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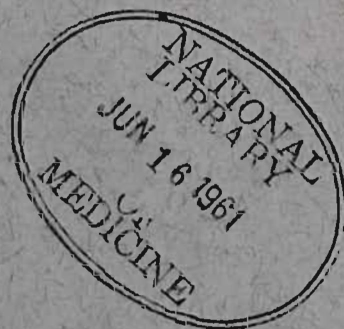
COMMITTEE ON DRUG ADDICTION AND NARCOTICS

Minutes of Twenty-third Meeting

16 and 17 January 1961

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Bulletin, Drug Addiction
and Narcotics
1961 p. 2384

NATIONAL ACADEMY OF SCIENCES - NATIONAL RESEARCH COUNCIL
Division of Medical Sciences

Committee on Drug Addiction and Narcotics

Minutes of Twenty-third Meeting - 16 and 17 January, 1961
New York, N. Y.

16 January - Open Session

Riverside Hospital, North Brother Island
New York, N.Y.

ATTENDANCE:

Committee: Dr. Nathan B. Eddy, Chairman, Drs. Raymond N. Bieter, Henry Brill, Dale C. Cameron, Jonathan O. Cole, Marshall Gates, Joseph M. Hayman, Jr., Maurice H. Seevers, Ralph G. Smith, and Isaac Starr.

Liaison:

Treasury Department: Mr. Carl De Baggio, Chief Counsel, Bureau of Narcotics

U.S. Public Health Service:
Addiction Research Center: Dr. H. F. Fraser

National Institutes of Health: Dr. Carl L. Anderson, Dr. Everette L. May, Chief, Section on Medicinal Chemistry, NIAMD.

Office of the Surgeon General: Dr. Harris Isbell, Chief, Addiction Research Center, NIMH.

Veterans Administration: Drs. J. F. Casey, Lyndon E. Lee, Jr., and Cecil P. Peck.

National Narcotic Enforcement Officers' Association: Donald B. Ant, Joseph S. Cardino, Joseph L. Cannizzaro, Joseph De Ambrose, Sidney Joffe, Sam Kirschenbaum, Frank A. La Porte, W. A. Moschauer, Irving Power, and Leonard J. Valero, Narcotic

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<u>National Narcotic Enforcement Officers Association, cont.:</u> Bureau, State of New York Health Department; Emanuel Bund, New York, N. Y.; Daniel A. Belmont, U.S. Bureau of Narcotics, New York, N.Y.; Arthur M. Grennan, New York City Police Department; Robert C. Grieb and Herman T. Reinsch, Jr., Narcotics Control, Connecticut State Department of Health; William E. Hoag, Thomas A. Kenny, and Maurice J. Nazareta, Newark Police Department; Leonard J. Iatesta, New York State Police; John F. Kreppeim, Queens County Court Probation Officer, Long Island City, N. Y.

<u>Riverside Hospital Staff:</u> Dr. Rafael R. Gamso, Medical Superintendent, Drs. Milford Blackwell, Takis Evdokas, Seymour Gurchin, Vincent Ippolito, A. Iwaniukowicz, Hyman Kachalsky, Arthur Kaplan, Theodore Lanning, Percy Mason, Charles Messeloff, Robert Osmos, Emanuel Rubin and Arnold Zucker; Joseph Argrett, Roger Baretz, Eric D. Brown, Anna B. Chase, Stanley Einstein, Aleathea Griffin, Martha Herman, Ida Jiggetts, Ferdinand Jones, Raya Kowarsky, David Laskowitz, Lester Lefkowitz, Ruth I. Mock, Kate L. Trent, Arthur Stein, Janet Strong, Samuel Waksman, Herbert Walcoe, and Eric B. Weiss.

<u>Guests:</u> Drs. Robert O. Bauer, U.C.L.A. Medical Center, Los Angeles, Calif.

John J. Bellizzi, Chief, Narcotic Control, New York State Health Department, Albany, N.Y.

Dr. J. Weldon Bellville, Stanford University, Palo Alto, Calif.

Guests - continued:

Dr. Hylan A. Bickerman and Sylvia E. Itkin, Goldwater Memorial Hospital, New York, N.Y.

Drs. L.S. Bender, Herbert Waltzer and Stanley W. Weitzner, Downstate Medical Center, State University of New York, Brooklyn, N.Y.

Dr. Rose C. Boyer, New York City Department of Correction.

Dr. Victor H. Breth, Metropolitan Hospital, New York, N.Y.

