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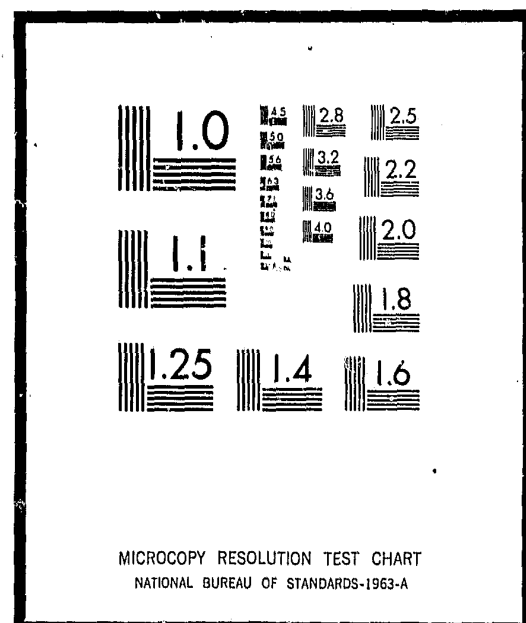

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SYNOPSES OF LECTURES AND DISCUSSIONS ON ADDICTS, ADDICTION, DRUGS AND REHABILITATION.

ABSTRACT:

MEETINGS WERE HELD AT THE RIKERS ISLAND PENITENTIARY, A FACILITY OF THE NEW YORK CITY DEPARTMENT OF CORRECTIONS. STATED PURPOSES WERE TO ENHANCE THE KNOWLEDGE OF CORRECTIONS PERSONNEL CONCERNING DRUG ADDICTION AND THE DRUG ADDICT DIRECTLY, TO IMPROVE THEIR KNOWLEDGE OF MENTAL HYGIENE PRINCIPLES AND PROCEDURES, TO FACILITATE THE DEVELOPMENT OF SENSITIVITY AMONG THE PARTICIPANTS TOWARD THEMSELVES AND THE INMATES SO THAT EACH STAFF PERSON COULD BECOME MORE EFFECTIVE IN THE MANAGEMENT AND REHABILITATION OF THE IMPRISONED OFFENDER, TO DEMONSTRATE A PROTOTYPE OF AN IN-SERVICE TRAINING PROCEDURE THAT HAD APPLICABILITY AND FEASIBILITY FOR ADOPTION AND INCORPORATION INTO ONGOING PERSONNEL PRACTICES IN ANY CORRECTIONS FACILITY, AND TO EVALUATE THE EFFECT OF THE PROGRAM ON PARTICIPATING PERSONNEL TO PROVIDE AN OBJECTIVE BASIS FOR FURTHER APPLICATION OR MODIFICATION OF THE PROCEDURES WHICH WERE THE MAJOR COMPONENT PARTS OF THE PROJECT. (AUTHOR ABSTRACT MODIFIED)

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Final Narrative Report

Staff Development and Training for Personnel Concerned with Narcotic Addicts

Grant No. 201

Conducted by

The Postgraduate Center for Mental Health

and

The New York City Department of Correction

New York, New York

Irwin B. Gould, Ph.D.
Project Director

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I. Background and Description

This project entitled Staff Development and Training for Personnel concerned with Narcotic Addicts was initiated September 20, 1967 and concluded June 19, 1968, and consisted of a total of nineteen formal meetings conducted over this period of time.[1] The location of the meetings was at the Rikers Island Penitentiary, a facility of the New York City Department of Corrections situated on an island in the East River between the boroughs of Queens and the Bronx.

A. Purpose

This project was conceived to fulfill four purposes:

1. To enhance the knowledge of corrections personnel with regard to drug addiction and the drug addict directly; and to enhance their knowledge of mental hygiene principles and procedures.

2. To facilitate the development of sensitivity among the participants toward themselves and the inmates so that each staff person would become more effective in the management and rehabilitation of the imprisoned offender.

3. To demonstrate a prototype of an in-service training procedure that would have applicability and feasibility for adoption and incorporation into ongoing personnel practices in any given corrections facility.

4. To evaluate the effect of the program on participating personnel in order to provide an objective basis for further application or modification of the various procedures which were the major component parts of the project.

1. Appendix I - Program

B. Rationale for this Project

The current status of drug addiction is one of alarming increase throughout the country. A report issued by the New York City Police Department on February 26, 1966[2] is reflective of that status. Due to existing laws, drug addiction is seen first of all as a legal offense and secondly as an illness. A consequence of this fact is the disposition of the majority of apprehended narcotics abusers to correctional facilities, whether or not the drug abuse was a primary or secondary offense. As a result our already overburdened correctional facilities are receiving an ever increasing number of narcotics users. This increase represents an additional responsibility for personnel and an additional challenge to rehabilitation efforts. While the drug addict population of our corrections facilities is increasing, the development of personnel equipped to care for them has not advanced accordingly.

