New York Post
January 10, 1958

DRUG ADDICTS, U.S.A.

ARTICLE V

By FERN MARJA and WILLIAM DUFTY

This is the Mecca of the drug addict:

A collection of gaunt, red-brick buildings set down on 1,200 acres that formerly belonged to two blue grass plantations, now famed throughout the world as the U. S. Public Health Hospital at Lexington, Ky.

It is all things to all people:

¶The cure-all that Federal Narcotics Commissioner Anslinger envisions when he talks of "compulsory hospitalization" as a must for addicts;

¶The voluntary haven for the junkie who is "hot" or broke or just wants to reduce his habit;

¶The maximum security jail where federal prisoners found to be addicts serve time;

¶The lesser of two evils for the convicted pusher who, on advice of counsel, shoots himself full of heroin to weasel out of the stiff sentences handed down to non-addicts;

¶The springboard of promotion for hospital administrators who bounce from Lexington to better-paid, higher-prestige government jobs;

¶The training ground for smooth-cheeked medicos who want to learn psychiatry under a paid-as-you-go plan.

One thing motivates all Lexington's inmates, patients and professionals alike:

A common desire to make their stay as brief as possible.

For the "winder," the self-committed patient who wants out as soon as he gets in, this may mean a week or even less; for the ambitious interne, it may be two years.

The Parader

brass as clinical director and medical officer in temporary charge of Lexington on the occasion of these reporters' visit, put it this way:

"We speak in terms of 5 per cent being in intensive therapy. We also have 80 people in group therapy."

But even this naked admission conveys only part of the grim picture. Lexington's "graduates" insist that psychiatry is available only for the prisoners:

"The voluntary patients don't stand a chance."

Confronted with this charge, Sturgell confirmed it. In essence:

"Probably a pretty high percentage of patients getting psychiatric treatment would be prisoners," he said.

The explanation, he suggested, lies in the nature of therapy, which demands long-term treatment. The self-committed patients just aren't in the hospital long enough to give psychiatry a chance.

Sturgell went on to defend this practice:

"There is no one who asks for treatment who doesn't get it. Oh, maybe not the same day. But the thing that happens is that we don't find enough patients who are suited to therapy."

Unfortunately, the truth is that Lexington can't afford to find patients who are suited to therapy.

("Lexington has a great deal of mealy-mouthed talk about addiction being a sickness," Prince said. "No one believes this, including the patients. The whole psychiatric set-up is sabotaged by the attitude of the non-medical staff. They say to patients, 'You want to get bugged by a headshrinker?' That does it. No one asks for therapy after that.")

What does Lexington accomplish?

No one knows.

Shortchanged by Washington on funds and personnel, the institution has no follow-up program that would measure its degree of success or failure. This is hard to believe in view of Lexington's highly-touted reputation, but Sturgell said:

"One out of every three patients returns here. We don't know what happens to the other two. We want to believe something happens, but we can't prove it because we don't have follow-up figures."

In other words Lexington's plight can be compared to Kentucky over and over again

2963 knocked on the door Saturday

and the self-committed are not segregated.

Lexington is a grey place, full of shadows, real and imaginary. Time loses its landmarks. Newcomers learn to fill minutes and hours by combaring notes. They are soon initiated into the advanced intricacies of addiction by junkies with arrest-studded records.

("The kid whose heroin is so diluted when he gets it from his pusher that he's really using flea powder gets to Lexington and is given methadone during the withdrawal period," said Prince. "That's when he really gets the habit.

("He meets the swamis and the soothsayers who teach him how to get codeine out of paregoric, and other pearls of wisdom. They sit around and talk about nothing but addiction and women. The women are boasts, but the drugs are real.")

With all its faults and blind techniques, Lexington offers the drug addict one positive contribution: a retreat where he can lick his spiritual wounds while getting a sound physical overhaul. Since only one other federal hospital in the entire country performs a similar service—the U. S. Public Health Hospital at Fort Worth, Tex., which is closed to women—this can scarcely be classified as a minor matter.

Hospitalization at Lexington may not provide uplift for the psyche, but it does strengthen the addict for the rat-race pace required of him when he returns to the outside world in quest of junk.

Occupational therapy and vocational counseling are largely confined to the industries that keep Lexington's budget trim: cooking, tailoring, carpentry, maintenance work.

Boredom is the chief extracurricular activity. Some of this is relieved by total griping, some by meetings of Narcotics Anonymous, an organization patterned after Alcoholics Anonymous that has survived only fitfully outside institutional walls.

("There's a mystic element about NA that's terrifying," said Prince. "They all get together and confess their sins and, after you listen to five or six of them, you realize how much pleasure they're getting out of it. They're empty people and this is their only adventure.")

The Repeaters

Long on theory, short on application, Lexington remains the fixed star in the addict's horizon. There is, after all, no other alternative for the junkie who hits bottom. So the great uncured, the patients who can't resist their narcotics compulsion any more than a kleptomaniac can resist stealing, make the long trek

Lexington is an international paradox. It boasts of its "integrated" approach to the addict, stressing in equal parts medical and psychiatric techniques.