Mr. Leon Brill, Demonstration Center, U.S. Public Health Service, New York, N.Y.

Drs. Leo J. Cass, Willem S. Frederik and Franklin F. Snyder, Harvard University, Boston, Mass.

Dr. McKeen Cattell, Cornel University Medical College, New York, N.Y.

Drs. Benjamin J. Ciliberti and Grete Teutsch, Veterans Administration Hospital, Bronx, N.Y.

Dr. D. H. Clouet, New York State Psychiatric Institute, New York, N.Y.

Dr. Joseph Cochin, Hugh Jackson, and Dr. M.E. Odoroff, National Institutes of Health, Bethesda, Md.

Dr. Thomas J. De Kornfeld and Sadeo Morikawa, Baltimore City Hospital, Baltimore, Md.

Dr. Gerald A. Deneau, University of Michigan, Ann Arbor, Mich.

Dr. Charles Farmilo, Food and Drug Directorate, Ottawa, Canada

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Guests - continued:

Loretta M. Gore, Knickerbocker Hospital, New York, N.Y.

Drs. E.G. Gross and J.P. Long, State University of Iowa, Iowa City, Iowa.

Dr. Leonard Grumbach, Albany Medical College, Albany, N.Y.

R. C. Hammond, Narcotic Control, Department of Health and Welfare, Ottawa, Canada.

Dr. James R. Harris, Philadelphia General Hospital, Philadelphia, Pa.

Dr. Raymond W. Houde, Terence W. Murphey, Ada Rogers and Stanley Wallenstein, Sloan-Kettering Cancer Center, New York, N.Y.

Dr. Edward J. Humphreys, Institute for Alcoholism and Narcotic Addiction, Philadelphia, Pa.

Dr. Eric Kast, Chicago, Ill.

Dr. Arthur S. Keats, Baylor University, Houston, Texas.

Dr. Conan Kornetsky, Boston University School of Medicine, Boston, Mass.

Dr. John T. Laing, Long Island Hospital, Boston, Mass.

Dr. William R. Martin, Addiction Research Center, Lexington, Ky.

Dr. Gladys Mc Dermaid, Kings County Hospital, Brooklyn, N.Y.

Dr. James Moore, Mercy Hospital, Pittsburgh, Pa.

Guests - continued:

Clyde Nichols, United Nations Division of Narcotic Drugs, Geneva, Switzerland.

Dr. Fred W. Oberst, Directorate of Medical Research, Army Chemical Center, Md.

Dr. Maurice Pruitt, Rossville, Ga.

Dr. Henry Rapoport, University of California, Berkeley, Calif.

Dr. Henry L. Richman, Manhattan General Hospital, New York, N.Y.

Dr. Theodore Rosenthal, New York City Health Department, New York, N.Y.

Dr. Phyllis F. Schroff, Veterans Administration Center, Los Angeles, Calif.

Dr. A. Sunshine, New York University College of Medicine, New York, N.Y.

Dr. Geoffrey Woodard, Herndon, Va.

Drug Manufacturers' Representatives:

Abbott Laboratories:
Dr. E. T. Kimura

Baxter Laboratories:
Dr. Edward H. Bowen, Jr.

C. H. Boehringer Sohn, Germany:
Drs. Kurt Freter, Helmut Wick and Karl Zeile.

Bristol-Myers Laboratories:
Drs. Samuel Kuna and Peter D. Orahovats.

Burroughs Wellcome & Co.:
Dr. John C. Seed.

Ciba Laboratories:
Drs. G. Stevens and L. B. Wilkin

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Drug Manufacturers'
Representatives - Continued:

Endo Laboratories:
Dr. Harold Blumberg, David L. Klein and Drs. M. J. Lewenstein and Nathan Weiner.

Geigy Research Laboratories:
Dr. Joseph Marrus.

Irwin-Neisler & Co.:
Dr. Thomas B. O'Dell.

Hoffmann-La Roche:
Drs. John A. Aeschliman, John Lee, Leo A. Pirk and M. J. Schiffrin.

Knoll Pharmaceutical Co.:
Dr. Rudolf O. Hauck.

Lederle Laboratories:
Drs. Selby B. Davis and Robert A. Hardy, Jr.

Eli Lilly & Co.:
Drs. Don Carlos Hines, Charles M. Gruber, Jr., Albert Pohland, Raymond M. Rice, E. Brown Robbins and David L. Stone.

Mallinckrodt Chemical Works:
Drs. Floyd P. Hallett, George B. Hoey, August H. Homeyer and Harold E. Thayer.

