Medical Counseling Clinics for Young Narcotic Addicts

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MEDICAL COUNSELING CLINICS FOR YOUNG NARCOTIC ADDICTS

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In this paper a plan for medical prevention and long term follow-up care of narcotic addiction among adolescents and young adults will be described.[1] The incidence of addiction has reached epidemic proportions in certain areas of the United States. Figures from the United States Public Health Hospital for the treatment of addiction at Lexington, Ky.,[1a] indicate that about one-half of the population of that hospital comes from New York City and about one-fourth from Chicago. Reports in increasing numbers tell of the spread of addiction to smaller cities and rural areas.

There is extensive evidence that the drugs are distributed by an organized underworld system reaching outside the continental United States, with its terminals located primarily in the poorest and most densely populated communities. These illicit drugs are planted first in neighborhoods that have the least social and political prestige. The instruments of social malbehavior and crime—whether they be houses of prostitution, "policy wheels," "bootleg" liquor, or juvenile "dope dens"—are usually found in greatest numbers in areas of greatest economic depravity. These areas offer the most immunity for the organized distributors of the instruments of crime. The community incidence of drug addiction in Chicago follows the pattern of distribution of the sources of supply

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Read at a symposium of the Cook County Physicians Association and the Chicago Crime Prevention Bureau, LaSalle Hotel, Chicago, May 9, 1951.

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1. House Bill No. 1257 of the 67th Illinois General Assembly, sponsored by Representatives Romano, Kart, McClory, Thon, Jenkins and Davis and Senator Libonati, authorizing narcotic clinics, was based on this plan.

1a. Vogel, V. C.: Personal communication to the author.

of the drugs. Statistics collected by the Chicago Crime Prevention Bureau [2] show that the densely populated South Side was one of the first areas to show an incidence of addiction in epidemic proportions. The incidence is also very high along West Madison Street's so-called Skid Row and in the vicinity of North Clark Street. The fad is fast extending into all areas of the city, into suburban areas, and even into rural districts.

There is no evidence that susceptibility to drug addiction has anything to do with race. The concept of single causes to explain a given type of social behavior is hazardous. Many young persons from socially well-adjusted families are already drug addicts or are seriously imperiled because of the spreading availability of the drugs. The very nature of adolescence, with its instability of personality, underdeveloped poise and willpower, and abundance of adventuresomeness, curiosity, and courage, offers some degree of susceptibility to drug addiction.

Ultimate control of the drugs at the distribution level is seen as the final stroke which may destroy the epidemic nature of the problem. Until this is done, it remains the problem of the medical profession to press vigorously for medical prevention of addiction and rehabilitation of the thousands of youths at all social levels who have been victimized and enslaved by drug addiction.

The prognosis of narcotic addiction as a disease is grave. Society and the majority of those who deal with the problem of narcotic addiction generally consider it to be criminal behavior. On the other hand, psychiatrists, psychologists, and clinicians who have studied the problem conceive of addiction as primarily a psychosomatic disease, the criminal aspect occurring secondarily. The medical approach to the problem has lagged behind the educational and law enforcement efforts in this field. However, law enforcement is a formidable job.

The medical care of addicts is usually carried out in institutions (drug withdrawal should not be attempted in clinics), where gradual withdrawal of the drug is

2. Higgins, L.: Personal communication to the author.

undertaken with a varying amount of after-care. At the Lexington, Ky., hospital the optimum treatment time is four to six months. It is estimated on the basis of the number of patients who return and other information [3] that about four out of five will return to the use of the drugs. Figures from the earlier literature show an even greater relapse rate. Only 2.5% of the treated patients in one series were still off the drug after five years. These observations were made before the present epidemic among adolescents. It is evident that a longer period of medical supervision will be necessary for effective rehabilitation.

A study of the literature and interviews with authorities in Chicago, Lexington, New York, and elsewhere revealed no comprehensive medical program for long-term follow-up and medical prevention of narcotic addiction. The plan of medical counseling clinics which follows was formulated after preliminary investigation and study of the problem.

Medical Prevention Program (Fig. 1).—The first step in the prevention plan is case finding, which is done primarily among high school groups and those who have recently graduated or dropped out of school and are not greatly addicted. These persons would be at the "reefer-smoking" stage or would have had only an occasional "shot" of heroin, and would not have been in the hands of the law. These young persons would be induced to come into the clinic and receive counseling against the tragedy of greater addiction. They would be given physical examinations, psychiatric screening or detailed psychiatric tests, vocational or occupational counseling, and other types of therapy (to be detailed later in this paper).