Yet, for its 1,065 patients, prisoners and probationers, this hospital with bars has precisely four fully qualified psychiatrists, two of whom are entirely involved with administration.

This leaves the enormous complexities of therapy —a long, patient, highly-skilled practice that can be a dangerous tool in the hands of the untrained and the inexperienced—to a patched-together team of:

¶Two certified psychiatrists;

¶Six physicians who have completed three years of psychiatric training at Lexington or elsewhere but have not yet had the two years of clinical experience that is required before they can take the American Board of Psychiatry and Neurology exam;

¶Eight residents who have completed their interneships and are still in the first, second or third year of their psychiatric training;

¶Two physicans with no psychiatric background whatsoever but who have what was described by a superior as **"an interest in psychiatry."**

Under-staffing (the authorized medical corps of 28 has six vacancies) forces the hospital directors to toss the tyros into the hopper, dividing all the cases among the real and would-be psychiatrists, even when the latter are just beginning the first year of training.

("You know what's wrong with Lexington?" asked a man we'll call Alton Prince, a writer of wit and sophistication who took the cure four times at Lexington, three times of his own volition, once by courtesy of the Federal Narcotics Bureau. "No one there is qualified to treat the addict.

("Little boys whose moustaches haven't yet grown out are pretending to be psychiatrists and come up against the most devious people this earth has ever spawned. And so what happens? I wound up telling my psychiatrist that his problems with his wife would work themselves out.

("There are no individual villains at Lexington. There are just Midwestern squares dealing with dissolute swamp blossoms. That's not good enough.")

There are 40 hours in each doctor's work week. The inevitable result is that only the exceptional patient, like Prince, gets the benefit of even pseudo-psychiatric treatment.

Dr. Joseph Sturgell, who was himself doubling in to that of a surgeon who operates, stitches up his patient and departs, not knowing whether the patient lives or dies. Such an Alice-in-Wonderland method of coping with drug addicts permits observers to reach the conclusions they prefer.

Anslinger, who makes Lexington the keystone of his enforcement program, likes to talk in terms of the hospital's cures. When pressed to the wall, he says 17 per cent of the addicts serviced at the institution have remained clean.

But Sturgell was candid enough to say:

"Commissioner Anslinger is very complimentary about this hospital. He thinks a lot of people stay off drugs after they leave here. But we are scientists and we are interested in facts. And so we say we don't know."

The Figures

Anslinger's 17 per cent figure can be traced back to a survey Lexington conducted by mail some 18 years ago. About 50 per cent returned the questionnaires. Of that haphazard sampling, roughly 15 per cent of Lexington's former patrons indicated they had remained drug-free.

Lexington's administrators are the first to agree that such unverified statistical evidence is meaningless. They proved it by never publishing the results of the survey.

"That '17 per cent cure' business grates on me," said Sturgell. "What IS a 'cure'?"

Without a follow-up, Lexington must continue to work in the dark, its vaunted program little more than a farce.

("I have no grudge against Lexington," said Prince. "I'm very grateful to it. They got me off the toxic effects of the drugs, which I couldn't do myself. They do the best job in the country along that line. But, until my wife came along, I was never cured for more than a couple of days after leaving Lexington.

("Lexington's only a stopgap, like putting a filling in a hollow tooth. Under the filling, the tooth is rotten. I kept in touch with some of the nicer guys I met there. They are all back on the stuff.

("They go back because the misery they were in that drove them to drugs is there waiting for them when they cross Lexington's threshold on the way out. What has changed? Nothing. Why should they want to tune out on life? That's the problem Lexington doesn't begin to touch.")

Of the 3,336 men and women admitted to Lexington during the year ended last June, 339 were prisoners,

"Of the 34,559 admissions at Lexington over a stretch of years," Sturgell said, "11,358 were first admissions. This is 33 per cent. But it's 64 per cent of the people, since some have been here two and three times."

The repeaters who have swung in and out of the institution six and more times make up 3.5 per cent of the patients, Sturgell reported. One winder has a record of more than 25 admissions.

("I've been at Lexington five times in the last ten years," Flora Silverson—her name has been disguised—said shamefacedly. She had elected to take cold-turkey withdrawal from her morphine addiction at New York City's House of Detention rather than face Lexington again.

("I stayed each time from four days to three weeks. The last time, the doctor told me my record was very bad. 'Why do you run away?' he asked me. 'Why don't you stay and clean up for good?'

("I said, 'I'm sick; I can't stand it here; I'll go to my own doctor.' He said, 'Suicide.' He said, 'You have to wait six months to one year before you come back here. You're not eligible until the middle of 1958.'")

There is at present a waiting period of three weeks for men who want to enter Lexington, a little less than a week for women. This is a formidable period for addicts who are slipping into the anguish of withdrawal or engaged in dodging the police.

It is equally formidable for the honest physicians who want to treat them, but fear retaliation from the Narcotics Bureau, which claims jurisdiction over every phase of addiction and regards private treatment as a threat to its benevolent despotism.

"Every day," said Sturgell wearily, "doctors call me long distance and say, 'My God, doctor, what will I do with this case during the waiting period?' And every case is an emergency.

"I tell them I don't know. They're just as good doctors as I am. Doctors seem to think there is some kind of mystical treatment for addicts here.

