as a means of sobering up after alchoholic sprees. He has a history of at least two voluntary cures, with relapse through the alchoholic route. There is no history of earlier misdemeanors. His family history shows a prevalence of alchoholic addiction.

6. Drug addiction associated with psychosis. Less than 1% of all cases are included here. It is comprised of individuals suffering from frank psychosis, organic, toxic, or functional.

SUMMARY

It can be seen, from all of the foregoing, that the addict as an individual can have a background as varied as any in the general population. He is the person accidentally addicted, and he is the individual who deliberately resorts to drugs because of its euphoric effects. As a child, he may have been studious or flighty, well-behaved or obstreperous. Whatever the case, soon or later the fact of his addiction begins to put him in a group that, for its own protection and interests, uses its own language code, follows a pattern of clannishness, and, in general, comes to regard itself as a distinctly separate unit in society. Whatever their individual differences among themselves, drug addicts -- the great majority of them -- do feel that they are somewhat different from others, and that they are, because of their unique way of living and adjusting with drugs, in a social grouping by themselves.

Chapter III

SOCIAL ASPECTS

Informational material thus far presented indicates rather clearly that drug addicts are not of one distinct type: their backgrounds vary considerably, as do their degrees of intelligence, their adjustments at work and in the neighborhood, their marital relationships, etc. It would seem, then, that involved in the causation of addiction are many factors; and to determine these factors, it would be enlightening to view the drug addict not only from the purely psychological points of view, but from the medical, emotional, and sociological viewpoints as well. It would, in other words, be helpful to see him as he develops from childhood on, and to notice in this development, and in his present circumstances, all those pressures which, singly or in combination, impel him toward this sort of deviancy.

SOCIAL HISTORIES OF NARCOTIC ADDICTS

It is extremely precarious, for reasons already presented, to deal confidently with statistics giving background data of addicts. Studies made at hospitals or prisons, e.g., are not necessarily representative of the addicted population at large; to be accurate, one can only say that the facts brought out are indicative only of those associated with the particular institution in question. It is very likely, in addition, that the institution in question is dealing only with the more

glaring cases, so that the more routine strain of addicts is left uncharted; such limited observation can only serve to dilute, or even negate in some cases, many of the conclusions that can be drawn from the studies.

On this continent, by far the most thorough study made has been that done at the Lexington farm, and appraisals included in the following section are drawn primarily from these studies.[1] Other surveys are accredited as they appear.

In more than half the cases studied, the childhood of the patients can be described as normal. Among the others, incorrigibility, truancy, delinquency, marked shyness, and feelings of inferiority were characteristic. In school, the average grade completed was the eighth, though many went to college. In both Canada and the United States, the general education level of all known addicts is lower than that of the general population.[2] The average mental age is 13 years 8 months, as contrasted to an M. A. of 15 years for the general population. 41.7% of the patients at Lexington had no history of familial diseases or psychopathic determinants. Addiction occurred in other members of the family in 8.2% of the cases. Over 50% of them had blood relatives with nervous difficulties (psychosis, asthma, alchoholism, etc.). The majority came from intact homes; a big minority from disrupted ones. In most of the latter, the mother took care of the children after the separation or divorce; a majority of the patients in this group did not remain at home

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1 M. J. Pescor, U S P H S # 143. (1943).

2 Josie, op. cit., p. 22

to help support the family, thus revealing a lack of responsibility even prior to their addiction. Most patients came from congenial homes where average discipline was applied; about 40% had poor discipline at home. A small percentage show a mother fixation, and a smaller group expressed hatred for their fathers. The majority had religious training in childhood, but gave up their religious devotions in later years. Over half the patients had poor dentition; as children, their medical history was not unlike that of the general population. About half the married patients have no children, but some of the others have large families. Occupationally, the biggest concentration is in the domestic and personal services; many professional individuals, especially physicians, are included. A majority are in marginal economic circumstances, and above one-third are comfortably off.

Regarding medical history, it is interesting to note how addiction so often starts as a result of medical attention. In one study of 1225 addicts among whom the development of addiction was traced, it was noted that in 23% of the cases, addiction stemmed from previous use of drugs in medical treatment, and in 17% of the cases, to self-administration of drugs for the relief of pain.[3] It is likely that, as a rule, addiction does not result simply from 'shots' of morphine given to alleviate pain. If a "normal" person has a chronic, painful condition for which opiates have to be given, and he develops physical dependence, the result is not necessarily a drug addict. If his physical dependence can be relieved, he can live without going back to drugs. But if he suffers

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3 Davenport, op. cit., p. 3

from marked tension plus pain, and finds that opiates give him relief from physiological unhappiness, then he may become addicted.[4]

SOCIAL PRESSURES

Recent studies at Bellevue Hospital in New York City throw light on the strong situational and social forces which are often cooperative in the genesis of addiction among adolescents. In one study,[5] all but one of twenty-two cases observed came from minority groups, and all of these youths suffered psychologically from racial discrimination. These youths, who first obtained drugs free from 'peddlers', or -- as is more often the case -- from other youths in the neighbourhood already addicted, took drugs as a result of either curiosity or group pressure: to remain in the neighborhood gangs to which they belonged, they had to follow the drug-taking pattern already established. Perusal of their social histories reveal this picture of the young addicts: they have many casual friends, but few real ones. At home, the mother is the dominant person; they reveal little rapport with their fathers. None of these mothers took a punitive attitude towards the boys, and many of the youths wanted to go into an effeminate occupation; most felt their closest relationship in the family is with the mother. Heroin is the drug of their choice because it helps them counteract their feelings of weakness and inferiority. Their I. Q.'s tend towards the dull-normal; emotionally they are immature, unstable, have low frustrations and anxiety tolerance.

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4 Reichard, D N S, Vol. IV (1943), p. 277.

5 P. Zimmering and J. Toolan, "Heroin Addiction among Adolescent Boys", Journal of Nervous and Mental Diseases, July, 1951, pp. 19-29.

Confronted with anxiety-arousing situations, they usually do not respond with open and impulsive aggression, but rather, they repress their hostile feelings and draw into their fantasies. They also regress to an oral, dependent stage.

Other studies of teen-age addicts bear out the fact of broken homes in the big majority of cases; in these homes, inadequate parental control, a lack of moral and ethical values, and a total disregard for personal responsibility is noticeably the picture. In areas where such addiction is rampant, there is a marked hostility evident towards all symbols of authority.[6]

The social forces which are effective in helping to precipitate addiction can be detected in much of the evidence about teen-age addiction. Caseworkers at the Bellevue Hospital who are in contact with young addicts both in and out of the hospital feel strongly that group pressure and group association is a major cause for the youngster turning to drugs. They go far beyond the claim of studies such as the Toolan one which concluded that young addicts are the dependent, passive type.[7] Experience with cases from all areas has led these social workers to the conclusion that group pressure and influence was often sufficiently strong to bring into the ranks of addicts youngsters of almost every personality type. Among adults, too, association with users of drugs is generally the most usual way in which recruits are added.[8] Broadly viewed, it can be seen how the

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6 Dumpson, op. cit., p. 12

7 Zimmering and Toolan, op. cit.,

8 Orgel, op. cit., p. 206.

entire turbulent picture of today contributes to the instability, uncertainty, and insecurity of family and community life, and this in turn adding to forces within the family making for added nervous tensions among the members.