This project, then, was conceived to foster higher standards for this important group of personnel through a specialized training program; it was a demonstration project to introduce new content, knowledge, techniques and approaches in working with addict offenders

The need in the field appeared to be for informed and sensitive corrections personnel who would be enabled to deal more effectively with the addict. A superficial acquaintance with the addiction syndrome is not the same as a systematically organized educational experience, which is geared to yielding a greater mental health orientation. Further, there is a need for personnel to initiate

2. Appendix II - Police Report

and implement programs that will make significant inroads on the recidivist rate of the addict population. Thus, information, education, and training were primary needs to be met, but there was yet an even more meaningful need. That need is a concern with the morale and sense of recognition that people in this field require. Because the addict is so frustrating and typically unresponsive to rehabilitative efforts, persons working with him can derive little gratification. This in turn, often leads to apathy and hostility -- counter rehabilitative attitudes. Therefore, the recognition and acknowledgement implied in formalized training could be expected to do much to mobilize the personnel's interest in working with this group.

C. Project Design

In order to implement the purposes of this Project (see Page 1) three educational modalities were utilized: Formal lectures by acknowledged leaders in the field; small group discussion and interactive experiences; and round table discussions. The lecture method, of course, is an old established traditional form of pedagogy and is designed so that an essentially active feeding lecturer supplies a varying amount of information to an essentially passive, receptive audience. In the process it is intended to enhance one's body of knowledge and can be expected to have but limited impact on one's attitudes and perceptions toward a given phenomenon. Since a major purpose of this project was to bring about positive alterations in the attitudes toward, and the perceptions of, the drug abuser, something more dynamic than just lecturing was necessary. Hence, the

small group experiences.

This modality has an impressive history in the field of clinical psychology and has developed out of the combined contributions of the fields of sociology, group dynamics and group therapy. Because of its demonstrated ability to involve the participant emotionally as well as intellectually, it has become an increasingly popular addition to the armamentarium of the educator. Although the group interaction is closely allied to clinical approaches, it is important to underline that it is not intended as a therapeutic device, but rather, when properly managed, to facilitate greater self-awareness in pre-defined areas such as specific attitude positions and ways of understanding individuals and phenomena. It is important to recognize that in order to achieve changes in attitudes and perceptions toward a given area, awareness of already existing attitudes and understandings are necessary. A given individual is going to be much more prone to change, however, if he is confronted with, and made aware of, things that are interfering with his effective functioning.

The round table procedure is actually something between the formal lecture and the small group experience which makes its own unique contribution. That contribution comes about through the phenomena of identification, role model and vicarious experience. The members of an audience viewing a round table discussion tend to see themselves in one or more of the participants, and in so doing become more involved than they would by just listening to a lecture. The audience witnesses the manner in which individuals in a group setting (the round table) interact and participate with each other under the direction of a discussion leader. In so doing, they are being exposed to models of some-

thing they will be doing. Finally, in the process of identifying with the round table members, they will have the feeling of being right there; the feeling that we call a vicarious experience. It is the sort of thing one can easily see by watching spectators at any sporting contest -- they run with the ball, get hit with the punch, and feel the sensation of pleasure as their man rounds the bases after a homer; or desolation if it is the other team.

The design then was conceived to involve the participants intellectually and emotionally and to do this in a multi-level, multi-faceted way in order to enhance knowledge, facilitate awareness, and finally to bring about attitudinal and perceptual changes within the Target Population.

D. Target Population

Personnel of the New York City Department of Corrections were recruited[3] from among members of the mental health staff, uniformed force, and volunteers plus certain interested persons from community agencies in the metropolitan area.

Following the first session this population was organized into small heterogenous groups and assigned to a group leader. The groups were organized so that there would be a uniform mix of all participant categories in each group. Thus a representative group consisted of a member of the uniformed force, ranging in rank from corrections officer to deputy warden; mental health personnel selected from among psychiatrists, social workers, psychologists; administrative and line staff from community agencies; and rehabilitation personnel including specially trained priests and ministers as well as rehabilitation coun-

3. Appendix III - Recruitment Announcement

selors. Each of these groups (ultimately there were seven) were under the direction and guidance of a skilled group leader.

There was a total of ninety-four persons registered in the project, distributed as follows:

1. Thirty-five members of the uniformed force of the Department of Corrections, ranging from Deputy Warden to Corrections Officer.