"One doctor telephoned me from Philadelphia and said he had a patient of 68 who has been bedridden for eight years and is an addict. If there was a waiting period for admission, what should he do? I told him, 'Treat her—she's bedridden and can't get the narcotics. What's your problem? Treat her yourself.'"

But private physicians long ago abandoned the field, retreating discreetly before Anslinger's advances.

The government-sponsored monopoly continues. Lexington's popularity rating remains high.

(Continued in the Week-End Edition)

New York Post, January 14, 1958

DRUG ADDICTS, USA

By WILLIAM DUFTY and FERN MARJA

"How did it end?" the baby sitter asked the young couple when they returned from the movie "Hatful of Rain."

Aware that this was a leading question, the wife weighed her words. "Well," she said, "Eva Marie Saint finds out her husband got to be a dope addict in the Korean War. She calls the police and tells them to come get him."

"Shoot," the older brown-skinned woman exploded. "They won't come get him. Not in New York. This supposed to happen in New York?"

ARTICLE VIII

"It was filmed here," the wife explained. "At a housing project on the East Side."

"One thing would happen, then," said the baby sitter. "They'd get thrown out of the project. Him *and* her."

From her bitter crop of offscreen experiences with an addict son, the Negro woman weighed the film and found it wanting. She hit a point generally overlooked by the critics as well as U. S. Narcotics Commissioner Anslinger, who has had nothing but praise for the picture.

Inspector Coyle of the New York Police Narcotics Bureau admits the woman is right about the call-the-cops finish. Former Bureau Chief Peter Terranova agrees. The cops could do nothing. Addiction is not a crime.

If the movie husband had dope on him—or if a desperate wife or family had planted it there—the police could take him off their hands and send him to jail.

Otherwise, he would face the same false and desperate choice every over-21 addict faces in Our Town: Rikers Island penitentiary or the waiting list for the Lexington, Ky., federal hospital.

The sick husband's chances of being treated medically instead of punitively would be slim indeed. Ditto for the couple's chances of staying in the project. Ditto for the marriage. So the real story begins where the film ended.

The Romance

Without even trying, these reporters encountered an attractive New York couple in the throes of the real-life role-playing done on the screen by Miss Saint and Don Murray. The real Johnny is a shade less heroic than the Korean vet of the movies, more Brando than Don Murray. And his wife, Celia, is far less square than the movie bride; more Jean Simmons than Eva Marie Saint.

a police record, ruined his chances for all kinds of jobs. And finished our marriage."

For Johnny was one of those heroin addicts who don't exist statistically, as far as the police census is concerned. Despite confident federal claims that every addict falls into the toils of the law within two years after he becomes a user, Johnny and the score of addicts in his circle had gone unmolested for four years. He always had money to support his habit. He was white. He stayed out of Harlem, avoided all stereotypes of the "junkie." He dodged the Narcotics Squad as handily as a discreet homosexual stays out of the Vice Squad's toils for a lifetime.

Celia had heard about Narcotics Anonymous. She got their address. She didn't know that it had virtually ceased to exist. Meanwhile, Johnny decided to look up a psychiatrist.

"I told him my heroin problem was just incidental. But when I mentioned the word, he flipped, didn't even want me in his office. He told me to call Riverside Hospital. That's for kids, I told him. All they do is give them a guilty complex. I left."

Time was running out. Celia wrote to NA, portraying herself as an addict in need of help. After several days, she got a call from Major Dorothy Berry of the Salvation Army's Prison Department. The hearty Shavian Major is a veteran of many frustrating years trying to help the problem people in the city's underground. Major Berry referred Johnny and Celia to Nathan Zucker, director of the National Family Council on Drug Addiction at 401 West End Av. They got an appointment the same day.

The Future

Celia and Johnny have nothing but praise for Zucker, a professional family counselor who's had 30 years' experience with the narcotics problem. Zucker insists that the sine qua non of helping the addict is taking on his whole family. His therapy is a deceptive combination of a warm heart and cold Pepsi Cola.

"I think," says Celia, "one reason Mr. Zucker succeeds is he doesn't dig too deep. He got through to Johnny where the psychiatrist didn't. He made him realize he's still part of the human race; that there's no such thing as being permanently 'drug-prone.' He made him feel like coming back to him whether he was succeeding or not."

Veteran Major Berry, weary of brush-offs from fancy social agencies that say "You take the addict, we'll take the family," adds her testimonial. "Zucker is the only man I know, acting completely without pressure, who succeeds in having people keep their appointments, come on time and keep coming."

Zucker starts with a review of government facilities. He urges addicts to commit themselves to Rikers Island or Lexington for the first step—kicking the habit. If they are reluctant to go—and they usually are—he steels them for the ordeal of kicking at home, with the family's help.

With the family brought in for counseling, knowing what to expect and what it can do to help, the grim

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Another difference between life and art was this: The cute meeting between the Lower East Side Italian boy and the upper class girl happened because he was an addict. This brought them together.

"A cab driver introduced us," Celia recalls. "I thought how exciting. Johnny was a nice, confused, inhibited sort of guy. I thought I was so clever, adding another affair to my collection. I should have taken the bus."