Another interesting bit of evidence on the influence of social forces in drug addiction can be seen in the history of narcotics addiction among women. Whereas, in the late 1800's, female addicts exceeded male addicts two to one, today there are at least three or four male addicts to each female addict. The reasons can be attributed largely to the keener sensitivity of females in our society to social taboos than males. During the earlier period, taboos and laws against use of drugs were comparatively slight, and women experiencing serious frustrations, having few other outlets, often chose narcotics as their solution. Today with our stiffer laws and attitudes, female indulgence as compared with male has dropped sharply.[9]

In consequence of these sociological pressures which help foster addiction, the addict is more or less forced into the singular situation in which he is held in contempt, not only by society at large, but by the 'underworld' as well. He is thus drawn ever closer into the inner circle of his co-addicts and their unique way of life.

EMOTIONAL FACTORS IN ADDICTION

The tendency to regard the addict as a sort of defective psychopath, responsible for his own condition, has been noted by many authorities

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9 Kolb, "Drug Addiction Among Women". U S P H S Bulletin

in the field. Lindesmith deplores this as being more in the nature of placing blame than in helping to explain the condition. In his view, users of drugs do not become addicts until after they have experienced withdrawal distress, known its nature, experienced relief of withdrawal symptoms by re-administration of the drug, and have learned the name of the drug. It is, as he claims, the knowledge of the true significance of the withdrawal symptoms when they appear and the use of the drugs thereafter for the consciously understood motive of avoiding these symptoms that makes the user an addict.[10]

It is not the purpose here to become engaged in the polemics of the controversy regarding cause of addiction. Rather, it would appear that because social and emotional distresses are so often associated with addiction that the understanding -- and then relief -- of these conditions would be most pertinent for social work purposes in dealing with the problem. That these factors do appear in most cases is already evident.

The escapist basis for so much of addiction is interestingly indicated in this very terse and very typical comment of an addict who speaks of his reason for taking opiates: "It makes my troubles roll off my mind." The emotional conflicts and feelings of inadequacy are suggested in such remarks. By taking opium, the user realizes a feeling of mental peace and calm to which he is not accustomed, and cannot normally achieve. It appears that the intensity of pleasure produced by opiates is in direct proportion to the degree of psychopathy of the person who becomes addicted,

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10 Lindesmith, A J S (Jan. 1938).

and that the subsequent depression resulting from long-continued use of the drug carries him as far below his normal emotional plane as the first exaltation carried him above it.[11] Persons suffering from marked feelings of inferiority find that use of drugs does help inflate the personality, but in an un-aggressive way. The morose, irritable, discontented person takes the drug, becomes temporarily agreeable, pleasant, and non-aggressive. While under the influence, the addict feels contented, and has no ambition; he feels that nothing matters. The near-universal desire to escape the disagreeable features of life help explain why cocaine users so often switch to opiates; where cocaine stimulates the senses, opiates depress them. In the long run, the use of drugs complicates the situation in which the addict finds himself, and for treatment purposes, frequently makes it more difficult to handle. It is to be noted that use of drugs is essentially a result, and not the cause, of a person's abnormality.[12]

DETERIORATION AND RECIDIVISM

To speak of the deteriorating effects of drugs is to speak in generalities which, for one thing, are in fact often contrary to the evidence, and for another, may render an inaccurate impression. A group of twenty-five professional men who are addicts, for example, was studied for signs of degeneration, and only eight of them revealed

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11 Kolb, U S P H S # 211.

12 Reichard, Fed. Probation, Vol. VI, No. 4, p. 18.

mental deterioration.[13] Some persons have taken opiates for over twenty years, and have shown no moral or intellectual deterioration; these addicts have started off with a varying degree of mental and moral equipment that has not demonstrably been changed by the use of opiates.[14] A large proportion, of course, have deteriorated, and in isolated cases, particularly among former drunkards, the use of opium has actually been of help in this respect. From all evidence, it would appear that : (a) criminal psychopaths and inebriates are already deteriorated before becoming addicted; and (b) the near-normal addicts generally are stable enough to withstand deterioration despite their addiction. The greatest deterioration appears in the group of carefree, pleasure-seeking young persons who are mildly neurotic or slightly deviant, and who get addicted. In conclusion, one cannot easily say that the drugs caused moral deterioration in any addict; in most cases, the early life of these people has already been a distorted one, and resorting to drugs merely added another handicap to good adjustment. Where "mental deterioration" appears to be the case, it remains a moot question as to whether this is the condition per se, or whether a decline in clear thinking is not simply characteristic of the social consequences of a life of addiction. The fact that seventeen of the twenty five professional men referred to above, who are addicted, did not show signs of mental deterioration would indicate that ordinarily the use of drugs has no such negative effects, but that the psychological effects of associating with other addicts, dodging the

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13 Kolb, U S P H S #211, pp. 9-14.

14 Loc. cit.

police, resorting to drugs for escape, etc., will, in itself, tend to cloud clear thinking. The same habit-patterns of evasion of reality, seclusion, improper association, etc., which are all concomitants of the addiction process, leads also, as a rule, to the social and ethical regression characteristically found in the addict group.

The high rate of relapse among treated narcotic addicts is certainly one of the most distressing features of the entire therapeutic attempts. A lapse -- away from drugs -- of months, a year, often several years, is characteristic of the individual released from a hospital, or even the addict who voluntarily enforces his own abstinence; but statistics show the strong proclivity of these people to then return to their former habit. The reason for this recidivism is explainable not only by the physical dependence which urges him to take drugs again, but also by the very psychic stresses which originally impelled him in that direction.[15] The addicted individual over the years experiences a constant cycle of alternate comfort and discomfort: his need (both psychological and physiological) for the drug, the struggle to get it, the dodging of the police to get it, etc., all contribute to his discomfort; and, in strong contrast to this feeling is the comfort he enjoys when he does obtain his drug. The strongly addicted person in this predicament becomes restless, discontented, and unhappy. He soon derives less satisfaction out of life than he did before addicted because as his physical addiction grows in intensity and more drug is needed for his comfort, the power of that drug to give him temporary relief from the original

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15 L. Kolb and C. Himmelsbach, "Clinical Studies of Drug Addiction", Supplement # 128 to the Public Health Reports, Wash., 1938.

inferiority is proportionately lessened until a point is finally reached where pleasure is completely over-shadowed by pain. It is at this point that he generally seeks a cure which, in most cases, is rather easily achieved from the point of view of relief from withdrawal symptoms and the physical need for the drug. This original treatment is then followed by an improvement in his health; but coupled with this the fundamental emotional disturbances which in the first place inclined him to the use of drugs, again assert themselves. The addict thus "cured" recalls the original pleasures of the drug, and soon is again resolving his predicament in his original way. It is in this manner that the phenomena of the repeated cures and relapses of certain types of addicts occurs. These cycles of comfort and discomfort may be several years in length, but in long-standing cases of addiction without cure, the depressive phase is continuous.[16] Thus it can be seen that the cause of relapse is due to the original cause of addiction, to which is added the greater dependence upon drugs for the relief of any unpleasantness, the force of habit, and the many impelling memory associations of the relief afforded by narcotics.

SOCIAL IMPLICATIONS

It becomes evident, in reviewing the situations surrounding and preceding narcotics addiction, that the factors leading to this condition are many; and quite often, more than one cause is responsible.

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16 Kolb, U S P H S # 211, pp. 1-2.

There are the emotional and psychological stresses stemming, for example, from inadequate constitutional ability, or from poor childhood adjustment, or from inability to socialize properly, or from work that is too demanding. There is the fortuitous addiction resulting from medical attention; there are the strong sociological factors of group pressures, social disorganization, availability of narcotics in the illicit market, etc. In short, any or all of a number of psychological, physiological, and sociological forces can and do contribute to narcotics addiction, and all of which demonstrates the broad social implications of the entire problem. It is for these reasons that narcotics addiction needs to be recognized as a social problem; and, correspondingly, it points to the need for treatment on a social scale much broader than now exists on this continent.