Mead, Johnson & Co.:
Drs. Byron B. Clark and Earl T. Lewis.

Merck & Co.:
Arthur J. Basso, W. E. Clapham and H. W. Estey.

Merck Research Institute:
Drs. S.C. Strickland and Charles A. Winter.

Drug Manufacturers'
Representatives - continued:

Miles Laboratories:
Dr. L. A. Crandall.

S. B. Penick & Co.:
Drs. Bernard B. Brown and W. G. Bywater and James G. Flanagan.

Parke, Davis & Co.:
Drs. George H. De Stevens, Alex Z. Lane, Duncan A. Mc Carthy, Franklin W. Short and C. V. Winder.

Richardson-Merrill Co.:
Dr. Thomas C. Grubb.

A. H. Robins Co.:
Drs. Robert S. Murphey and Fletcher B. Owen, Jr.

Schering Corporation:
Dr. Samuel Irwin.

G. D. Searle & Co.:
Dr. Thomas H. Hayes.

Smith, Kline & French Laboratories:
Drs. Patricia W. Evers, Maxwell Gordon, Edward Macko, Murray G. Smythe, Jr., and David H. Tedeschi.

E. R. Squibb Institute:
Drs. Bradford Craver, James A. Dingwall and John Krapcho.

Sterling-Winthrop Research Institute:
Drs. Sydney Archer and Louis S. Harris.

The Upjohn Co.:
Dr. R. James Collins, H. V. Demissianos, Hugh H. Keasling, Louis Skaletzky, and Alan B. Varley.

Wallace Laboratories:
Drs. J. C. Ryan and S. E. Wilson.

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Drug Manufacturers' Representatives - Continued:

Warner-Lambert Research Institute:
Dr. Arthur D. Flanagan.

Winthrop Laboratories:
Dr. M. C. Wynes.

Wyeth Laboratories:
Drs. Patrick T. Mc Loughlin, Joseph Seifter and Fred A. Tate.

National Research Council:

Drs. R. Keith Cannan and Isaac D. Welt, Mr. Herbert N. Gardner, Mrs. Lois Bowen and Mrs. Barbara Rusteberg.

11:00 A.M. Dr. Nathan B. Eddy, Chairman, welcomed the Committee's guests, thanked Dr. Gamso for inviting the Committee to visit Riverside Hospital, and thanked the S.B. Penick and Company for furnishing transportation and otherwise assisting in the arrangements for the meeting.

The following reports were presented and discussed:

1. Treatment of Young Narcotic Addicts at Riverside Hospital. By Drs. Rafael R. Gamso, Medical Superintendent, and Percy Mason, Attending Psychiatrist, Riverside Hospital, New York, N.Y. See Appendix 1, p. 2414.

2. Preliminary Experiences of a Pilot Project in Drug Addiction. By Leon Brill, New York Demonstration Center, U.S. Public Health Service, New York, N.Y. See Appendix 2, p. 2425

3. Statement on Program for Narcotic Addicts. By Dr. Henry Brill, Assistant Commissioner, State of New York Department of Mental Hygiene, Albany, N.Y. See Appendix 3, p. 2433.

4. Coordinate and Liaison Services for Addictive Disorders at the Pennsylvania Institute for Alcoholism and Narcotic Addiction. By Dr. Edward J. Humphreys, Director, Institute for Alcoholism and Narcotic Addiction, and - Dr. James R. Harris, Psychiatrist-in-Chief, Philadelphia General Hospital, Philadelphia, Pa. See Appendix 4, p. 2438.

12:30 P.M. Luncheon at Riverside Hospital.

1:30 P.M. Presentation of Reports Continued:

5. Morphine Metabolism Studies in Humans with Radioactive Morphine, with a Note on the Biosynthesis of Morphine. By Dr. Henry Rapoport, Department of Chemistry, University of California, Berkeley, Calif. See Appendix 5, p. 2444.

6. The Toxicity of Meperidine in the Monkey as Influenced by its Rate of Absorption. By Drs. Gerald A. Deneau and Kengo Nakai, Department of Pharmacology, University of Michigan Medical Center, Ann Arbor, Mich. See Appendix 6, p. 2460.

7. Annual Report on Analgesic Testing at Baltimore City Hospitals and the Johns Hopkins Hospital. By Drs. Thomas J. De Kornfeld and Louis Lasagna, Departments of Anesthesiology and Clinical Pharmacology, The Johns Hopkins University Hospital, Baltimore, Md. See Appendix 7, p. 2470.