2. Twenty-one members of the Mental Health Division of the Department of Corrections consisting of psychiatrists, psychologists and psychiatric social workers.

3. Fifteen members of the Rehabilitation Division of the Department of Corrections, consisting of physicians, rehabilitation counselors, caseworkers and administrative personnel.

4. Twenty-three representatives of the following community agencies:

Department of Welfare
Westchester County Mental Health Board
New York State Department of Parole
Start
Greenwich House
Village Haven Inc.
Friendly Visitors
Salvation Army
New York City Board of Education
Volunteers

All participants were informed that they would receive a certificate[4] for their participation at the conclusion of the program. A breakdown of participating personnel as to organization affiliation, job title and average number of sessions attended will be found in the evaluation section of this report.

4. Appendix IV - Certificate

E. Faculty

All the group leaders were trained psychoanalysts who have had group therapy training as well as experience in the fields of drug addiction and correctional psychology. The project director and the group leaders comprised the permanent faculty of the project and were present at all scheduled meetings. The remainder of the faculty consisted of lecturers[5] and consultants chosen for their particular expertise.

The faculty for the project consisted of consultants, group leaders and lecturers.

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5. see APPENDIX I - PROGRAM

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This will certify that ______________________

has fulfilled the requirements of the 1967-1968 In Service Training Program in Narcotic Addiction jointly sponsored by the New York City Department of Correction and the Postgraduate Center for Mental Health and supported by the United States Department of Justice Office of Law Enforcement Assistance.

Arlene Wolberg, M.S.W.
Director
Department of Community
Services and Education

Irwin B. Gould, Ph.D.
Director
Drug Addiction Institute

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Having indicated that the responses by the participants in the program can be described as reflecting only small shifts, these changes will now be considered in more detail. It is apparent that a high degree of agreement with items reflecting an authoritarian approach might, if the assumption that these attitudes are indicative of behavior on the job, impede rehabilitative work with the addict. In this sense, an authoritarian approach would make communication with the addict more difficult. It implies a tendency toward rigidity or a closed-minded approach to issues, problems and people.

An authoritarian approach is understood to be a personally defensive one. If one places a premium on the personal relations between the staff and the addict, then the extent to which staff members need to be authoritarian in their approach, manner, behavior and belief places a wall in front of the addict. Conscious agreement with statements reflecting an authoritarian approach remains relatively small and unchanged throughout the course of the study. For those who need to hold authoritarian views, the group leaders rating from suggests some basis for their views. For some participants the addict is the embodiment of a total lack of impulse control. To them this means that he is very likely to assault or attack, take advantage and manipulate. While one can easily document the extent to which these are justified expectations from a number of addicts the point is that these tendencies of the addict become a personal threat to some participants. They feel personally threatened by these characteristics of some addicts and respond to their feelings of threat by suspecting and condemning all addicts of these tendencies. The authoritarian approach, for some participants, serves as a protection against the excessive threat which they experience in their work with addicts.

Another basis for the adherence to authoritarian beliefs among some participants in the study, suggested by the group discussion leaders, can best be described as envy of the addicts' dependent status. Comments to this effect were made quite explicitly by participants in the program. What must be inferred, however, is how this envy of the addict, of the care he receives without having to work for it, of his ability to "get away with things" relates to the utilization of an authoritarian approach by those staff members in their work with addicts. While fear of the addict or envy of the addict does not exhaust the bases for needing a protective authoritarianism in working with addicts, these were the only two underlying factors that became apparent to the group leaders. Clearly, there are probably a variety of factors that relate to authoritarian attitudes in work with addicts but the instruments need to assess these attitudes, and the time available for the group leaders to aquaint themselves with the participants in the program was too short to permit greater insight into this issue.

It was the impression of the group leaders that both authoritarian and socially restrictive attitudes were more prevalent than the direct statements and opinions offered in the group discussions would indicate. However, the opinions voiced in the group discussions paralleled the opinions expressed on the questionnaire. In both cases, there were shifts from strong agreemnt with items on the authoritarian factor to mild agreement and/or mild disagreement. At the very least one might conclude that this group recognized that such attitudes were contrary to the philosophy presented in the program, and there was thus a shift toward giving the questioner what the participant thought was expected.

It is of course possible that this shift represents a genuine change in conviction as a result of the experience of having participated in the program. To what extent this is so and to what extent the former hypothesis applies can not be determined within the scope of the present study.

A number of items on the questionnaire tapped the extent to which the respondent needs to distinguish between the addict and other people. The point is, to what extent is the continuum that addicts are like other patients, like other people and hence, like oneself, accepted. To make a dichotomy between oneself and addicts goes contrary to the belief that the differences between "healthy" people and addicts, or other people suffering from personality disorders, are differences in "degree". To insist on the dichotomy would thus indicate a barrier to understanding the plight of the addict and make it difficult to empathize with his dilemmas.