Chapter IV

TREATMENT

There has been, to date, a number of schemes formulated in various parts of this continent for treatment of drug addicts, some of which have had varying degrees of success when applied, and a few of which have not existed long enough to allow for study of results. The narcotics farm has been tried at both Fort Worth, Texas, and at Lexington, Kentucky; this latter remains as the biggest treatment center in the United States. Several clinics, the Menninger Clinic among them, have worked with the problem, as have several public hospitals in various parts of the country. On a smaller scale, there is the occasional work done by welfare agencies with individual addicts, and the attempts by some psychiatrists to treat addicted patients. Of all the efforts, the narcotics farm has been attracting the bulk of attention by experts, and is certainly deserving of most study.

Institutional Commi ttal

The sending of an addict to an institution such as a narcotics farm is rapidly being recognized by authorities in the field of narcotics addiction as the major positive method of treatment for addicts. The reasons for this conviction are many, and include the following:-

1. In cases of long standing addiction, physical readjustment to abstinence is not complete for months after withdrawal, a readjustment which would be extremely difficult in a surrounding less sheltered than that of a hospital;

2. Treatment of neurotic, psychopathic, and psychotic disorders which help pre-dispose individuals towards addiction often calls for intense, sustained attention attainable only in properly staffed and equipped hospitals;

3. The addict's attachment to his drug is very strong; so strong, that, for most cases, only the careful observation and control exercised in a hospital prevents the addict from returning to his drug while treatment is in progress. In a proper hospital, he would thus have no opportunity for such immediate relapse;

4. An institutional setting puts the patient in an environment which does not have those factors which hitherto abetted his addiction. Among young addicts, e. g., the efforts of group psycho-therapists to work with them right within their own neighborhoods has often been negated by the continual group pressure put on the youths by their gangs to continue the habit. In the same sense, the hospital would not have the frustrating or vitiating influences that the adult encounters in the community, and which impel him to drug usage.

Treatment of addicts within institutions has certain weaknesses which, by their nature, would preclude certain types from obtaining adequate help there. In many cities in the United States, magistrates often depend upon a good social history and recommendation from a probation

officer before disposing of an addiction case. Such officers -- and the trend today is definitely to require that these men have some psychiatric social work training -- thus find it their function to help decide whether the individual concerned should go to a narcotics farm, be placed on local probation, with withdrawal effected at any local hospital, or should be remanded to a prison. Weaknesses of a narcotic hospital or farm include the fact that such an arrangement calls for a rigid, routinized, and childhood level type of existence which, in effect, may place an additional stress upon the person going there. If the stay is long, feelings of dependency are increased, and ability to cope in the competitive outside world is lessened. For this reason, the addict who is comparatively mature is probably better off being placed on probation away from such an institution.

Existing narcotic farms have not had much success with very disturbed individuals (the psychopathic personality, e.g., as explained in Chapter II) or with certain cases of very long-standing addiction. Because of limited 'farm' facilities and the fact that other groups have shown favorable prognosis while there, it would perhaps be as well to recommend these burdensome poor-prognosis cases to a mental clinic of hospital for treatment. Finally, an institutional program calls for close association among inmates, and the addict giving indication of being a corrupting influence to the others is definitely a bad risk at the farm, and should not be recommended for such placement. In working with youthful addicts, it has been found, though somewhat tentatively, that assignment to a rural correctional camp where behavior cases are handled and where the emphasis is proper group living, is often

sufficiently effective in producing satisfactory changes in conduct away from drugs. Such camps, preferably under trained caseworkers for the more disturbed individuals, regard all inmates -- addict and non-addict -- as behavior problems, and devote the bulk of their energies towards proper socialization. Hence, for the majority of youthful drug offenders, recommendation to a behavior-correcting camp seems advisable where his remaining at home on probation would continue to expose him to too many doubtful influences.

The general manner in which institutional care should be employed has been suggested by the Welfare Council of New York, which recently completed an intensive study of the problem of addiction in that area.[1] The principles recommended by the council are:

1. Effective treatment for withdrawal and rehabilitation requires custodial care, under the control of staff trained in the various phases of treatment.

2. Persons not guilty of a criminal offense or adjudged delinquent should not be committed to penal and correctional institutions for treatment of addiction.

The question of enforced custodial care, both during and after institutionalization, remains a tenous one. Modification of attitudes, interests, and values is the central purpose of the trained staff working with addicts, and, as casework and psychiatric principle, it is fundamental that such modification come from within the individual, and not be imposed from without. Force or pressure in any form directed at the

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1 J. Dumpson, op. cit.

addict may arouse either antagonism or mechanical submission, both of which tend to defeat the very purpose of the program. The securing of a cooperative attitude on the part of the patient is a paramount task within the institution, and a necessary accomplishment if treatment is to be effective. That the addict will not feel cooperative if he feels that he is being unduly pressured is to be expected. It is in this area that the psychiatric social worker can be most valuable in helping the patient to understand the reasons for the treatment program. The intake worker, in particular, can be of tremendous help in relieving the apprehensions of new patients who expect to suffer considerably during withdrawal treatment. Many newcomers even fear death; hence, proper interpretation can minimise such fears and help pave the way for subsequent worker-patient relationships. In all cases, the worker is in a position to help the newcomer realize that treatment, not punishment, is the sole intention of the hospital staff.

The need for some degree of enforced control over the addict while under treatment nevertheless appears evident from earlier experiences. Too often, a non-sentenced addict will voluntarily seek hospital care when the disagreeable phases of his habit overbalance the agreeable ones. Then, once in a hospital, and relieved of his withdrawal distress, he will ask for his discharge, and once again become his old addicted self when the original factors for addiction again come to the fore. His original problem, in short, has not been dealt with, and to all purposes, he is as much an addict as ever. On this same point, the evidence also points to the

need for additional probationary care once the patient is discharged from the hospital and on his own again. His re-adjustment within society is certainly a most trying experience; a few brief encounters with former friends still addicted, or with aggravating experiences, and the wheels are again set in motion for relapse. The need for close -- and compulsory -- follow-up is apparently requisite to the patient's fuller recovery. Tactful and sympathetic interpretation of this latter area of treatment is just as necessary as it is for the former area.

In Kentucky, one part of this problem is being solved by allowing volunteers who come to the Lexington farm for treatment -- and when they arrive they realize most painfully the need for complete cure -- to register with the legal authorities as users of the drug; once they thus agree to offer themselves as "violators", the judge will automatically suspend sentence, provided that the violators go immediately to the narcotic farm and remain there until such time as the Medical Officer in Charge deems them fit to leave. In this way, the addict has no choice; he must remain at the farm until fully exposed to treatment. If he leaves prematurely, then the police arrest him at the gates as a parole or probation violator. The near-futility of volunteer treatment (i.e. treatment during which the patient is free to leave at his own discretion) is well illustrated at Lexington where 90% of voluntary patients leave prematurely against medical advice.[2] Drug addiction, by its very definition, implies a loss of self-control, and it is for this reason that treatment of the patient will probably be unsuccessful unless there is

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2 Vogel, U S P H S Reprint, p. 5.

authority to hold him until he gains self-control.

Many psychiatrists working with addicts, especially the younger ones, feel that even this extent of control being tried in Kentucky does not go far enough; that after discharge the addict should be placed on legal parole, compelled to return to a clinic for periodic check-ups, and to accept help from a probation officer adequately trained as a psychiatric worker. Because both measures for compulsion just described might tend to cause resentment in the patient -- and adult addicts who have been to treatment centers like Lexington almost unanimously agree about their extreme sensitivity regarding coercion by the authorities and staff -- it remains for the team at the hospital to employ all its skill in presenting the reasons for parole to the addict in as understanding and sympathetic a manner as possible.