8. Annual Report: (1) Morphine Antagonists as Analgesics; and (2) Analgesic Potency of 1-(p-Chlorophenethyl)-6,7-dimethoxy-2-methyl-1,2,3,4-tetrahydroisoquinoline. By Drs. Arthur S. Keats, R. Jane Telford and C. N. Papadopoulos, Division of Anesthesiology, Baylor University College of Medicine and Jefferson Davis Hospital, Houston, Texas. See Appendix 8, p. 2484.

9. Clinical Observations on the Use of Ro 4-1778/1 (1-[p-Chlorophenethyl]-6,7-dimethoxy-2-methyl-1,2,3,4-tetrahydroisoquinoline). By Drs. Max S. Sadove, M. J. Schiffrin and S. Ali, Division of Anesthesiology, University of Illinois, Chicago, Illinois. See Appendix 9, p. 2501.

10. Studies on the Respiratory and Circulatory Effects of Ro 4-1778/1. By Dr. James Moore, Mercy Hospital, Pittsburgh, Pa. See Appendix 10, p. 2510.

11. Determination of Physical Dependence Potentiality of Milder Analgesics when Administered Repeatedly for Chronic Pain. By Drs. Leo J. Cass, John T. Laing and Willem S. Frederik, Harvard University and Long Island Hospital, Boston, Mass. See Appendix 11, p. 2516.

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12. Meeting Pain Relief Problems with Oral Phenazocine. By Dr. Joseph Cochin, Section on Medicinal Chemistry, National Institute of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda, Md. See Appendix 12, p. 2529.

5:15 P.M. Open Session adjourned.

7:00 P.M. Reception for the Committee and its guests at Hotel Lexington. Hosts, S.B. Penick & Co.

8:00 P.M. Dinner at Hotel Lexington (Committee and 120 guests) followed by talk by Dr. Harris Isbell on The Addiction Situation in Europe. Dr. Isbell described his contacts with many people in various European countries during his year of residence there and their attitudes towards and his impressions of the addiction situation particularly in England. He discussed conditions which might contribute to differences in the addiction problem in Eurpoe and the United States.

The 17th January continuation of the Open Session was called to order by the Chairman, Dr. Nathan B. Eddy, at 9:15 A.M. in the Auditorium of the National Academy of Sciences.

The presentation of reports continued as follows:

13. The Annual Report from the Memorial Cancer Center. Clinical Studies of Morphine, Codeine, Aspirin, 1,2-Dimethyl-3-phenyl-3-propionoxypyrrolidine hydrochloride and α-dl-3-acetoxy-6-methylamino-4,4-diphenylheptane. By Drs. Raymond W. Houde and J. Weldon Bellville and Mr. Stanley L. Wallenstein, Division of Clinical Investigation, Sloan-Kettering Institute for Cancer Research, New York, N.Y. See Appendix 13, p. 2533.

14. Demonstration of Tolerance and Physical Dependence Following a Short-term Infusion of Morphine. By Drs. William R. Martin and C. G. Eades, National Institute of Mental Health, Addiction Research Center, U.S. Public Health Service Hospital, Lexington, Ky. See Appendix 14, p. 2557.

15. The Relationship of Physical Dependence to the Dual Action Concept of Morphine Action. By Drs. Maurice H. Seevers and Gerald A. Deneau, Department of Pharmacology, University of Michigan Medical Center, Ann Arbor, Mich. See Appendix 15, p. 2575.

16. An Hypothesis of Opiate Action. By Dr. Leonard Grumbach, Department of Physiology, Albany Medical College, Albany, N.Y. See Appendix 16, p. 2585.

17. Evaluation of Factors Relating to Morphine-like Physical Dependence in the Monkey (Macaca mulatta) and Report on Substances Tested for Physical Dependence Capacity. By Drs. Gerald A. Deneau and Maurice H. Seevers, Department of Pharmacology, University of Michigan Medical Center, Ann Arbor, Mich. The report was not read but a mimeographed copy of the data from the testing program was distributed. See Addendum 1, following p. 2678.

18. Addiction Liability of 1-(p-Chlorophenethyl)-6,7-dimethoxy-2-methyl-1,2,3,4-tetrahydroisoquinoline (I-K-1; Ro 4-1778/1). By Drs. H. F. Fraser, W.R. Martin and A.B. Wolbach, National Institute of Mental Health, Addiction Research Center, U.S. Public Health Service Hospital, Lexington, Ky. See Appendix 17, p. 2593.