Celia's father was a Naval officer. Johnny's biggest military feat was evening the score with his draft board by studying medical texts, picking a suitable psychotic category and bucking for what used to be called a Section 8, a medical discharge on psychiatric grounds. He made it.

He devoted so much energy to the bouts with Army psychologists that civilian life seemed suddenly empty. He had messed with heroin before, found it a less expensive and demanding habit than liquor—to which he was prone. So he drifted into an elite beat coterie where heroin solved all problems. He became a bouncer in a Greenwich Village cafe. Supply was no problem. Neither was money. He cleared over $100 a week and had no other expenses.

The excitement of the chase, the close calls with the cops were clearly as big a lure as the calm, serene, chemical afterglow of being by heroin possessed.

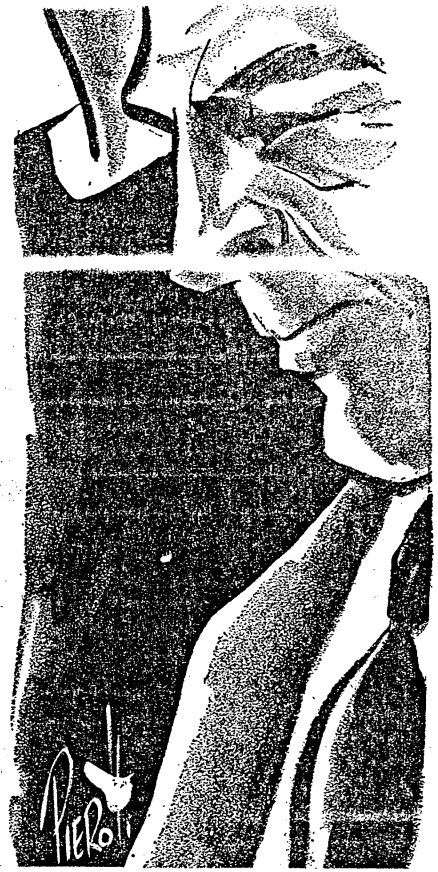
It was love that trapped them. Celia intended to walk through the affair. Johnny found the girl from another world a challenge. Celia began to talk herself into thinking marriage was possible, even desirable.

The Struggle

They broke off the first time when heroin came between them. "Johnny didn't see anything wrong in it," Celia found. "I couldn't ask him to stop for me. If he did, he'd resent me. He had to stop for himself."

One day he did. He kicked the habit all by himself, to prove he could do it. Johnny knew it didn't mean much more than that. But Celia at this point was as naive as any movie heroine. She thought Johnny had licked it. So they were married.

Relapse, doctors say, is part of the pattern. But



Celia wasn't expecting it. When Johnny relapsed and started on heroin again, Celia was baffled, shaken. When she finally had to face it, she ruled out melodrama and settled for what she thought was an intelligent approach. She knew Johnny wasn't ready to kick again. She determined to take advantage of the meantime.

"I was stupid, sure," Celia admits. "But never stupid enough to think of calling the police. One call to the police would have fouled Johnny up forever, given him

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With the family brought in for counseling, knowing what to expect and what it can do to help, the grim ordeal is never as awful as it seems. Addicts keep coming for daily or weekly appointments at Zucker's office when they are able. If they relapse, they keep coming. They lose no status. They try again.

Zucker has another advantage over the medical profession. Suffering addicts know he has no drugs to give them to tide them over the withdrawal period. So they can't hold that against him.

Johnny's weeks of sessions with the family counselor followed the up-again, down-again pattern. He kicked. He stuck it out for a couple of weeks. He relapsed. He kept coming. He kicked again.

Celia was counseled too. ("Knocking on the bathroom door is the worst thing a family can do. Misdirected love, it's called.") Johnny's parents, who had had no idea of his predicament for years, were eventually brought around. Zucker talked to them. Celia's relatives, oblivious of the problem, were brought into the act.

("An aunt of mine saw 'Hatful of Rain' and came away a big authority," Celia recalls wryly. "She told me the whole story one afternoon while Johnny and I were in the middle of our worst period. I don't know how I kept from screaming.")

Johnny had to start from the ground up. He gave up his friends, the wrong set sprinkled with drug users. He gave up his job, where temptation abounded. Celia went back to work to help tide them over. After several weeks they had their feet on the ground. Neither hopeful nor hopeless, they had found at least a way of living with the problem; at best a way of licking it.

If Nathan Zucker's organization didn't exist, it would have to be invented before the saga of Celia and Johnny could be steered permanently clear of the police blotters, courts and jails.

The treatment he got wasn't strictly medical. But it wasn't penal either. And it happened despite anything society has officially to offer, not because of it.

Anslinger's bureau keeps a secret interdepartmental file of some 35,000 addicts known to local and federal police throughout the country.

As far as these central files are concerned, Johnny still doesn't exist. If he's lucky, he can keep it that way.

Continued tomorrow.

New York Post–January 19, 1958

DRUG ADDICTS, USA

By FERN MARJA and WILLIAM DUFTY

ARTICLE XII

The kids had the toughness and the cynicism that mean survival in the lower depths, and their gutter knowledge carried the stamp of authenticity.