The need for some type of compulsory treatment, without the stigma or suggestion of criminality, has been similarly suggested by the recent report of the Mayor's Committee of New York City. Here too, psychiatric parole or probation is called for.[3] As a point of interest, it can be related how, in certain other parts of the world where the addiction problem became acute, attempts were made by the government authorities to allow addicts to either register as addicts (with no penalties involved) or to go to government hospitals for treatment. In one attempt (Formosa, 1929), only 30 out of 25,000 known addicts asked for the cure.[4] It would be pertinent, at this point, to record certain

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3 Mayor's Committee Report, Spring 3100.

4 Lindesmith, A J S (Jan. 1938), p. 595.

evidence brought out during the June, 1951 investigations into drug addiction in New York. At the hearings, many of the young addicts stated quite strongly that they had often felt desperate during their addiction days, and would gladly have gone for help to the authorities if it were not for the fact that the 'authorities' generally means the police, and they resented or feared going on that basis. In their words, had they been able to go directly to a clinic or hospital, they would have accepted all measures of treatment offered by these institutions. Going on these revelations, it would seem logical to suggest that here in British Columbia, any program of treatment would best fall -- in its entirety -- under the Department of Health and Welfare, where both hospital service and psychiatric parole are already within that department's jurisdiction.

To summarize, the steps in treatment which today seem most efficacious are:

1. Control of the addict, which means physically holding him in custody in a hospital or quasi-hospital setting. Treatments can be more effective where the team has fuller control over the patient, but even with this, it may be difficult, and often may not work satisfactorily the first time of admission. Here, again, the interpretive role of a social worker can be vital to help prevent the relapsed patient from becoming hopelessly fatalistic and discouraged.

2. Relief of physical dependence. This transition from a life with drugs to one without is fraught with dangers, the nature of which is not fully understood at present. At Lexington, the number of

deaths during this stage is far beyond normal expectation,[5] and points to the need for this withdrawal to be carried out only under most careful hands. Withdrawal itself can be: (a) slow, a method in universal use up to forty-five years ago, in which daily dosages of opiates were gradually reduced over one month; (b) rapid, withdrawal being completed in from several days to two weeks; (c) abrupt. Where the habit is strong, abrupt withdrawal is not only cruel and dangerous, but unnecessary. In any withdrawal therapy, the psychological factor is considered most significant: the patient must feel that something is being done for him; that is, he must feel that he is actually being helped, and not that the hospital is just cutting off his drug. Good interpretation is therefore essential. In some centers, it has been found that stabilizing the strongly addicted patients when they are first admitted by giving them a few grains of morphine per day has been of very positive value; the patient thus has an opportunity to become used to the environment, and realizes that he is not going to be harshly treated. After stabilization, withdrawal is effected in from four to ten days. Along with withdrawal, the patient is given up to three warm baths per day to reduce agitation. It has been noted that lobotomy has managed to reduce craving for drugs in strongly addicted patients, but it is not yet certain that personality weaknesses resulting from such operations are preferable to problems associated with narcotics addiction.[6]

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5 Reichard, D N S, Vol IV, No. 9 (Sept. 1943), pp. 279-281.

6 Wikler, op. cit., pp. 160-163

3. Making the addict willing and able to live without drugs. Most addicts coming to the hospital are willing; it remains for the hospital team to help him in his ability to do so. If physical handicap is a factor, then that must be dealt with. His emotional problems, where they exist, need studying. Psychotherapeutic attempts must be made to discover why the patient finds it necessary to resort to drugs.[7] Finally, in planning for his rehabilitation, a well-regulated, orderly life with interesting work and sufficient recreation become important habits that need to be instilled in him while at the hospital. Idleness, by all means, has to be avoided, and this is more than so for the neurotic patient. The psychotherapist must help the patient to achieve a substitution of more socially acceptable means of gratifying his needs than by his resorting to drugs.

The usefulness of group therapy within the hospital has been repeatedly stressed by treated ex-addicts; in the words of one such individual, it is at these sessions that the addict has his greatest opportunity to discover why he took to drugs. In this group, he is with fellow sufferers; he and the others can discuss mutual problems; the "leader" (as he is called by this individual) is himself one of them -- except that he has better insight into his problem. In this setting, the addict finds himself ready to dig deeper into himself to find the causes of his problem. Such a group functions best when limited to no more than ten or fifteen members; and, in addition has been useful to the addict only after he is fully relieved of his withdrawal symptoms. The further benefit of such therapy is the pattern it sets for post-

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7 Orgel, op. cit., p. 209.

institutional work with him. Group therapy in the community with the discharged patient is just as important as treatment within the hospital; with their experiences with such sessions already provided, the future meetings on the outside can then go along that much more smoothly and effectively.

Hypnotism has been suggested as a means of implanting healthier attitudes into patients' minds after withdrawal has been accomplished.[8] but its value has been questioned inasmuch as hypnotic suggestion is too seldom assimilated into the actual psychological attitudes of the patient. All told, lengths of treatment within the hospitals vary from four months where prognosis is very good, to an average of six months, and to a maximum of twelve months for difficult cases.

4. Placement after discharge, and proper follow-up. Here, the social worker enters the picture as a major figure in readjustment. Placement back in society offers the most difficulty, not because the addict re-enters still uncured, but because, among other things, society is inclined to regard him as incurable, unreliable, and potentially dangerous because of his old habits. A fuller discussion of these post-institutional problems will be given in the following chapter. Suffice it to say here that post-institutional worker-patient rapport depends largely upon the patients' experiences with the social service staff while in hospital. The discharged addict is usually very badly in need of a helpful friend once he is on his own; if, while in the hospital, he felt that his social worker was both warmly sympathetic and competently

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8 J. Wortis, Soviet Psychiatry, Baltimore, Williams and Wilkins Co., 1950. p. 88

helpful, then it is a matter of course that his next, outside, social worker will be most welcome to him in his attempts at readjustment.

THE NARCOTICS FARM

The outstanding effort made on this continent to contend with the addiction problem on a treatment basis is the "Narcotics Farm", as it is familiarly known, at Lexington, Kentucky. Founded in 1935, addicts who were, at that time, at the Fort Leavenworth Penitentiary were transferred to the farm for attempts at rehabilitation. This move, with Dr. Kolb as the first Medical Officer in Charge, represented the pioneer effort in the United States to separate the addict from the regular prison population. From its beginning in May, 1935, until January, 1948, 11,041 addicts were received. Of this number, 2,199 were females.[9] The staff at this hospital includes physicians, psychiatrists, supervisory guardians, social workers, occupational therapists, nurses, etc.

The big majority of patients at Lexington are sent there as prisoners or probationers; the median sentence of the prisoner-patient is from 18 to 24 months. United States judges have the prerogative of sending addicts to the hospital on probation; when thus sentenced, the addict must agree to remain until cleared for dismissal by the hospital. If the offender is primarily an addict, then he is treated as such by the hospital; if he is a criminal --that is, would be a thief despite drugs -- then it is urged that he be sent elsewhere, as his anti-social habits may have a

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9 Vogel, Fed. Probation, (June, 1948) p. 1

disrupting effect on the others. Voluntary cases are accepted at the hospital, but, on an average, such patients remain only eighteen days. Only 0.2% of voluntary patients who leave against medical advice after a stay of less than thirty days remain off drugs. In contrast, of volunteers who remain the full time, 24% become abstainers.[10]

When patients are admitted to the farm, no drugs are given until definite signs of the abstinence syndrome occur. Usually, it takes ten days to relieve him of physical distress. To occupy his time and interests, there is a farm, clothing factory, furniture factory, plus all types of activity, from the very simple to the very complex. Length of treatment at the hospital extends from four to twelve months, the time depending on when it is thought the period of treatment is necessary to give the patient the best possible chance to abstain from drugs. Where the court remands an addict to the farm for a period longer than is deemed necessary for treatment, hospital authorities have no recourse but to retain the prisoner for the full time. This is not an ideal situation inasmuch as the additional time on the farm often undoes much of the good effected by the desired course of treatment. An indeterminate sentence, with the time limit set by the hospital itself, is obviously a more desirable arrangement.