19. I. Evaluation of Carisoprodol and Phenyramidol for Addictiveness. By Drs. H F. Fraser, C.F. Essig and A.B. Wolbach. II. Human Pharmacology and Addictiveness of Certain Opioid Dextroisomers. (a) d-3-Hydroxy-N-phenethylmorphinan; (b) d-3-Methoxy-N-phenethylmorphinan; (c) d-Methadone. By Drs. H.F. Fraser and Harris Isbell, National Institute of Mental Health, Addiction Research Center, Lexington, Ky. See Appendix 18, p. 2615.

20. The Addiction Liability of α-dl-3-Acetoxy-6-methylamino-4,4-diphenylheptane hydrrochloride and of 6-Acetyl-3-ethoxy-dihydromorphine. By Drs. H.F. Fraser and A. B. Wolbach, National Institute of Mental Health Addiction Research Center, Lexington, Ky.

Dr. Fraser summarized briefly the results with the substances listed in items 19 and 20 without describing them in detail. See Appendix 18, p. 2615 and Addendum 2.

The Open Session adjourned at 11:15 A.M.

APPENDIX 1

Treatment of Young Narcotic Addicts at Riverside Hospital

by

Drs. Rafael R. Gamso, Medical Superintendent and
Percy Mason, Visiting Psychiatrist
Riverside Hospital, North Brother Island,
New York, N. Y.

Since this distinguished Committee has decided to hold its Annual Meeting at Riverside Hospital, we would like to give you some information about the hospital, its patients, and its functioning.

Riverside Hospital (1) is located on North Brother Island which has an approximate area of 13 acres. The hospital has a capacity of 140 beds although the usual census is closer to 160. The hospital was opened for the treatment of young drug addicts in July of 1952. It is one of the hospitals operated by the New York City Department of Hospitals. The hospital was opened as the result of the mounting pressure of public opinion which became aroused in the late 40's and early 50's by the rising tide of narcotic addiction among young people. Many alarming and disquieting headlines in the newspapers and in other media of communication had caused apprehension and concern. The Governor, the Attorney General of the State of New York, the Mayor, the Superintendent of Schools, and other community agencies decided to act, and under this pressure the hospital was opened. Since its inception, the hospital has had almost 2300 first admissions, who had a total of over 6000 hospitalizations.

Admission to the hospital is in accordance with the Public Health Law of the State of New York, section 3360-3366, which states that persons under the age of 21 adjudged to be narcotic addicts may be committed to the hospital following a petition by parent, guardian or an interested adult and remain under its jurisdiction for a period of three years for care, treatment, guidance and rehabilitation. They must be addicted to opium, its derivatives or synthetic equivalents, cocaine, or marihuana. The enormous majority of Riverside patients are addicted to heroin which seems to be the drug of choice today. They are primarily residents of New York City although, as set forth in the law, the hospital may receive patients from all parts of the state, and actually has received a few from other counties of the State of New York. The fact that the hospital is established under the Public Health Law rather than a criminal statute, is an important advance in the approach to the problem of

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three ethnic groups of the Riverside patient population on first admission. In 1954-55, there has been a drop in Negro first admissions while simultaneously, the rate of admission of Whites and Puerto Ricans has risen. The trend reversed itself in 1959, the Negro first admissions predominatory again. The reasons for these shifts are not at all clear.

As far as the population distribution by sex is concerned, this is outlined in Table 3. It can be seen from it that in any given year between 10 and 20 percent of the population consisted of females, which is a bit below the accepted ratio of three males to one female given as the usual statistical finding among the addicted population elsewhere.

Table 3

First admissions to Riverside Hospital, shown by sex.

| Year | Males | Females | Total |
|---|---|---|---|
| 1952 | 152 | 21 | 173 |
| 1953 | 224 | 36 | 260 |
| 1954 | 178 | 36 | 214 |
| 1955 | 207 | 40 | 247 |
| 1956 | 241 | 20 | 261 |
| 1957 | 177 | 27 | 204 |
| 1958 | 227 | 31 | 258 |
| 1959 | 357 | 81 | 438 |
| 1960 | 186 | 39 | 225 |
| Total | 1949 | 331 | 2280 |

As far as the diagnostic categories are concerned, 65 percent of the patients fell into the category of personality disorder, 25 percent were diagnosed as schizophrenia in different stages of development (there were only a small number of cases that had to be transferred to a state hospital). The psychoneuroses accounted for 6 percent of the cases; 1.5 percent had transient situational personality disorders. Less than 1.0 percent were diagnosed as mental defectives or having organic brain disorders (including epilepsy).