It may be that for some members of the groups, authoritarian views are confused with the necessity to provide structure and set limits in ones work with addicts. For those who through the course of the discussion groups were able to learn to make this distinction, the shift from authoritarian and socially restrictive positions may, indeed be quite genuine.

The benevolent attitude is in some ways quite similar to the authoritarian one in that there is a degree of infantilization of the addict contained in both. However, the authoritarian viewpoint would be more restrictive and punitive while the benevolent one more kindly and nuturing.

The attitude of benevolence found far wider acceptance among the group than any others. While on the surface this kindly attitude may be desirable, closer examination reveals the extent to which an infantilization and hence a depreciation of the addict is implicit. While one might argue it is better to be a kind authority than a punitive one, that is not the issue here. It must be kept in mind that the concern here is not with the extent to which the participants exercize rational authority in their work (rational authority would be neither kind nor restrictive), but to what extent certain attitudes may be conveyed by them in their work.

The slight shift toward mild disagreement with the items of the benevolence factor is, in this context, seen as a favorable shift. It is, however, a miniscule shift considering the popularity of benevolent attitudes among the participants. The tendency to view someone who is "sick" and "helpless" as a child is quite understandable but, from the standpoint of rehabilitation, to view addicts in this way, can produce difficulties. An aim, sometimes explicit, always implicit, of any rehabilitative program, is to facilitate an identification by those in the program with those who run the program. This becomes a particularly crucial factor since the attitude on the part of the addict toward addiction, toward himself, and toward the rest of society is of utmost importance. If the attitude toward the addict by those running the program contains subtle but consistent elements of contempt, or a patronizing approach, there will tend to be a rejection of the rehabilitative attempt. In turn, this inspires a response on the part of the addict which is often increased manipulativeness, contempt to counter contempt and suspicion and distrust.

The extent to which this benevolent approach has remained characteristic of a large number of the participants of the program raises a number of questions. First, it should be noted that the group leaders found it uniformly difficult to evaluate this factor through the group discussions. Thus, while items reflecting benevolence found considerable agreement among the participants, there is no data suggesting how these attitudes are manifesting themselves, specifically. Additional studies would have to be under taken to spell this out in more detail. If we assume, however, that the attitudes expressed on the questionnaire do parallel real-life behavior, then one would have to conclude that these attitudes remained essentially unaffected by the program, that they were prevalent prior to the program, and that they remained after the program. Certainly, this might be taken into

consideration in the planning of future programs.

Just as authoritarianism is often a misunderstanding of the necessity for a rational authority to impose limits and structure, benevolence is often a misunderstanding of the ideology of mental health. That such a misunderstanding existed for some of the participants in the program would, of course, have to be investigated in greater detail. A general agreement with the ideas of the mental health approach was relatively weak. Though there was a marked increase 7% in mild agreement with the items reflecting this approach, there was an almost as great a decline 5% of those expressing strong agreement with statements reflecting the mental health viewpoint over the course of the program.

The shift in response to the items reflecting the mental hygiene idiology, may reflect a degree of disenchantment or disillusionment by some of the participants with the tenets of the mental health approach. A genuine acceptance of the ideology of mental health would be within a context recognizing the complexities of the problem of drug addiction and the difficulties from a variety of sources, that are encountered in attempting a program of rehabilitation for addicts. The mental health ideology thus includes a realistic appraisal of problems and a justifiable degree of scepticism as to the possibilities for change. It may thus be suspected that for some participants in the program either mental health was interpreted as benevolence and as such was unsuccessful, leading to a feeling of disappointment. Possibly there was an unrealistically high expectation from the contributions of the mental health field, one that could only fail to be achieved. Thus, the shift from strong agreement to mild agreement may reflect either disillusionment or a less naive and a more realistic understanding of what can be expected. The shift in attitude to the statement that drug addiction is curable is a case in point. Through the course of the program there was a shift in opinion form strong agreement to mild disagreement.

While there was a decline in the opinion that drug addiction is "curable", there was an increase in the extent to which addicts are seen as motivated to change. The attitudes that addicts do want to work and that they would remain in institutions even if they were free to go, gained greater acceptance. This would reflect a degree of respect for the addict as well as some acceptance of the mental hygiene ideology. A generally greater sympathy for the plight of the addict and cognizance of his problems emerged. In turn, this increased understanding may have diminished the threat against which, it was suggested, some participants in the program must protect themselves. In turn, the less the addict is experienced as a personal threat the better that staff member can work with him, the greater the chance for his rehabilitation.