They met every week with a psychologist from the Board of Education's Bureau of Child Guidance, Mrs. Edna Mann, who was trying to prevent their armored defenses from rolling them into the area of delinquency.

This particular week, at the suggestion of NYU researchers, she asked the group to discuss drug addiction. The kids were not addicts, but they came from neighborhoods where drug addiction is a fact of life.

Why, Mrs. Mann asked them, do juveniles take drugs?

"Because they have a lot of trouble," one boy said. "They can't get along with people."

"Anybody could get on it," volunteered another. "Something happens home. You don't care any more. You lose your girl friend. Before you know it, you are on the kick."

What about marijuana?

"I did it—it is not habit-forming."

Another boy confirmed this: "It can't kill you. I did it, too. You don't go crazy from reefers."

The group comedian burst into song, "Sweet marijuana, go too high, touch the sky . . ." But the kids were involved in the discussion now, moving with it, and during that session and the next they came up with the following concepts:

ON TREATING ADDICTS:

"They should be talked to."

"You got to understand them, bear with them, try to settle their problems. To determine why they take it—that's the point. Maybe you can give them another habit, like chewing gum or going to the movies."

"Talk to them friendly."

ON THE LURE OF DRUGS:

"You feel fine, happy, lively, itch all over."

"When they get that dope in them, they don't know what they're doing. They get a notion they can do whatever they want. Like a king with power over all his land. In a way, they do have power

The place might be raided and you'd have two fellows in trouble instead of one."

Virtually the only place left then where addicts, former addicts and their relatives and friends can meet in safety is on hallowed ground. There are two such oases in Our Town.

In an eloquent, little volume called "Light the Dark Streets," published by Seabury Press, Rev. C. Kilmer Myers, vicar of St. Augustine's Episcopal Mission on the Lower East Side, tells some of the experiences of his parish in ministering to the addict as well as to the delinquent youth and the gang member.

"We have made many, many mistakes," he writes, "but at least the lines of communication were kept open."

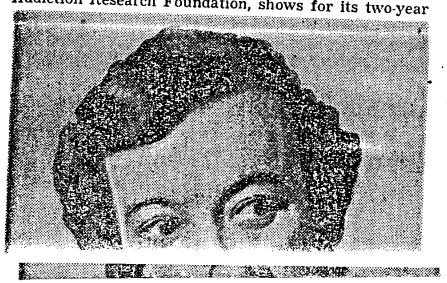
Wherever addicts are regarded as sick people rather than criminals, another church group is cited for valor —the East Harlem Protestant Parish, where the Rev. Norman C. Eddy is doing what has been described as "the best work in town."

Both these programs at present limit their efforts to before-and-after care for addicts who go to a hospital or a jail in search of a cure. But in a church basement in Chicago another Protestant parish has gone beyond anything tried by Myers or Eddy.

There St. Mark's Episcopal Church has established a clinic where addicts receive medical treatment to ease them through the withdrawal period on a voluntary, out-patient basis.

U. S. Narcotics Commissioner Anslinger refers to this kind of treatment as "ambulatory" and insists it is at best worthless, at worst forbidden.

But the St. Mark's program, now known as the Addiction Research Foundation, shows for its two-year



services to research aimed at isolating the emotional, social and environmental factors that cause addiction. Extensive interviews and tests are followed by individual or group therapy.

The totally voluntary character of the program serves as a self-screening process. The patients are motivated or they don't come back. Of the 75 per cent who relapse into addiction or make no real effort to kick their habit, Jenks say:

"We keep urging them to come back and try again. We tell them we don't hold their failures against them."

The third phase of the program grapples with the twilight zone of addiction, when physiological withdrawal is complete and self-understanding begins—and the temptation of relapse sets in. Five volunteer social workers cooperate with the medical staff and the church's professional staff to bring the whole gamut of socio-economic problems under scrutiny—jobs, food, shelter, emergency relief.

(It is precisely this feature that New York City's internationally famed Riverside Hospital lacks because of personnel and budget shortages.)

Trusted—or Untouchable?

Pulling the whole St. Mark's operation together is the pastoral phase, in which the church seeks to develop a personal relationship of confidence and trust with each patient in the hope of dispelling the effects of loneliness and rejection.

(Riverside confines itself to addicts under 21; St. Mark's takes all comers. "Actually," Jenks says, "this age differential works on our side. Our average addict is about 27. It is easier to establish a meaningful relationship with him than it is with the teen-agers on whom Riverside has to concentrate.")

Jenks has estimated the temporal value to Chicago of the St. Mark's clinic in the cold-cash terms of prevented crimes against property. He sets this at $108,000, a modest figure that doesn't allow for the avoided cost of detection, apprehension, court hearings, jail and the other expenses of the revolving-door police approach to the addict-turned-criminal.

The clinic, then, has saved Chicago an impressive sum and has earned the right to speak and be heard:

"We especially deplore the present punitive measures directed against the narcotic user," Jenks emphasizes. "We are pressing for legal measures which will deal with this problem in terms of therapy rather than penology."

Here in New York City the addict who drifts into his synthetic paradise on the wings of heroin is still marked untouchable, condemned to crime before he becomes a criminal.