As far as the sources of referral of patients are concerned, the courts are the main source of admission referring 44 percent of the patient population. Next come referrals by family and

friends, 19 percent; other social agencies and hospitals account for 18 percent, and clergy of the different faiths for 5 percent. Only 15 percent are self-referrals. It can be seen from this that considerable pressure is required to induce the addict to seek treatment at the hospital, that the admissions to Riverside represent only a small proportion of the total number of young addicts; this contention being supported by studies by Chein (2) as well as reports from other agencies.

For a patient to be admitted to Riverside Hospital, his guardian or an interested adult must file a petition with the Narcotics Term of the Magistrates Court, if the addict is over 16 years of age, or with the Bronx County Children's Court, if he is under 16. The magistrate establishes the patient's residence, his age, and the fact that he is a drug user, and orders him to the hospital for "examination, care, treatment, guidance and rehabilitation". The patient is then transported in an ambulance to the hospital where he receives a complete medical evaluation (including chest x-ray, and laboratory procedures).

The determination is also made at that time of how long the patient has used drugs, how much and when the last dose was taken, all of these matters being important elements for the proper diagnosis and treatment of withdrawal symptoms. At the same time, the patient is thoroughly searched (this search includes all bodily orifices) to prevent introduction of contraband drugs into the hospital.

In our experience, the withdrawal symptoms among our patients are rather mild. This seems to be due to the fact that our patients are rather young and rarely have any organic disabilities; that the percentage of pure drug in a "fix" is small, (according to the police department a "fix" contains only three to five percent pure heroin); also the total period of addiction is relatively short. The procedure of choice in the treatment of withdrawal symptoms is the substitution method, using methadone by mouth, and the patients are usually well enough within 48 to 72 hours after admission, to participate in ordinary ward activities. The withdrawal symptoms vary in the severity not only in proportion to the amount of drugs taken but also in relation to the personality make-up of the patient. The patient remains under close study for about 21 days, during which a complete medical and psychiatric work-up is performed. This includes not only the psychiatric history and status but also a complete social history which includes interview of the family, battery of psychological tests which usually include the Wechsler-Bellevue, Bender Gestalt, Rorschach, and Figure Drawing, a battery

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of aptitude tests, as well as observation by the nursing, recreational and school staffs. At the end of this period, the patient is presented to his psychiatric team, not only for diagnosis, but also for the discussion of his underlying psychological problems so as to determine not only his therapeutic potential but also the psychopathology.

All patients remain in the hospital for a minimum of six months upon their first admission. It is felt that this is the minimum time necessary to establish a relationship with the patient and to be able to assess his ability to utilize treatment and to move with treatment. During this period of time the patient is assigned either to a school program, a work program (3) or a combination of the two. In addition, while in the hospital, the patient is receiving therapy which may be individual psychotherapy, group therapy, supportive therapy, case work, or only milieu therapy. In addition to this, of course, he is participating in the daily activities of the hospital as prescribed and outlined above. The progress of the patient is reviewed periodically by the team, and changes in the program are made as necessary. One of the difficulties with the program is the fact that the majority of the patients are past high school age, and few are genuinely interested in furthering their scholastic achievements. The school, on the other hand, is not equipped to provide intensive vocational training which probably would be of greater benefit and interest to these patients than academic subjects. The work program provides vocational experience which centers mainly around daily ward, plant, and grounds maintenance, with dietary work and occasionally more ambitious and elaborate projects. In a general way, it may be said that the activities with a practical and realistic goal have the greatest appeal and best attendance.

The school and work program occupy the time from 9:00 a.m. to 3:00 p.m.; then recreational activities take over. The recreation department supervises movies, outdoor games and sports, indoor social activities, dramatics, trips, and so forth. It must unfortunately, be said that the patients' interest in these activities is less than wholehearted; they prefer to spend their time idly, watching television, or listening to the radio. It is also in the late afternoon, at night, and on weekends, that difficulties may occur since the program is least structured, and the least personnel are available, at that time. Many of the difficulties could be regarded as juvenile pranks, encountered in any dormitory. There are some, though, which are related to the patients' craving for drugs; there have been attempts to break into the hospital pharmacy to get narcotics, sedatives, tranquilizers or alcohol. Comparatively

few incidents can be ascribed to homosexual tensions, and those seem to occur mostly among the female patients. The presence of both male and female patients presents problems at times: There are the usual boy-girl situations, which at times remain on a purely "platonic" level because of the inability of these patients to get involved emotionally. On the other hand, many patients have backgrounds of promiscuity and there is a readiness for sexual involvement on the part of some patients. Some of the disturbances on the wards may be due to racial and cultural tensions (see Table 2); and these require a great deal of tact and diplomacy on the part of the ward personnel.