There is some further evidence that the shifts described in the direction of a more realistic acceptance of the ideology of mental health are meaningful shifts. Though the items on the factor described as interpersonal etiology are independent of those on the mental health factor, the latter is to some extent rooted in the belief that an understanding of human relations and understanding the contribution of pathological relationships are important aspects of the mental health approach. Thus, it is of interest that 6% of the group that disagreed with statements reflecting interpersonal etiology shifted to mild agreement after the program. It is here that the program might have made a most significant contribution.

VI Summary and Conclusions

This project was an exploratory effort to investigate elements of in-service training for corrections personnel that would enhance their knowledge and develop their sensitivity. It was further intended that as a result of this effort certain recommendations could be made toward developing effective in-service training programs for personnel working with narcotic addicts.

The project utilized formal lectures, round table discussions and small group experiences. The project consisted of nineteen sessions over a period of nine months. Thus meetings were held on an average of every other week. There was an initial enrollment of ninety-four persons however no more than seventy-one persons ever attended any single session. There was an average of sixty-three persons attending regularly.

It was originally planned to have ninety-six persons enrolled in order that eight groups of twelve could be formed. However, this number was never recruited, suggesting a reluctance on the part of personnel to make themselves available for this kind of training. This reluctance, in itself, is evidence for extensive needs for in-service training. One might conclude then, that the participants, rather than being representative of corrections personnel, are more likely an enlightened group.

Personnel in the project were drawn from the uniformed force, mental health and rehabilitation departments of the New York City Department of Correction. In addition, there were representatives of various community agencies.

Many points raised by the administration and evaluation of this training program deserve further emphasis. Lectures, round table discussions, and group meetings all have a place in the program, but what the optimal ratio of lecture-discussions and meetings would be is yet to be determined. From experience in other settings, it can be suggested that while the lectures are the most economical form of communication in terms of the size of the group reached, they also demand and presuppose the greatest commitment on the part of the listener. They demand that the listener already have the motivation and commitment along a particular line and needs only information to increase his ability. In this educational process the listener remains essentially passive. This is also inadequate as a model for the participants in the program. Thus, the participants can not in turn, use the "Lecture" approach in their contact with the addict. Here, too, the addict would not be drawn into the program just as the lectures do not invite the kind of participation that influences motivation and commitment to the program.

The round table discussions have some advantage over the lecture. In the discussion groups while there is still an audience of passive participants, there are at least attitudinal positions with which they can identify. In that sense there is a possibility of attitude change by identifying with an expressed position of a panel member. The discussion group thus offer a greater degree of participation potential than the straight lecture. For the population under evaluation, this is a distinct advantage. Of even greater potential advantage would be increased use of the group meetings. Of the training techniques used this promises to be the one most likely to involve the participants in an emotional way, while also providing a model

to the participants. To summarize, at this point, the question can be raised: what is the optimal combination of lectures, round-table discussions and group meetings? It may well be that for best effectiveness the initial phase of the program should consist of group meetings where attitudes may be influenced and lectures be confined to the last phase of the program. Thus, when the spirit of the population is one of openmindedness, then the informational nature of lectures may be most useful. To offer a program of lectures to an audience that may not be receptive or open to them is surely wasteful.

It need not be reiterated that an essential aspect of the program would be to maintain the attendance of the entire target population. What motivated some individuals to discontinue the program is not clear. What effect the discontinuance in the program of higher administrative and supervisory personnel has on the attendance of the rest of the group was not studied. Viewed from the standpoint of the model conveyed by such behavior the participation by the upper echelons of administration is seen as an essential aspect of the success of the program.

Of the measures used in the evaluation of the program, the group leaders ratings offer the greatest promise for studying, in detail, the diverging and converging changes that occur in the course of learning. The changes can sometimes not be observed in the more structured measures because we are interested in evaluating complex and subtle characteristics. With the information obtained through this evaluation, the attitudinal dimensions can be spelled out in more detail, While there was general anti-authoritarian sentiment expressed, a benevolent authoritarianism remained. The subtler, more

covert, more insiduous, authoritarian attitudes were not adequately tapped by the structured tests but did begin to emerge in the group discussions. Hence they could be included in the group leaders rating scales. An important correlary to these scales would be reports of the actual work of the participants in the program. Work sample reports were not available for the current evaluation. Developing such reports for inclusion in any future program is seen as essential.