The case-finding job through the public schools would depend largely on cooperation among principals, teachers, school psychiatrists, truant officers and the clinic, with the clinic field social worker as a liaison person. Many young drug addicts are free in the larger communities, groping for help outside the law. Many parents

3. Vogel, V. C.: Quoted at a symposium on narcotic addiction of the Cook County Physicians Association and the Chicago Crime Prevention Bureau, Chicago, May 9, 1951.

of drug addicts are looking for help for their children and would gladly cooperate to get them into the hands of physicians before they get into the hands of the law. Victims helped by the clinic would undoubtedly send in their friends. Welfare agencies, churches, and law courts are potential sources of early referrals.

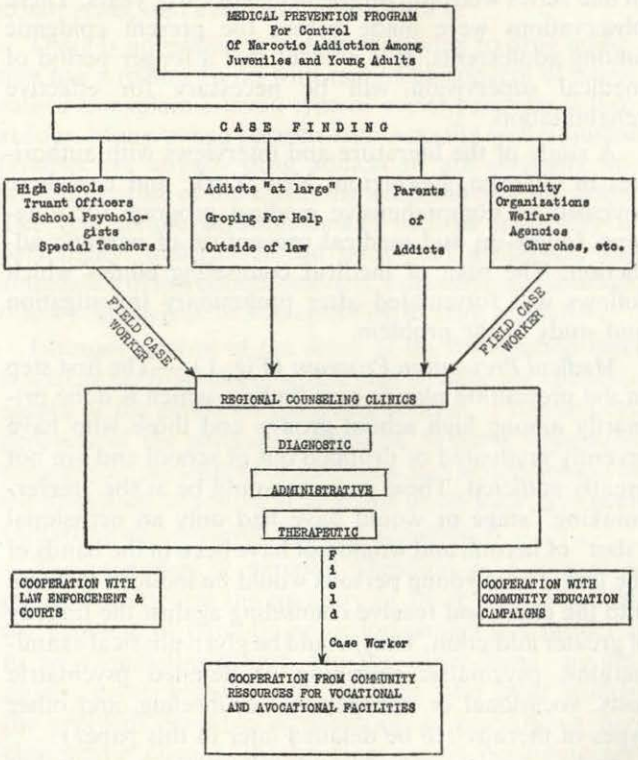

Figure 1

Some persons contacted by these methods would be only at the marijuana stage or their use of stronger drugs would be sufficiently recent to justify clinic care. The final decision to accept a case in the clinic for preventive or follow-up care would depend on results of medical examination and psychiatric evaluation of the individual

personality. Of course, some cases would not meet the standards of acceptance, but the clinic facilities would aid in their placement in hospitals for adequate withdrawal treatment. Thus, the clinic would serve as a clearing house, the value of which would be measured in terms of removing from the community sources of "infection" and "reinfection" of other susceptible persons. To carry the case-finding job further in institutions like public and private schools, group psychiatric screening tests could be applied by social workers, school teachers, or others after a briefing course by a psychiatrist.[4] By this method potential addicts or highly susceptible persons might be identified and future programs worked out. Far-reaching community contacts and the cooperation of a large number of civic institutions and organizations, public and private, would be necessary for successful operation of this plan. But the threat of social disintegration of a large segment of the youthful citizens more than justifies the magnitude of the effort.

In developing this plan in Chicago a large citizens' advisory committee [5] representing a broad cross section of community institutions and services gave advice and pledged cooperation in its implementation. Among the members of the committee were psychiatrists, internists, clinical psychologists, psychiatric social workers, welfare workers, occupational therapists, vocational counselors, probation and truant officers, and representatives of the school board, employment services, crime prevention bureau, law enforcement agencies, courts, and religious organizations.

Medical Counseling Clinics (Fig. 2).—The clinics would be attached to existing out-patient departments of strategically located hospitals. A patient would first have a diagnostic study, including physical and psychiatric

4. Sherman, I.: Personal communication to the author.

5. The subcommittee of the advisory group was composed of the following persons: psychiatrists, Dr. Walter Adams and Dr. Irene Sherman; psychologists, Dr. Thelma Thurstone and Dr. Albert Beckham; internists and hospital administrators, Dr. Henry B. Matthews, Dr. Arthur G. Falls, and Dr. John C. Troxel; occupational therapist, Beatrice Wade; probation officer, Harry Hill; psychiatric social worker, Henrice Gould, and journalist, Charles Davis.

examinations. Blood and urine tests for drug concentration would be used or further developed. History and physical examination might show evidence of drug use through old or recent needle marks, undernutrition, and other diseases incident to addiction. The patient might be deeply disturbed and in need of psychotherapy or he may