In the hospital, signs of abstinence syndrome serve as a significant measure of the patients' progress, and nurses on duty have the responsible task of observing carefully all symptoms. Many patients will attempt to get drugs by begging, bribery, and some even by threatening or

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10 Vogel, "Treatment at Lexington" U S P H S Reprint, pp. 6-8

attempting suicide -- an attempt which is usually insincere because the patient is really seeking sympathy, and narcotics.[11] Regarding adjustment of patients at the hospital, the voluntary ones are the least co-operative, always seeking ways to get out. About 10% of all patients violated rules sufficient to call for disciplinary action; 2.5% were recommended for transfer to other institutions because they were regarded as detrimental to the other patients. Less than 10% of all patients were regarded as shirkers, about 50% were willing workers, and 25% did more than was asked of them. The majority liked to work with their fellow patients, and were regarded by custodial officers as pleasant and agreeable.[12]

The social service unit at Lexington has essentially the same function as the social service in any mental hospital; namely, establishing a relationship with the patient and his family as soon as possible after admission, using that relationship during his hospitalization to enable the patient to obtain the maximum possible benefit from hospitalization, and also using it to help in discharge planning. Social workers at Lexington feel that in working with addicts, as contrasted to working with usual psychiatric cases, they are more struck with the similarities than with the differences of such work.

Results of treatment at Lexington are difficult to tabulate because: (a) records of patients after discharge are difficult to keep -- usually, only the relapsed addict voluntarily returning for treatment, or the one caught by the police, is recorded; and (b) complete cure means lifetime abstinence, and it is far too early to speak in such terms at

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11 Himmelsbach and Mertes, op. cit., pp. 495-496

12 Pescor, U S P H.S 143, (1943) pp. 17-18.

this stage. To date, in a study of 4766 patients who have been out of the hospital from nine months to five years, 13.5% have remained abstinent; 39.9% relapsed; 7% are dead; and 39.6% unknown.[13] It is likely that a fair portion of the unknown group are abstinent: those who relapse usually get into trouble and the report then gets back to the hospital. The recidivism rate is 61.4% admitted only once; 25.6% twice; and 12.7% admitted three times or more.[14]

CONCLUSIONS AND SUGGESTIONS

From the above record, some doubt may arise as to the wisdom of employing so expensive an arrangement as a narcotics farm, since results thus far are far from convincing. In answer, it can first of all be stated that at least 13% -- and perhaps closer to 20 or 25% -- of all addicts admitted do remain abstinent after release. In terms of human life, this is important, and can hardly be overlooked. As for the others, it can be suggested that even under the most favorable circumstances (within the framework of our present knowledge and skills), a certain large proportion of addiction admittals could not benefit by treatment there -- that is, not any more than a comparable group of psychopaths, for example, could be benefitted by treatment at any modern mental hospital. Since the farm is established primarily to effect abstinence in addicts, it might seem pertinent to suggest that poor-prognosis cases should not be admitted in the first place: their own

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13 J. Reichard, D N S Vol. IV (Sept. 1943), p. 281.

14 Vogel, "Treatment at Lexington", U S P H S Reprint, p. 8

chances of rehabilitation are very slim, and by their presence at the farm, they prevent the staff from devoting more of its time and energies to patients more capable of achieving benefits. Unless and until farm facilities are expanded considerably, and better techniques for working with the more severe psychopaths are developed, it would appear to be pointless to have any such cases admitted for treatment. For these reasons, a classification arrangement for potential narcotics farm patients might well be in order. Such a classification set-up -- which could be similar in structure to the classification teams found in modern correctional schemes, the team consisting of psychiatrist, psychologist, and social worker, as a rule -- would be in a position to decide just which addicts can best benefit by going to the narcotics farm, and which ones had best be sent elsewhere for treatment or custody, as the case may be. The present method in the United States, whereby virtually any individual addicted to drugs can enter the farm, fails to deal with the treatment factor in these people; consequently, a continuingly low percentage of "cures" can, for the present, be expected in any such arrangement.

On the basis of treatment results under the Kolb classification scheme, such a classification team could, with some confidence in results, elect for admittance to a narcotics farm individuals in the following groups:

1. Normal individuals who are accidentally addicted.

2. Psychoneurotics.

3. Cases of psychopathic diathesis and psychopathy in which the deviant tendencies are not too pronounced, or where the individual's existing pattern of adjustment, aside from the addiction syndrome, is not too erratic.

Any grouping such as the above would, necessarily, have to be regarded wuth due flexibility; in the final analysis, each case needs to be considered on its own merits. Estimation of the treatability of individuals in the third group above would, of necessity, be rather difficult to determine accurately, and use of Rorschach tests, encephalographs, etc., would likely be needed to render a more careful evaluation. Intrinsic to the good prognosis of individuals in any of the groups would be the cooperative attitude of such persons to therapy; the addict showing consistent determination to resist therapy and to continue the habit would, ordinarily, not be one who could easily benefit by help at a narcotics farm. A psychiatrist or social worker discussing treatment with him before an evaluation is made may help considerably in making him more amenable to the acceptance of help. Of inestimable help in determining his attitude on the matter -- indeed, in determining much that would indicate treatability of any of the addicts -- would be the social history and evaluation submitted to the classification team by the caseworker involved in the case.

Groups to be discouraged from going to a narcotics farm would probably include the following:

1. The more serious psychopathic cases.
2. Criminal addicts whose presence would be disruptive at the farm.
3. Psychotics.
4. Relatively mature addicts capable of beneficial treatment in their own community, especially if the restrictive routine of institutional life would be disturbing to them.

5. Youthful addicts who can benefit by going to a borstal-type institution, or who can receive adequate guidance, where this would be sufficient, from a trained probation officer.

There are, or can be, treatment facilities other than the narcotics farm, and such resources should, of course, be considered by the classification team in disposing of each case. The following chapter will, in part, deal with these other methods, most of which would be found on the community level.

Chapter V

COMMUNITY IMPLICATIONS

Organized local attempts to treat narcotics addiction have been relatively rare on this continent. In 1920, two interesting but short-lived efforts were made in California, one in San Diego, the other in Los Angeles. In both areas, clinics were set up under the respective local Departments of Health, and both were operated on the basis of supplying addicts with their needed drugs, and at reasonable prices. Theoretically, the clinics hoped by such legal control of supply to accomplish several objectives, namely:

1. It was felt that addicts, when sure of their continuing supply, would not be reduced to carrying on in the frantic manner characteristic of those who must surreptitiously seek and obtain the drugs. The anxiety of this search in itself acts as an added stimulus to the more extensive usage by the individual concerned. Hence, by removing this doubt, the anxiety factor would be reduced, and with it the tensions contributing to heavier usage of drugs.

2. The illicit market would be eliminated. Not only would the big time pusher be thus deprived of his lucrative market, but, in the process, the by-product crimes and anomalies associated with the obtaining of the illicit high-priced drugs -- prostitution, peddling, robbing to pay for supply, social and personal deterioration resulting from such a life, etc., -- would be greatly diminished.