In future evaluative work, the group leaders rating scale can be revised to increase its sensitivity to some of the more subtle attitudinal manifestations and changes. That, however, does not account for the similarities between the initial and the post program measures. It is most likely that the program was insufficient in length and consisted of too few sessions spaced too far apart to influence the attitudes of the participants substantially. The reports of the group leaders about the decrease in defensiveness of some participants in the program are very much to the point. How many participants kept up their guard and were still buttressed against this program while giving lip service to the principles of mental health? Unless such a question can be answered any evaluation of a program can only serve a limited value. To answer such a question, every attempt to hold the entire target population must be made, criticisms and evaluations should be made an integral part of the program. Such a program, too, must offer sufficient time to permit a discussion of views and a gradual decrease in guardedness by all participants capable of doing so.

At this point a summary of the major or significant findings reported in this evaluation may be in order.

1. The participants shifted from strong agreement with authoritarian views to mild agreement.

   a. Addicts tended to be seen, at the close of the program, as human beings, deemphasizing the differences between them and other people.

   b. The extent to which the addict was seen as a danger or threat to the participants in the program diminished.

   c. There was some suggestive evidence that the authoritarian attitudes were rooted in a feeling of envy, held by participants in the program, toward the addict who is so well taken care of without having to work for it.

2. Both before and after the program there was strong disagreement with socially restrictive approach toward the problems of addiction.. However, the group leaders ratings indicated this factor played a much larger and more subtle role than the responses to the questionnaires.

3. The benevolent approach to the addict was most pervasive at the outset and remained essentially unchanged at the conclusion. It was expressed by viewing the addict as a "naughty child".

4. There was an increased awareness of the complexity of the causes of addiction with special cognizance of the role played by interpersonal or familial relationships.

5. There was a general shift, over the course of the program, toward mild agreement with the mental hygiene approach to the problems of addiction. There was an increasing awareness of sensitivity to the character of the drug addict.

   a. After the program, the addict was seen as more labile, conflicted and self destructive.

   b. After the program the addict was seen as more conscientious and motivated to seek help.

6. It should be an integral part of future training programs to make every effort to hold the entire target population.

The shift in attitudes summarized above indicate what can be accomplished in a small scale program. The indications are that these modest shifts in attitude are not superficial or artificial. They are the beginning of a process of change. These findings justify further attempts in this direction, but only if the approach is intensive and incorporates what has been learned from this evaluation.

APPENDIX I

The 1967-1968 In-service Training Program

for

The New York City Department of Corrections Personnel
in the Field of Narcotics Addiction

Sponsoring Agencies: United States Department of Justice, Office of Law Enforcement Assistance

New York City Department of Corrections

Postgraduate Center for Mental Health, Department of Community Services and Education

Project Director: Irwin B. Gould, PhD.
Director
Drug Addiction Institute, Postgraduate Center for Mental Health

THE COMMUNITY AND NARCOTICS ADDICTION

September 20, 1967
Lecture 1 - Hon. George F. McGrath, Commissioner of Correction, New York City Department of Correction, Lewis R. Wolberg, M.D., Medical Director, Dean, Postgraduate Center for Mental Health, Irwin B. Gould, Ph.D., Director of Drug Addiction Institute, Postgraduate Center for Mental Health:

Introduction, Orientation, Testing and Organization of Discussion Groups.
Distribution of Bibliography.

September 27, 1967
Lecture 2 - Efrem Ramirez, M.D., New York City Narcotics Coordinator:

The Experience of the Office of the Narcotics Coordinator to date.

October 18, 1967
Lecture 3 - Irving Lang, Counsel, State of New York, Narcotic Addiction Control Commission:

The Current Status of the New York State Narcotics Commission.

November 1, 1967
Lecture 4 - Harvey Bluestone, M.D., Past Director of Psychiatry, New York City Community Mental Health Board:

Community Efforts and Their Effect on Addiction.

November 15, 1967
Lecture 5 - Edward Preble, Associate Professor of Anthropology, New York School of Psychiatry:

The Addict in the Street.

LAW ENFORCEMENT AND THE ADDICT

November 29, 1967
Lecture 6 - Ira Bluth, Deputy Chief Inspector, Narcotics Bureau:

The Policeman's Experience with Addiction.

December 13, 1967
Lecture 7 - Arthur Markewich, Justice, Supreme Court of the State of New York:

The Courts and the Narcotics Addict.

January 10, 1968
Lecture 8 - Irwin B. Gould, Ph.D., and Corrections Officers in:

A Round Table Discussion of the Corrections Officers' Experience with the Addict.

January 24, 1968
Lecture 9 - Irwin B. Gould, Ph.D., Corrections Officers and Mental Health Staff in:

A Round Table Discussion.

February 7, 1968
Lecture 10 - Bertram Barall, M.D., Chief of Service, Mental Hygiene Unit, Division of Parole, State of New York:

The Addict and Parole.