The hospitals won't take him. Doctors, prompted by the Narcotics Bureau, reject him. Social service agencies shrink from him. The one community center that opened its door to adolescent addicts in recent years promptly slammed it shut again: Too little reward, too much danger of contamination.

Newspapers pump fresh printer's ink into flamboyant stories about junkies, periodically updating the poppy and the adventures of heroin [illegible]

Not real power. They think they can have whatever they want or do what they want."

"You have confidence."

ON CURING ADDICTS:

"Some you can cure, some you can't."

"They gotta do it theirself."

This hard wisdom was passed along to professors and psychiatrists working on the drug addiction project at NYU's Research Center for Humah Relations.

Eva Rosenfeld, assistant research professor, was sufficiently impressed to mimeograph excerpts for her colleagues with this comment:

"If you recall the summary of our findings on drug users, you will note the striking similarity in these boys' insights and our knowledge. As to the method of rehabilitation, we would only wish that our public officials had the instinctive understanding these boys show."

Research, then, is just beginning to catch up with street lore, theory with practice. Lagging far behind are the law and the lawmakers.

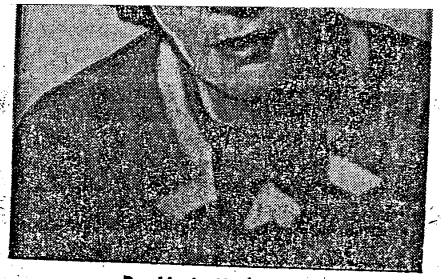
It may come as an awesome discovery for a doctor, a social worker, a Senator or a judge that the "dope fiend" is just another human being. But, for a theologian, it is an article of unchanging faith.

This, perhaps, is why the church is a tentative leader in meeting the problem of addiction in Our Town. In a medico-social area which the government has appropriated as its own and interpreted as almost exclusively legal, the church alone can offer sanctuary.

Even the crypto-religious ideas at the root of Narcotics Anonymous seem foredoomed to failure outside an institutional setting because of the shadow of the law. Major Dorothy Berry of the Salvation Army, a cheerful individualist who is waging a one-woman war against the myths that have been incorporated into drug addiction laws, sums it up out of bitter experience:

"The 12-step approach of Alcoholics Anonymous won't work with addicts unless you could try it in the lobby of the YMCA.

"If a fellow was about to go back on drugs and called a former addict to come to his room to sit with him and help him, the former addict couldn't risk it.



Dr. Marie Nyswander
"She was an Anslinger man . . ."

operation an apparent rate of success beyond the most optimistic claims ever put forth for the federal program by Anslinger himself.

Both patients and staff are volunteers. Father Robert T. Jenks, the chairman, reports that of the 390 Chicagoans (all but 17 of them heroin mainliners) who have patronized the clinic, 25 per cent have remained off drugs for four months or more.

What distinguishes St. Mark's is its attempt at the total approach. "We treat the addict in his own habitat," Father Jenks told The Post. "We think our follow-up program makes the difference between success and failure. We help each person in his own environment, following him into his home and into his job."

Two volunteer physicians direct the medical phase of the program. The tranquilizer reserpine is used, together with a non-barbiturate sleeping medication, to calm the addict during the acute stage of the abstinence syndrome.

Sometimes these mild techniques don't work. A total of 11 men and one woman were found to need in-patient care; another 38 addicts took the pills and never came back. BUT—80 per cent were successfully withdrawn after four days.

Step No. 2 at the Chicago clinic is an effort to get at the root cause—the "anxiety-producing failure"—of which addiction is usually the symptom.

Five clinical psychologists contribute their time and

Everyone talks about drug addiction, but no one does anything about it. There are, however, a few enlightened public servants who are willing to try. They dare at least to say in public what they think in private and their ranks are steadily growing.

Blind Spot

Today they form a kind of unofficial alliance, united in their desire to replace the old-fashioned, rigid, unsuccessful police techniques with more practicable, less punitive measures.

This fraternity looks with interest at the so-called British system of narcotics control and the variations on that theme that are in use in various countries of the Western world.

It is altogether revealing that Anslinger, the commissar of American narcotics enforcement, steadfastly denies the existence of the British system. Daniel might as well have denied the existence of the lion, Jonah of the whale.

The Commissioner, never the man to allow truth to interfere with private fantasy, insists: "The British law is the same as ours." This is true as far as it goes. What Anslinger blinds himself to is the vast difference in interpretation.

"In the United Kingdom," Britain has reported to the UN, "the treatment of a patient [addict] is considered to be a matter for the doctor concerned. The nature of the treatment given varies with the circumstances of each case."

Dr. Kenneth Chapman, a consultant with the U. S. Public Health Service, to whom Anslinger referred these reporters for information on the medical aspects of addiction, said he has seen the British system and is satisfied it works in the British Isles. Whether it could be transplanted to this country, he doesn't know.

"The British do not believe in giving drugs to addicts just to support their addiction," Chapman cautioned. "An eminent British physician said, 'We don't like the fact that you Americans talk of us as filling stations for addicts—our addicts get drugs only if they are sick.'