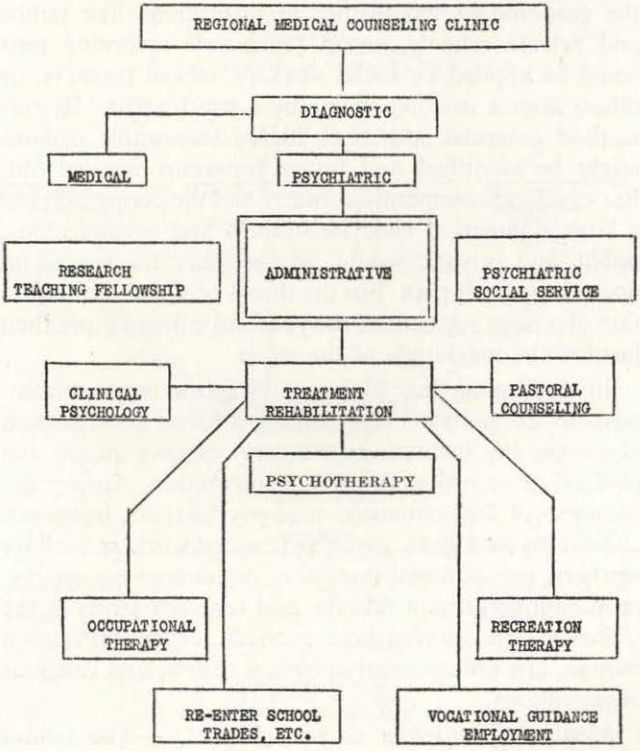

Figure 2

need only sympathetic direction and recreational or occupational therapy.

Vocational counseling and, finally, job placement would be an important part of the rehabilitation process. Such therapeutic facilities would be made available by internists, psychiatrists, clinical psychologists, psychiatric social workers, and job placement or occupational coun-

selors in the clinics. Referrals would be made to community resource facilities. Such facilities might be occupational therapy sources, job placement sources, such as state employment services, and direct contacts with personnel directors in industry. An understanding and cooperative personnel director in private industry might do a smoother job of reintegrating the former addict as a useful employee than a public employment agency.[6] Handling of the patient as an agency-referred employee, and not a routine job placement, would be important. Referrals might also be made to trade schools, academic night schools, and special job training programs. Other patients would find therapeutic help or integration into the recreational programs of groups such as the Young Men's Christian Association,[7] Young Women's Christian Association, and Catholic Youth Organization. During this period regular visits to the clinic would be required. Such a clinic, with adequate professional personnel, would combine sympathetic understanding with attempts to develop self-reliance and to discover potential talents for constructive contributions to society.

Medical Follow-Up Program (Fig. 3).—The follow-up phase of the program would involve case finding as the initial step. An important source would be patients discharged from the United States Public Health Service Hospitals. The director of the narcotics hospital at Lexington, Ky., feels that development of long-term follow-up programs in the various communities of the country would enhance the effectiveness of the hospital care at that institution. The hospital administration in turn would gladly cooperate with any well-organized follow-up program in local communities.[8] Cooperation, therefore, from federal narcotic hospitals to the extent of selling the clinic to patients about to be discharged in exchange for follow-up information would serve as mutual ground for cooperation between these hospitals and community clinics. General hospitals in large cities have addicts at all times admitted for other illnesses, which often are complica-

6. Troxel, J. C.: Personal communication to the author.
7. Morris, O. O.: Personal communication to the author.
8. Vogel, V. C.: Personal communication to the author.

tions of addiction. Complications frequently seen are hepatitis, cellulitis, meningitis, endocarditis, and, occasionally, acute tuberculosis. In a fatal case at Cook County Hospital in Chicago, the patient died of multiple liver abscesses due to the use of contaminated syringes and needles in self-administration of narcotic drugs.