3. The addict coming to the clinic would be encouraged to accept psychiatric help to end his craving for drugs; the plan was to sell gradually diminishing doses of the drugs, while at the same time, increased psychological help would be offered.

4. The addict, in utilizing the clinic, would still be able to remain home, support his family, and attempt to adjust in a normal way.

Unfortunately, neither one of the clinics lasted more than a year, so that results of both are far from conclusive. From all evidence, it appears that the closing of these clinics was in no way due to any obvious failures of the scheme.[1] Professor Lindesmith, who has done long and extensive research among addicts, is emphatic in his suggestions that legalization (which conceivably might be somewhat along this line) is the most feasible plan possible for coping with addiction.[2] But equally emphatic in rejecting any scheme whereby sale of narcotics would be legalized are many psychiatrists who have been working with addicts in the past years. Legalization would, in the opinion of those in this latter group, only serve to perpetuate the problem since it does little to solve the individual problems of those affected.

One of the very few city hospitals currently handling addicts is Bellevue Hospital in New York City. At this hospital, only young offenders who are not too seriously addicted or disturbed are treated;

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1 Terry and Pellens, op. cit., pp. 872-876

2 A. Lindesmith, "To Control Narcotics", N. Y. Times, July 15, 1951.

adult addicts and the serious young cases are urged on to the hospital at Lexington. The city hospital cares for both court cases (offenders remanded by the Children's Court) and volunteers, which would include any youngster brought in by a teacher, parent, policeman, etc., without a court order. Most of the youths in coming here ask to be sent to a correctional camp outside the city; this is in interesting contrast to the other (non-addict) delinquents at Bellevue in that the latter group generally resists any effort to send them away from their city area. In court cases, the youth, upon entering the hospital, is interviewed by a psychiatric social worker, a psychologist, and finally, a psychiatrist; as a rule, these interviews will be completed within the first few days of admittance. On the basis of mutual agreement among these three team members, the psychiatrist issues an evaluation of the case to the court, and also includes his recommendation as to what is needed for the youth. The team members do not necessarily hold a conference among themselves to decide about each case, but the psychiatrist here does depend in part upon the social worker's report in each case before drawing his own conclusions, using this report as a guide in his own evaluation.

In all cases admitted to the hospital, there is the preliminary investigation and study of the youth; if it is decided that he is to remain there, he is given occupational and recreational therapy, and he continues on with his schooling right on the hospital grounds. During the summer months, the youths generally engage in light work around the hospital. Regular movies and dances are held throughout the year.

Visits from the family to the youth occupy up to three afternoons a week, and visits by the team members take up still more of his time, so that, on the whole, each youngster is well occupied during his stay. Retention at the hospital ranges from three to six weeks at the most. Complete medical and psychiatric check-ups are provided. In the course of each committal, it becomes the function of the assigned social worker to establish family contact, and to work with the family when it is needed. It is also the worker's task to prepare each youth for his eventual dismissal from the hospital. If, e. g., it is felt that the youngster would need further guidance after release, then the worker will attempt to motivate him to contact a family agency in his neighborhood for the purpose of receiving this later help. Where the youth does accept this idea of continued guidance after release, the hospital worker may then arrange to have the appropriate agency send a worker to visit the youth while he is still in hospital so that worker-patient contact remains constant. In some cases, periodic visits back to the hospital are advisable after release. Here again, the hospital social worker discusses with the youth the need for these visits. Compulsion to make the young addict accept post-hospital help is avoided at all times; instead, team members employ understanding and interpretation to bring home to the youth the need for future visits. Some staff members at this hospital express the opinion that the brief period in which they have control over the young addict is insufficient for really effective results, and suggest that, after the youth's release, probation for at least nine months is desirable.

PSYCHIATRIC PAROLE

The institutional efforts made thus far to treat addicts on this continent have been few enough, and of these few, the outstanding one -- the narcotics farm at Lexington -- has had only fair success: up to 87% of all cases handled there return to their drug habit. The question arises as to whether or not such methods as are used in these institutions are adequate and feasible, and if so, why such a high percentage of relapse exists. Without getting too involved in this entire basic argument, it can be suggested here that the type of program offered at such institutions -- whatever the other weaknesses -- can likely be greatly augmented if the existing arrangement did not stop short as soon as the addict is discharged. That is, treatment at the institution, as far as it goes, may actually be far more helpful than the cold statistics on results indicate, but this treatment does not go far enough; it is actually incomplete. The addicts return to society is the real test to him, and for this challenging situation, he is almost always left on his own. The condition is almost analogous to the medical case given excellent surgery -- and then immediately discharged from the hospital upon leaving the operating room. The true addict's need for hospitalization has been made more urgent by the emotional distresses he has had to endure in his social area. To return him there relatively unprotected and unguided after hospitalization exposes him altogether too abruptly to the very conditions which originally weakened him. The hospital therapy and recuperation, it would appear, is not sufficient in itself for him; the

the setting while there is an artificial, protected one which, for its part, helps to comfort him while undergoing treatment. But it is to the competitive outside world that he is being returned, and for this final period of readjustment, the existing programs pay too little attention.

Dr. Vogel has stated that the patient treated under probation has the best chance for rehabilitation.[3] The director of Narcotics Anonymous, D. Carlsen, agrees that after hospitalization the addict should have the help of qualified workers. But as it is, the addict released from the hospital is, by and large, on his own, and the renewed pressures put on him in civilian life too often incline him again to seek escape from these pressures with the help of narcotics. Some addicts are released from the hospital on parole, as per court order, and so must make periodic reports to a parole officer in their home areas. Discussions with addicts who have been to institutions for treatment lead one to the conclusion that use of such officers for future guidance or correction is not a good idea. The exceptionally well-trained officer -- one having a background in psychiatric social work -- may be able to break down the resentment or distrust of his charge and establish warm enough rapport for constructive help. But by and large, the addict's extreme sensitiveness and shyness will make him rebel inwardly at his being treated like any malefactor on parole. Parole officers can hardly help their own conduct in being watchful and somewhat suspicious of their cases. That, after all, is part of parole. But the recovered addict

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3 Vogel, "Treatment of the Narcotic Addict", U S P H S Reprint, pp. 3-4

will do everything possible to avoid contact with his officer if he feels for a moment that he is being watched or is suspected of misconduct. Because of this sensitivity, and since most such officers lack the needed skills and attitudes, it would appear best to avoid putting any released addict into the hands of any individual so intimately associated with the police departments. The Probation Officer can, of course, effectively play the role in the handling of addicts, and that is in his pre-sentence report where addiction is involved: he can recommend those cases deemed able to benefit by treatment at a narcotics hospital; he can help weed out the addict who is primarily a criminal, and he can see the reason for not urging an addict to the hospital where the sentence will be a long one. In short, he is in a position to help the classification team, described earlier, decide which addict should go to the narcotics farm; which should remain on probation right within the community; which should be turned over to other custodial officers, etc. [4] But beyond helping in this selection, all evidence indicates the need for a non-judicial (in the full sense of the word) psychiatric social worker to handle all post-institutional cases, as well as most non institutional ones.