"Now the difference between the British and the American systems is in the interpretation of 'sick.' Their view of what constitute medical indications for the need of narcotics is broader than ours. In other

(Confronted with this figure, Anslinger, unmoved, said: "Eleven convictions are 11 convictions.")

The polar differences in the application of the twin American and British drug laws are dramatized in the following incident:

An American entertainer, known by the British police to be a heroin user, was performing at the London Palladium in 1954. The entertainer consulted a London physician, giving a false identity, and received a prescription for some heroin.

The entertainer was quietly arrested, convicted and deported, without any publicity. The contrast between the British operation and our own is underlined by the charge against him: giving false information to a doctor.

Dr. Alfred Lindesmith, an eminent American sociologist who is an admirer of the British form of narcotics control and is consequently viewed by Anslinger as a member of the disloyal opposition, asked the London authorities what might have happened if the entertainer had given the doctor his right name.

"In that case," they told him, "nothing would have happened. There would have been no violation of the law."

It is this system that is attracting the attention and speculation of American experts. Some of them want to adopt it here; some wonder if the British approach

Rev. C. Kilmer Myers
An oasis on hallowed ground.

"Second, we must have adequate research. This is so devastating an illness that we don't know how to cope with it at present.

"Third, we must have a follow-up program, which may take years. This is a very, very expensive illness.

"I advocate a strictly controlled experiment with the British plan. I don't advocate that the British system be adopted here until we try a controlled project."

The American Medical Assn., surely one of the least radical organizations in the country, recommends in the current report on drug addiction by its Council on Mental Health revision of the organization's 1924 resolution condemning "any system of treatment that puts opiates in the hands of addicts for self-administration."

Highlighted in the final sentence of the AMA statement is the significant declaration that "consideration should be given to broadening the resolution to include a plan indorsing regulations somewhat similar to those currently in force in England."

The Physician as Crutch

Even more comprehensive is the report just published by a study group of the World Health Organization, which states:

"It cannot be too strongly emphasized that the first principle of the treatment of drug addicts is that they should be looked upon as patients, that is to say, treated medically and not punitively."

The WHO document cites as the goal of treatment a good adjustment without drugs, but it does not hedge on the issue that most provokes Anslinger's ire. Challenging the Commissioner's dictum that supplying an addict with drugs is "mere gratification" of his habit and therefore wrong, the study group asserts:

"There are well-recognized obvious medical conditions, such as severe chronic or terminal illnesses, where continued administration of drugs is indicated. In addition, experience with the problems of addiction in several countries and newer knowledge of the psychology of addiction leads the medical profession to believe that in exceptional cases it is within the limits of good medical practice to administer drugs over continuing periods of time."

But perhaps the most revolutionary point the international body makes is that the addict patient should, so far as possible, be allowed to make—or feel that he has made—a free decision to obtain treatment.

This conclusion, which contradicts all federal procedures and objectives in the U. S., was repeatedly presented to these reporters by the most successful of the therapists now treating narcotics users.

A distinguished doctor in this city, who prefers to remain anonymous rather than risk a head-on collision with the Narcotics Squad, said:

"You cannot treat the addict by force. He has to have his own motivation to get cured. So I let him take his drugs. I don't stop him. You, the physician, are his addiction for a while.

"This is the basis of all psychotherapy. For a time, who is often bullied by the [illegible] Anslinger man when she was at Lexington—now she thinks I have horns"), put it in blunt terms:

"Let the doctors think this through medically and decide once and for all: Is it ethical or unethical for a physician to give drugs to an addict? Once this is decided, some other things will begin to fall into place."

(Some measure of the average doctor's enthusiasm for this controversy can be gained from the sales of Dr. Nyswander's book; less than 500 copies have been sold.)

For a year Dr. Nyswander conducted a telling experiment with addicts as out-patients. The project was sponsored by the Postgraduate Center for Psychotherapy and was similar in intent to Chicago's St. Mark's Clinic.

With 30 psychoanalytically trained psychotherapists, Dr. Nyswander studied the accessibility of narcotic addicts to voluntary treatment outside a hospital setting. Of the 64 addicts who were interviewed by this staff, 13 remained in treatment at the end of a year. Ten had ceased to use drugs, two had decreased their habit and one took drugs only occasionally.

"It has been demonstrated," the Nyswander group reported, "that some drug addicts will voluntarily present themselves for psychotherapy and that they do not seem to present untoward hazards. ***They may be treated on an ambulatory basis while still addicted."***

Of Anslinger's compulsory treatment-or-nothing ultimatum, Dr. Nyswander comments: "It shows ignorance of the true nature of the drug addict and addiction. The only time addicts cause trouble is when they're in places against their will."

But, so far, constructive thinking on the drug addiction problem falls under the heading of things to come—maybe. For things here and now, the outlook is foreboding.

The pessimism with which the addicts themselves react to the unrelieved darkness in which they move is illustrated by an experience Father Myers had with an unfinished film shot in the streets of the Lower East Side by youngsters at his Episcopal mission.

The film-makers needed no technical advice on addiction. According to Father Myers, the director had a habit and the teen-age cast was liberally sprinkled with heroin mainliners. ("The Judgment of God is upon those parishes which are not oases . . . ," Father Myers has written.)