THEORETICAL ASPECTS OF NARCOTICS ADDICTION

February 28, 1968
Lecture 11 - Charles Winick, Ph.D., Director of Research of the American Social Health:

Some Theoretical Considerations Relevant to Narcotics Addiction.

March 13, 1968
Lecture 12 - Lewis R. Wolberg, M.D.:

Dynamics of the Anti-Social Personality.

March 27, 1968
Lecture 13 - David Laskowitz, Ph.D., Director Drug Service, Mental Health Division, Lincoln Hospital:

The Use and Abuse of LSD; and the Use of Methadone and Cyclazozine in Rehabilitation Approaches to Narcotics Addiction.

April 24, 1968
Lecture 14 - Emanuel K. Schwartz, Ph.D., D.S.Sc., Dean of Training, Postgraduate Center for Mental Health:

Group Counseling with Impulse Disorders.

May 8, 1968
Lecture 15 - Mr. Issac Youcha, M.S.W., Lecturer, Postgraduate Center for Mental Health:

Family Dynamics of the Narcotics Addict.

REHABILITATION OF THE NARCOTICS ADDICT

May 22, 1968
Lecture 16 - Murray Bilmes, Ph.D., Associate Professor, New York School of Psychiatry:

Individual Treatment of the Addict.

June 5, 1968
Lecture 17 - Mrs. Margaret Eddy, Moderator, Reverend Loencia Rosado, Reverend Lynn L. Hageman, Father W.L. Damien Pitcaithly:

Religion's Role in the Rehabilitation of the Addict.

June 12, 1968
Lecture 18 - Stanley L. Portnow, M.D., Director of Psychiatry, New York City Community Mental Health Board:

Psychiatry, The Law and Drug Addiction.

June 19, 1968
Lecture 19 - Irwin B. Gould, Ph.D.:

Summary, Evaluation and Conclusions.

APPENDIX III

RECRUITMENT ANNOUNCEMENT

TO: Professional and Custodial Personnel

SUBJECT: A PROFESSIONAL AND EDUCATIONAL OPPORTUNITY

Beginning September 20, 1967 the second annual Drug Addiction Institute will be initiated under the direction of the Post-graduate Center for Mental Health and with the co-sponsorship of the New York City Department of Corrections and the United States Department of Justice.

The Institute for 1967-1968 will place on Rikers Island from 1:30 to 3:00 P.M. and run for twenty sessions concluding on June 26, 1968. The Institute will be greatly enlarged in its scope and opportunity covering the areas of:

1. The Community and the Addict
2. Law Enforcement and the Addict
3. Theoretical Issues in the Rehabilitation of the Addict
4. Technical and Practical Issues in the Rehabilitation of the Addict

An important addition to the format will be the formation of small study and discussion groups under the direction of a skilled professional leader for purposes of affording you an opportunity to integrate the content of the lecture and discuss your day to day work problems in managing and servicing inmates.

APPENDIX II

POLICE REPORT

In a report issued by the Police Department of the City of New York on February 26, 1966 on arrested narcotic users, the following is stated:

> Narcotic users comprised 9.2 per cent, or 18,668 of the 203,303 persons arrested in New York City in 1965 as compared to 9.1 per cent, or 19,091 of the 208,844 arrests in 1964. The study was based on admissions of narcotic users made on arrest.
>
> Police arrested 3,862 persons for felony violations of the narcotics laws in 1965 as compared to 3,375 in 1964, an increase or 14.4 per cent. These violations included the sale of narcotics and drugs and the possession of quantities sufficient to carry the presumption of intent to sell.
>
> The number of youngsters using drugs has also increased. One hundred juveniles (under 16 years of age) taken into custody for criminal offenses last year were admitted narcotic users. In 1964 there were 63 such admitted narcotic users among juveniles.
>
> Narcotic users represented 11.6 per cent -- 6,348 of 54,868 felony arrests; 44.7 per cent -- 8,004 of 17,888 arrests for serious misdemeanors and offenses; 3.7 per cent -- 4.124 of 112,137 persons arrested for other misdemeanors and offenses; and one per cent -- 192 of 18,410 persons held for other authorities by the New York City Police Department.
>
> There were 32 homicides attributed to narcotic users last year. Multiple arrests were made in some cases. Twenty-three resulted from altercations over narcotics.

In order for you to obtain maximum benefits from the Institute it will be necessary to attend all sessions. Therefore, we are circulating this memorandum in order to give you an early opportunity to enroll. Since the number we can include is limited to eighty people, enrollemnt will be on a first come first serve basis.