Our patient population is rather young and organic disabilities are rare, except for liver pathology which represents a real problem. A study (4) of 159 patients who took heroin intravenously elicited a history of icteric viral hepatitis in at least 25 percent of them. Five patients of this group showed evidence of serious liver disease. Although no clinical evidence of present hepatitis was found, 48 patients had bilirubinuria, 31 of them having no history of preceding hepatitis.

A study of 52 mortalities among patients under the hospital's jurisdiction reveals 38 proven deaths from overdose of drugs; two deaths due to homicide; two due to fatal liver disease.

After discharge from the hospital, the patients continue to receive treatment at the After Care Clinic. The After Care Clinic is located at Metropolitan Hospital, which is on the upper east side of Manhattan. Patients are seen four days a week from 6:00 p.m. to 9:00 p.m. Before they are discharged from the hospital specific help and recommendations as to living arrangements, employment, etc. are made. Attendance at the clinic is required and patients are usually seen by the same staff members who saw them in the hospital. The clinic attendance, in a general way, is better than that in other clinics for drug addicts, but it is not as good as it is desired, and many patients resist attendance. It requires pressure by letters, phone calls, and contact through the courts to make patients keep appointments, and continue in therapy. Whenever necessary, a patient may be readmitted to the hospital. One of the shortcomings is the lack of personnel to work with the families; and the feeling is that a great deal of persistent and energetic case work (including home visits) is necessary. The same applies to the field of employment, where contacts with employers could be vastly improved and expanded.

The prevalent custom of discharging patients from the hospital

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to the community - and to their families - is unsatisfactory in many instances. We realize that patients may not have been sufficiently strengthened by their stays in the hospital and by their therapy here to cope any better than before with the strains and stresses of unsatisfactory interpersonal relations in a family. At the same time, these patients have no other places to go; the majority of residence clubs and homes are not willing or able to accept them. It has been repeatedly stated that many patients need a half-way house, a place in the community where the patient can live and continue his therapy, go to work or to school during the day, and return afterward for organized and supervised activities in a therapeutic environment.

Only fragmentary studies of our patient population have been possible because of personnel and budgetary limitations. One study of the post-hospitalization adjustment of adolescent drug addicts revealed that about one-third showed some improvement at the end of one year after discharge. Further studies showed that the number of those who remained permanently abstinent was small. Eleven percent started using drugs within the first 48 hours after discharge; 75 percent were readdicted by the end of six months; four percent remained abstinent for three years or more (5). We must bear in mind that most of our patients had a poor adjustment prior to their admission to the hospital, that about 15 percent had addicted relatives, that about 20 percent spent some time in jail or in a mental hospital prior to their admission to Riverside Hospital, and that 73 percent had at least one arrest prior to admission to Riverside.

This is the service side, the purely functional description of Riverside Hospital. Behind this, there is a certain frame of reference within which we are trying to operate. One of the basic assumptions is that an addict is the product of several factors. One of them is the availability of the drug in the environment. The other is the peculiar personality structure of the addict. We are perfectly aware of the fact that there are many people to whom drugs are available but who do not reach out for them. On the other hand, we are aware of the fact that there are many personality structures similar to those of the addict who do not become addicted because drugs are not available to them. We are also aware of the fact that there are large numbers of patients every year who, because of a legitimate medical or surgical reason, received narcotic drugs, but only a very small percentage of them become addicted.

We are going to speak briefly about the problems of a personality

and the environment in which such a personality is operating. When we speak of the environment, we are not going to discuss the problems of narcotic traffic control which is in the province of the law enforcement agencies. We are not speaking of the already alluded to difficult economic, social, educational and vocational problems; but rather of the family and its interactions. These families have their own emotional problems, which they fail to recognize. The majority of our patients don't know what a positive father figure is. Our patients' fathers are frequently totally absent, either physically because of death or separation, or psychologically. Most of the time they are only the people who "bring home the bacon" and otherwise do not participate very much in the family affairs. On the other hand, we are aware of the fact that the mother (6) of our patient is a very formidable figure. She is usually an angry, hostile, overpowering, seductive, depressed person who on many occasions obtains certain satisfactions through the patient's behavior.