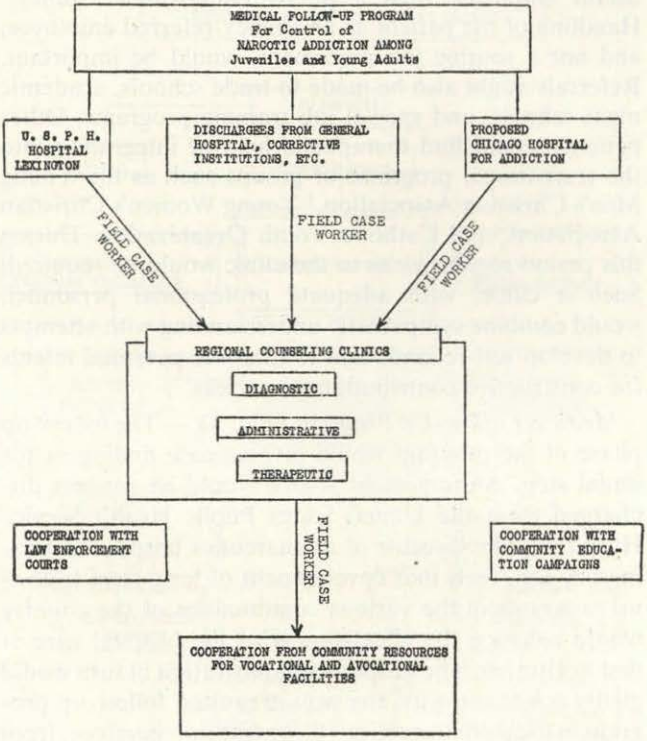

Figure 3

These patients, on discharge from general hospitals, usually have had little, if any, specific treatment for their addiction. However, their habit has been broken, in the parlance of the addicts, by the "cold turkey" method. Near the time of discharge these patients could be psychologically prepared by the hospital's social service department and referred directly to the narcotics clinic. The

liaison job at this point would be very important to the success of this type of referral.

In Chicago there is hope that a preliminary counseling clinic may be set up in the House of Correction as a part of this plan for care of narcotic addicts. Illinois Research and Provident Hospitals have also been proposed. Addicts being discharged from local penal institutions at present would be likely candidates for counseling clinics. On discharge they would be referred to regional counseling clinics attached to out-patient departments of local hospitals. Cooperation by the judges of the narcotics court, the juvenile court, and other branches of the courts of law would greatly facilitate this program. A probationary period of one year by a sympathetic court at this point would help to control patients during rehabilitation. The world's first narcotics court was established in Chicago several months ago, and this type of cooperation has already been promised to the local narcotic clinics which are being set up.[9] [Narcotic addicts discharged as cured from hospitals and penal institutions, since they are usually unsupervised, are a continuous source of contagion to other susceptible persons.]

Once the patient begins attendance at the clinic, his diagnosis, or diagnostic reevaluation in the case of those having had some medical care, would be made. From this point forward in general the plan of follow-up care and rehabilitation would be similar to that outlined under the prevention phase of the plan.

NUMBER OF CLINICS

A careful survey of local needs would determine the number of regional clinics to be set up in a given community. A minimal clinic unit should include a chief psychiatrist as administrative officer of the clinic, part time; an internist, part time; a clinical psychologist in charge, full time; an occupational counselor; a psychiatric social worker, full time; two field social workers, full time; an office secretary, full time; a typist, part time; and psychiatric and physiological research fellows.

A single clinic unit could be mobile and clinic sessions could be held at one or more locations where funds or

9. Judge E. G. Gorman: Personal communication to the author.

case load did not warrant two or more regional clinics.[10] It is believed that the best cooperation would be had when the clinics are close to the patient sources and are attached to already existing general hospital out-patient departments. In this way the drug addict could lose his social identity among the patients of the general clinic. Cooperation of the law enforcement agencies would be important at all times in an attempt to foil the hounding efforts of peddlers and in the management of patients who need their services.

The sources of funds might be federal, state, county, municipal, or private. A rental fee might have to be paid to local hospitals or to the hospitals housing the clinic. This fee would include compensation for minimal nursing care and laboratory facilities. Such hospitals could serve as the administrators of the funds for salaries to clinic personnel.

The implementation and supervision of the regional group of narcotic clinics could be handled by a working subcommittee of about 12 technical experts who would be representatives of a much larger advisory board. The larger board should have representatives of welfare organizations, employment services, the school board, religious, business, and industrial organizations, courts of law, and press relations. Because the early high incidence will occur in poorer communities, racial connotations may be injected into the interpretation of statistical data, but such interpretations have no basis in fact, and race or religion should not influence the type, character, or location of treatment facilities. Improper handling of this problem may lead to unfortunate community attitudes and tend to exaggerate the pathological feelings of inferiority or superiority in the addicts whom these efforts are designed to help.

A narcotic clinic program should provide for psychiatric and physiological research to be carried out along with a program of clinical care. Controlled information from widely distributed sources throughout

10. Cross, R.: Personal communication to the author.

the country would help to solve the problems of causes and possible "cures" for narcotic addiction as it manifests itself in nation-wide epidemic proportions.

SUMMARY

Narcotic addiction among juveniles and young adults has reached epidemic proportions throughout the nation. An international underworld system controls the sales promotion and distribution of the drugs. Medical prevention and follow-up care is a reasonable community responsibility of the medical services and allied organizations. Withdrawal of narcotic drugs is best carried out in a hospital, but about four out of five addicts return to drug use after the best available treatment. A plan of long-term regional counseling and rehabilitation clinics is presented.

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