The role of the social worker within the institution has already been dealt with. His role outside the hospital is a much bigger one, and it is essentially his job alone, for here the team is not in the picture to help him. The case worker must know his addict as well as his casework thoroughly, and, more than that, he must know the meaning and manifestations of the whole problem of drug addiction. The significance

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4 J. D. Reichard, "The Role of the Probation Officer in the Treatment of Drug Addiction", Federal Probation, Washington, D. C., Vol. VI, No. 4 pp. 18-20.

of this latter point will be discussed shortly. On the former, it should be brought out that a great number of recovered addicts who have had professional contact with social workers complain of the many pretensions surrounding so many workers in their work; the addict, in accepting the help of a social worker, wants simplicity, wants real understanding; he wants to be considered a human being; he emphatically does not want to be a "case". The addicts find the cold, analytical approach common in these inept social workers very repugnant. He resents being studied; instead, he seeks the warm, human touch; he seeks, in plain, a helpful friend. These observations by recovered addicts suggest but one thing: only thoroughly skilled social workers-- and only workers with appropriately sympathetic personalities -- can and should be trusted to work with addicts. Lacking these essentials, the assigned worker in any case can only cause additional stress to a discharged patient, and so become a hindrance to his re-adjustment.

Aside from his general casework skills, the worker must also have a good understanding of what drugs mean to the individual who is addicted. It has already been shown how addicts turn to drugs for any of a multitude of reasons. To know and properly understand his addict, the worker has to know what the particular reasons were for each separate case: if case A followed group pressure, for example, then re-direction of interests into other groups is indicated; if cases B deals with a weakened ego by taking heroin, then ego-support is to be stressed, etc. For these reasons, the worker has to be in close touch with the institution from which his case was discharged, learning from them all that should be

known regarding social history, type of personality, ways of adjustment previously adopted by the addict, etc. Among drug addicts, deception becomes in time almost a way of life for them. The addict may impress his worker as being the most cooperative person possible, yet at the very same time, he may be again secretly taking drugs. He will use every ingenious means at his command to conceal the fact, and his ability to do so is borne out by the fact that even doctors experienced in treating addicts are often fooled by this deception. An incompetent worker could hardly expect to learn of such early relapse in time, yet these first shots, indeed the very first shot, are the danger signals showing that relapse is taking place, and return to a hospital has to be considered immediately. Probation officers working with treated addicts are often told not to get alarmed if they discover that their case has, on the sly, taken a few shots. But recovered addicts agree that the first shot is the dangerous one, and if help is to be effective, it must be dealt with properly at that time. The help of local physicians and psychiatrists is therefore often necessary, and the efficient discernment in time by a good worker is mandatory to check this relapse when it first appears.

For reasons still not clear, treated addicts remain overly-sensitive to drugs for some time after hospitalization. Quite often a treated addict will go to his home doctor for a sedative when he wants to "settle his nerves". In all innocence, and even with his doctor's awareness that the patient once took narcotics, he may receive an otherwise innocuous prescription of barbiturates. Again, experience has shown how even these mild sedatives can prove disastrous. Many a treated

addict has found himself slowly re-introduced to drug usage by this apparently harmless route. The worker knowing enough of the medical aspects of addiction is in a position to realize the possible danger of this move, and so by pointing out to the ones concerned the meaning of sedatives to recently treated addicts, he can play a vital part in checking relapse from this source. Still another addict in his -- the worker's -- care may be fighting consciously, with all his might, any reversion to drugs after he has returned home. Subconsciously though, this same individual may well be looking for a reason to return to drugs, and so -- subconsciously -- may be engaging in behavior that will result in his illness. Practically every addict who has been free of drugs for a year has also been ill enough during that year to provide him with an "excuse" for resorting to drugs again. The worker must be quick to learn of these illnesses, and must realize the significance of such sickness in order to cope with it, for it may well be the overt sign of the addict's covert desire to take drugs again.

The above are some of the special problems encountered in doing casework with treated addicts. Aside from all this, there still remains for the parole worker the usual methods of casework applicable to the whole field of social work. Work with the families is as important here as elsewhere in behavior problems. Oftentimes it is unsatisfactory home conditions -- inter-family relationships, family attitudes, etc., -- which are despairing to the addict. Effective results with the addict may remain blocked unless and until these sore spots are significantly eliminated. The addict, returning from a hospital may want a whole new

environment in which he can start anew; here, the worker may well be his only contact and friend until he gets established in the new area. Starting work again may prove another trial for the addict: a prospective employer may want to know what he has done in the recent years. The worker will have to discuss fully with him this problem of how to explain his past. Neighbours may hear that he was a "dope fiend", and treat him accordingly; under such circumstances, he will need a maximum of interpretation and ego-support from his worker. If he himself feels that he is slipping, and is thinking of taking drugs again, he should feel free enough to discuss this with his worker, and feel adequately comfortable within himself -- after such discussion -- if he decides to return to the hospital for treatment. It is up to the worker to leave him feeling that return is a positive step, and is not cause for despondency.

This ever-present danger of relapse is perhaps another reason why probation for a long period -- it may be for life in some cases -- seems advisable whenever an individual is first entered into an institution for treatment. Under probation, he is free to return to the hospital whenever he feels the need; he does not have to endure any further court orders, studies, investigations, etc., with all their disturbing effects, if he has taken to drugs again. Rather, he simply checks in at the hospital, and is discharged when this part of treatment is over.

In large cities, where many treated addicts may be congregated, the social worker may urge his ex-patient client to attend group therapy sessions where others in predicaments similar to his own get together to

discuss their mutual problems and solutions. The value of such group therapy can hardly be stressed enough. In such groups, the addict feels that he belongs, that these others can really understand him. He trusts them enough to admit that he is having trouble when he is tempted with relapse; faced with this challenge, his group will usually do all in its power to help him. In effect, the others, in thus helping him, are actually strengthening their own position in their fight to stay free of drugs. It is this mutual assistance which can make group therapy effective on the community level, and which is, actually, one of the psychological pillars of such groups formed into the organization known as Narcotics Anonymous.

NARCOTICS ANONYMOUS

Patients at the Lexington farm have long been encouraged to join Alchohol Anonymous chapters in order to be with others who, like themselves, want to stay free of addiction in any form. Many have heeded such advice, but by and large, this step has proven ineffectual. Drug addicts complain that the alchoholics do not understand them, that they have their own special problems, and so feel left out in A. A. meetings. Misunderstandings and ill-feelings have resulted where the two groups mixed, with the result that the drug addicts usually drop out from the organization. In an attempt to solve this problem, Narcotics Anonymous chapters are now beginning to appear in some large cities in the United States. Structurally and philosophically, the two organizations are similar: there are, in Narcotics Anonymous, no dues, no assessments, no

constitution, no officers, and no by-laws. They have no religious committments, and steer clear of all controversial issues. N. A. offers its services only to those who want it, and in their words, they make no pretense at being reformers.