The patient has great difficulty to identify with a parent in such a setting. This is especially difficult for males. They cannot identify properly with a weak father and at the same time they are afraid of a strong and seductive mother. This is well demonstrated in our psychological tests in which sexual confusion about oneself, as well as inability to identify with the parent of the same sex are constantly found. We also find that the internal environment of these patients contains a very low frustration tolerance level, as well as a large amount of dysphoria, and that in a general way, these people's ego and their ability to utilize the forces of reason and judgment are questionable.

An important factor in the treatment of our patients is the attitude of the community towards them. Unfortunately, for reasons which are not understood, within the community the drug addict is regarded as a depraved fiend, as a person who is morally reprehensible and who belongs in jail rather than in a hospital. One has the feeling that even in establishing Riverside Hospital the desire of some members of the community was for isolation of the addicts from the community like lepers rather than any genuine desire to help them through treatment. This attitude unfortunately also pervades the medical profession and the professions in general. For this reason, we are very impressed and pleased by the fact that this distinguished body of scientists is meeting at Riverside Hospital, lifting it out of the classification of ghettos into the realm of legitimate scientific endeavors. We believe that the clinician and the research scientists in the different fields pertaining to addiction will have to abandon their reluctance and their isolation

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and come in touch with the patient directly and personally. We have been disappointed by the difficulties in recruiting personnel, professional personnel especially; this may be due to the aura of disrespectability which envelopes anybody who is connected with this problem. This reluctance to attack the problem of drug addiction is very similar to our reluctance to come to grips with many other problems, like those of sex offenses, gambling, delinquency, alcoholism, and other behavior deviations. We believe that the period when the solution was "off with their heads" is gone by now and that we have to realize that these problems are here to stay and that we have to do something about them. At the same time, we would like to get away from any Polly Anna-ish approach to the problem. We would like to say that any of the behavior deviations are difficult to deal with and that any expectations of easy cures are rather unrealistic. "Cure" is a word which is practically unknown in many fields of medicine. We should rather search and strive for realistic goals to achieve abstinence and functional adjustment to society.

We, at Riverside, have been doing our part to share our experience with the community by trying to show what is being done and what can be done; this program should be continued and expanded. We have had numerous professional interested groups visit the hospital, the total number being close to a thousand a year. Members of our staff have spoken to many groups in the community. We have made our hospital facilities, our findings available to many professional people and have invited them to study our patients, or to use our material for scientific purposes. We must say with regret that our invitations, for the most part, have remained unanswered. Participation of the whole community including the medical fraternity is needed to guide our patients into wholesome social, cultural, economic and psychological adjustment. Leadership in that area is of the essence.

## References

1. Gamso, R.R. and Mason, P. "A Hospital for Adolescent Drug Addicts", Psychiatric Quarterly Suppl. (1958), 32, 99.

2. Chein, I. and Rosenfeld, E. "Juvenile Narcotics Use", Law and Contemporary Problems (Duke University) (1957), 22, 52.

3. Gould, J.B., Smith, L., Barker, W., and Gamso, R. R. "A Specific Approach to Vocational Needs of Adolescent Users of Narcotics at Riverside Hospital". Psychiatric Quarterly Suppl. (1954) 28, 199.

4. Messeloff, C.R., and Gamso, R. R., "Viral Hepatitis in Heroin Addicts". Unpublished.

5. Alksne, H., "A Follow-up Study of Treated Narcotics Users" Unpublished Study by Colombia University School of Public Health and Administrative Medicine (1959).

6. Mason, P., "The Mother of the Addict", Psychiatric Quarterly Suppl. (1958) 32, 189.

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## Discussion

Dr. Isbell asked about the basis for setting six months as the period for in-patient treatment. Are the results better, do the patients remain abstinent longer, or is there some other reason for such prolonged in-patient treatment?

Dr. Mason could not say that patients in the hospital for six months did better than those who stayed one month or ten years. He had no feeling that they were going to accomplish more cures. They were trying to approach the patients on a psychological basis and he felt that a period of six months was required to really establish contact with the patient.

Dr. Isbell asked about Dr. Mason's view with respect to the use of some form of compulsion in the treatment of these patients.

Dr. Mason felt that some form of compulsion would usually be needed.

Dr. Eddy asked whether after eight and a half years the hospital had any estimate of the number of patients who had remained off drugs.

Dr. Mason said that four percent had remained abstinent for three years or more, a good result in his opinion.