There was little argument about early story points. How to end the production, however, precipitated a conference more bitter and heated than the fight for control of MGM. Some of the youngsters insisted on an upbeat finish; others held out for a hopeless fade-out after the adolescent addict gets killed by a cop.

A vote formalized the deadlock. Four (non-junkies) voted for hope. Four (junkies) voted for death.

The rector proposed ending the movie with a question mark.

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(Last of a Series)

New York Post - January 19, 1958

words, they leave it up to the physician to determine whether a patient needs drugs.

"They would not deny that they also have a provision for the individual who appears not to be able to lead a socially productive life when he is off narcotics. How often it is used, I don't know."

In effect, the British approach centers on the physician, the American on the police.

Dr. Jeffrey Bishop of London makes just this point in his report in Dr. Marie Nyswander's recent book, "The Drug Addict as a Patient," published by Grune and Stratton. Britain's Dangerous Drugs Act of 1920, the equivalent of our Harrison Act, Bishop writes, "places the responsibility for the management and treatment of the addict in the hands of the medical profession."

He underlines the fact that to be a drug addict in England "has never been and is not now illegal," and adds: "The addict is committing an offense only if drugs found in his possession have been unlawfully obtained. He is regarded as a sick person in need of medical care and not as a criminal to be hounded by the police."

Bishop then blueprints the basis of the British plan:

"Doctors may only supply or prescribe dangerous drugs for their patients when a real medical need for the drug exists; but the Home Office recognizes that to supply an addict with minimal maintenance doses does, in some cases, constitute a medical need."

This is the heart of the matter. The English physician notes in conclusion:

"The number of addicts known to the Home Office (less than 400) represents, for all practical purposes, the actual number of addicts in the country and there is no evidence of organized traffic. Drug addiction presents no real problem in the United Kingdom."

Narcotics, including heroin and morphine, are legally provided by private physicians for registered British addicts under the National Health Service Act, which compensates doctors for such treatment.

The British Way

Obviously this setup removes the profit from black market operations in drugs. Compared to the astronomical number of arrests made in the U. S. every year involving junkies and pushers, England last year had a total of 11 addicts sent to prison for any offense whatsoever.

(Confronted with this figure, Anslinger, unmoved, said: "Eleven convictions are 11 convictions.")

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would work in the U. S. in the absence of British self-discipline; some feel we should at least try it, on the grounds that experimenting with the new and failing is preferable to adhering to a program that has consistently failed for 40 years.

It is less morality than humanity that these crusaders wish to invoke. They recognize that there can be no simple solution to so complex a problem. They realize that too little is known still about the addict and his drugs to arrive at an ideal solution.

But they have this in common: they see the addict as a troubled human being; they want to help him, not judge him. It is as simple as that.

Chief Magistrate Murtagh says:

"Some 40 years of blunders have so aggravated and complicated the situation that it is unfair to ask us for an alternative solution.

"Basically, my attitude is that we should get to the point where the British are—where the doctor is not in fear of being accused of being called a criminal if he treats the addict. We should ask ourselves whether our government approach is not sparking drug addiction instead of curing it."

'It's Worth a Trial'

Corrections Commissioner Kross, who is required to house self-committed addicts in the city jails and is performing a herculean task in trying to carry out this assignment against grotesque odds, says:

"I personally feel no individual should be sent to jail for drug addiction. I certainly don't feel self-committed addicts are criminals. I think Mr. Anslinger hasn't moved in his thinking since 1914. I think the application of the Harrison Act should be changed.

"I won't pretend I have the answer. But I believe the British system is worth a trial here. I can't vouch for the fact that it would work here. But I *can* vouch for the fact that the system we have now is *not* working here."

Sen. Javits, one of the rare politicians who is informed on drug addiction, abruptly changed his course:

"I made a speech before the Association of Attorneys General in 1956 in which I broke with the past and adopted the Nyswander thesis that drug addicts are sick people. I believe in a threefold attack.

"First, treatment facilities should be made available to these people so that they can have clinical attention.

"Second, we must have adequate research. This is so devastating an illness that we don't know how to cope with it at present.

"Third, we must have a follow-up program, which may take years. This is a very, very expensive illness.

"I advocate a strictly controlled experiment with the British plan. I don't advocate that the British system be adopted here until we try a controlled project."

The American Medical Assn., surely one of the least radical organizations in the country, recommends in the current report on drug addiction by its Council on

Major Dorothy Berry

Anonymity has its perils.

the patient uses you as his crutch. Then you can take his other crutch, the drug, away from him—that is, he reaches the point where he can give up his addiction himself with your encouragement."

All of this focuses attention on the physician, whose spirit is willing but whose flesh is too weak to oppose Anslinger's power and glory.

Dr. Nyswander, who spent a year on the staff of the U. S. Public Health Hospital at Lexington, Ky., and then moved on from there in her thinking ("I don't understand what has happened to her," said Anslinger, who is often baffled by the obvious. "She was an Anslinger man when she was at Lexington—now she thinks I have horns"), put it in blunt terms:

"Let the doctors think this through medically and decide once and for all: Is it ethical or unethical for a physician to give drugs to an addict? Once this is decided, some other things will begin to fall into place."

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