The strength of this organization lies, for one thing, in its function as group therapy units. There is a definite sense of belonging among the members, and there exists the strong desire among them to help one another in the common fight against addiction. Each member can thus draw strength and courage from the others. Briefly, the organization describes its steps of recovery as proceeding in this fashion: first, the addict must be honest with himself, honest enough to realize that he is powerless to control his habit; second, he must realize, or at least keep an open mind on this point -- that there is a power stronger than himself. This power can be of whatever description he chooses: God, an inner self, etc; whatever that power, he must rely on it, and pray to that power for strength; thirdly, he must decide to relate personally to that power. In doing this, he undergoes the profound mental and emotional change needed in his recovery; and finally, he must engage in a more effective way of living.[5]

Narcotics Anonymous claims to be effective with many of its members, some of whom had previously been to many psychiatrists and institutions without success. That this group has some merit seems clear from the record, and it should be accepted by social workers as an auxiliary service in follow-up treatment of addicts. Among its other activities, N. A. tries to convince addicts that they can find a new way of life; it tries to show beginners the dangers of addiction; it secures psychiatric help for members needing this; and for those requiring hospitalization,

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5 "Our Way of Life", Published by N. Y. C. chapter, Narcotics Anonymous.

it points out the possible benefits of going. For those just returning from an institution, it helps obtain satisfactory employment. [6]

SOCIAL WORK AGENCIES AND DRUG ADDICTION

In areas where psychiatric parole for treated addicts is not provided, the task of continued guidance may rest on social work agencies, both public and private, within the community. In the New York area, for example, where addicted youths are treated at a city hospital and then released in full, it becomes the function of neighborhood family agencies to assume responsibility for further casework and help when it is needed. A youngster may receive very valuable vocational therapy within the institution, but it could easily be an acquired skill gone to waste if the youth, upon his release, does not have someone ready to help him capitalize upon it. The agency worker acts as a sort of big brother to the young addict, aiding him in translating his learning into a realistic new way of life. For many youngsters, a complete change of environment after release is necessary. It is then the worker's responsibility to explore use of possible relatives, foster homes in the country, etc., for this change. It has been mentioned that many addicts do desire to make a break from old acquaintances in order to free themselves of addiction and all that it involves. But attempts to steer them into groups such as Boys' Clubs, Y. M. C. A's, etc., usually meet with resistance because the youngster fears the derision from his old gang if he tries

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6 D. Carlsen, op. cit.

to go to such organizations. This fear thus becomes another factor in considering those cases where re-location may then be deemed advisable.

Work with addiction-prone youths is by no means confined to those who have been to a hospital for treatment. It has been shown already how the average age of inchoate addiction is probably in the middle and late teens. Actually, most such youths have not been found to be truly habituated; but lack of attention to the problems of these youths at this early stage can result in the complete addict later. In this sense, any youngster presenting behavior problems can be regarded as a possible addict later, and attempts by workers in working with them should be to help them face reality according to their own situation, and not to resolve their problems by use of such releases as drugs. Any youngster, of whatever personality type, falling into groups that use drugs needs to be helped to be free of such influences. Narcotics addiction is still too generally regarded as an adult problem, whereas case studies point out irrefutably the fact that the problem begins to crystallize in adolescence. Hence, any worker in the community -- group worker or caseworker -- is dealing with a phase of the matter when he works with disturbed or deviant youths. It needs to be recognized by such workers that the youths involved in addiction are of all personality types, and so any youth in trouble can be rightly regarded as possible addict material because he -- the youth -- is that much closer to staying or going on drugs if he has serious emotional problems which he finds temporarily alleviated by resorting to narcotics.

Disturbed youngsters who have been found to have had just one

or two shots do not ipso facto present a threatening addiction problem. Presented with any such case, it remains for the caseworker involved to estimate how serious it may be, and to take steps commensurate with such seriousness. A mildly neurotic youth taking a few shots can, perhaps, be handled right in the community, with the caseworker himself taking full charge. This would hold equally true for the adult user who gives signs of being sufficiently mature to remain in his neighborhood while a local hospital administers his withdrawal. Ordinary casework, done by any adequately trained social worker in a family or public agency, would be sufficient for such individuals. In brief then, where institutional treatment and psychiatric parole would not apply to an addiction case, then the family and public welfare agencies can most often become operative in such work. Generally, casework with any such individual would follow the usual pattern of established techniques in the field; and since the case in question was not, in the first place, considered serious enough to call for institutional committal, it is likely that the agency case worker involved would not need to have any special awareness of the addiction problem to do a satisfactory job with the addict.

CONCLUSION

The final picture evolving from the mass of data and opinions recorded in the foregoing pages is, unfortunately, neither too clear nor too encouraging, as far as the entire addict population is concerned. It can be seen that drug addicts are of all types: they have varied backgrounds, constitutions, ways of adjustment, attitudes, and abilities.

They include some who were predisposed to a life such as they now lead by home conditions traceable to the pre-oedipal period; and they include others who would be free of any drift to addiction were it not for purely fortuitous circumstances occurring in their later life. There are some who can work well though addicted, some who adjust better in the community after they become addicted, and some -- the big majority -- who experience severe disorganization, either before or during their addiction, which more or less hinders them in any proper adjustment. Some present a simple problem in their rehabilitation; others appear to be hopelessly involved. Some are addicts whose addiction is only incidental to their other anomalies; others are anomalous only in their addiction. The narcotically addicted population, in short, is an extremely heterogeneous one, and to understand the addict, it is necessary to know him as an individual. Certain features are held in common by a great majority of them: the secretive life they lead to gain drugs, the use of drugs as an escape mechanism, the feeling of being separate from others, etc., these help set them apart. But this separation notwithstanding, the addict himself stands forth as unique in his own particular background and present circumstances. To know him well, it becomes necessary to know both the sociological factors which make him part of a distinct group, and the psychological and physiological factors which lead him into that group.

It is because this addicted group runs the whole gamut of personality types that the treatment picture for all addicts can, for the moment, be neither too clear not too hopeful. Treatment for addicts,

if it is to be based on a psychiatric approach, necessarily calls for differentiation according to types within the larger group. This means that mildly disturbed cases, neurotics, etc., stand to gain much from treatment; for them total abstinence is a real possibility if they agree to accept enlightened help. But it also means that a very large percentage of the addicted population cannot be aided by this same approach. Psychotics and pronounced psychopaths, who do form a large segment of the addicted population, do not gain much from treatment in mental hospitals or on narcotic farms; to send them to a narcotic farm would likely be of no help to them, and would be a hindrance to others present who are more treatable. Remanding them to already overcrowded mental hospitals does not help much either. And to put them in prison if addiction is their only offense would only aggravate an already bad situation. This part of the picture may seem to lend itself to the argument advanced by some for legalized control of the drug traffic: for those individuals in this very disturbed group who can somehow manage to live tolerably well in the community without menace to others, the legal sale and control of drugs may help to placate them; at the same time, it would help to reduce or eliminate the entire illicit narcotics trade with all its accompanying evils.

For the present, at least, it would appear that neither psychiatrists nor social workers can be of much real help to this poor-prognosis group. One can only hope -- and work -- for mitigation of the general social scene with all of its disturbing pressures, to the end that social -- i. e. non-constitutional -- factors contributing to serious personality

disorders will be eliminated. Little can be done at the moment for the individual who has become a pronounced psychopath and who is an addict; but much can be done to rid society of those forces which have helped contribute to his regrettable condition.

The argument for legalized control of drug sale to users has this serious drawback: easy procurement of drugs would be too tempting for individuals who might otherwise receive therapeutic help that could be useful to them. A great many addicts can be helped, not only to be freed of the habit per se, but also of the emotional disturbances which impel them to use drugs. If drugs are legally obtainable for these treatable people, it may prove much more convenient for them to persist in their habit rather than to accept proper assistance. An answer to this dilemma -- how to simultaneously satisfy the needs of both treatable and 'untreatable' addicts -- will not be attempted here; final decision in this matter may well rest with a classification team such as the one discussed earlier. Rather, it can only be repeated here that for individuals who are not too seriously disturbed, and who are ready to accept help in overcoming their addiction, there are a number of methods that can be applied. Narcotic farms, borstals, probation, local clinics, welfare agencies, etc., can all be profitably utilized, each according to the type of case in question. In each, there is a place for social workers. Indeed, not only can social workers offer their share of services in the usual institutional settings, but potentially they have a great deal more to offer in the very area where existing programs are weakest: the community follow-up treatment for those returning from institutions such as the

narcotics farm. The social work profession, in short, has much that it can contribute to the alleviation of the problem of drug addiction, and elimination of the problem will be that much closer to reality when its skills are appropriately exploited.

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