A Certificate will be issued at the conclusion of the Institute by the Postgraduate Center to all those who have attended and will be duly noted in your Personnel Record.

Registration can be arranged by contacting_______________. Do it right away -- we cannot wait for the last minute to make arrangements for you.

a particular example, comment, vignette or description of a group interaction. It was anticipated that this information would broaden the understanding of the ratings and make changes in attitude more clear. The Group Leaders' Rating Scale is included in the Appendix.[1]

c. The Dynamics of Drug Addiction Scale

The items of the Dynamics of Drug Addiction Scale[2] were culled from the literature on drug addiction as well as from popular beliefs or misconceptions about addicts. The items were also reworded to make them applicable to the population of this program since, originally the items were designed for use with psychologists, psychiatrists and social workers and hence included professional terminology.

The scale, in its reworded form is included in the appendix.[3] The respondents were asked to indicate for each statement, whether in their opinion, the statement applied to 25%, 50%, 75%, or 99% of the populations of drug addicts. This scale was initially developed to study the degree of agreement among treating personnel in reference to the dynamics of a population of drug addicts and to study the similarities and differences among these disciplines in reference to their overall impressions of the drug addict population. In the current contex, the scale is to serve as a vehicle for assessing the entire group's overall impression of the addict population to be compared with their impression of addicts after the inservice training program.

1. Appendix VI
2. Gould, I., The Dynamics of Drug Addiction: A Comparison of treatment staff impressions with those in the Literature Mimeo.
3. Appendix VII

Here ends the descriptive summary of the five factors, paraphrased from the Cohen and Struening reference. The authoritarian and social restrictive factor exemplify punitive approaches. Benevolence contains a degree of authoritarianism in a paternalistic sense. This raises a psychological rather than a physical wall between staff and addict. The factors of mental hygiene, ideology and interpersonal etiology are relevant not because they are presented as the old approach to the addict but because they embody an attitude essential in any approach.

d. Treatment of the Information Gathered

The Opinion Questionnaire

The responses to the opinion questionnaire, were tallied for each factor. There, within each factor the totals for strong and mild agreement and strong and mild disagreement were converted into percentage scores. These percentages then reflect the segment of the group that shares the attitudes described by the factor table. The calculations were performed for the D - group and for the P - group both at the start and at the close of the program. Percentages are used since they make group comparisons clearer and since the number of items comprising each of the factors differs.

The attempt will be made to specify the kind and direction of attitude changes occurring concurrent with the training program by noting what percentage of the group shifted its attitudes and toward which direction.

The Group Leaders Ratings

The judgements of the group leaders will be combined for each factor in a manner similar to the attitude scale. The number of people who may be characterized as possessing a particular attitude will again be converted into a percentage of the total group as described above. The attempt will be made to specify the kind and direction of attitude changes occurring concurrently with the training program by noting what percentage of the group shifted its attitudes and in what direction.

The Dynamic of Drug Addiction Scale

The items of the Dynamics of Drug Addiction Scale will be divided into two groups - those which at the start of the program were said by at least 66% of the respondents to be descriptive of more than 50% of the addict population and those items said by at least 66% of the respondents to be descriptive of half the addict population or less. These percentage cut-offs were used by Gould in his initial work on the scale. A picture of the addict as he is seen at the start of the training program can then be contrasted with the picture that emerges from the responses to this scale at the close of the program.

Tabulation of Results

The percentages of the D - group sharing each attitudinal factor are presented in Table XI. For each factor the percentage of the group agreeing strongly or mildly or disagreeing strongly or mildly with the items of that scale are listed.

The percentages of the P - group sharing each attitudinal factor before and after the training program are presented in Table XII. For each factor, the percentages of the group agreeing strongly or mildly or disagreeing strongly or mildly with the items of that scale both before and after the program, are listed.

The evaluation by the group leaders are summarized in Table XIII. The percentages of the P - group judged by the group leader is showing evidence of the presence of each of the attitudinal factors are presented. These ratings were made after the fifth meeting and at the close of the study.

Those items of the Dynamics of Drug Addiction Scale which more than 66% of the P - group indicated to be descriptive of the majority of addicts, are listed in Table XIV. The items describing 50% or fewer of the drug addict population as indicated by 66% or more of those responding are listed in Table XV. There were some items which evoked a 66% or more agreement after the program. Both the items describing more than 50% of the population after the program but not before and the item describing 50% or less of the addict population, after the program but not before, according to the respondents, are presented in Table XVI.

TABLE X

Various Intensities of Each Attitudinal Factor for D - Group

	Attitude Intensity			
Factor	Strongly Disagree	Disagree Mildly	Agree Mildly	Strongly Agree
Authoritarianism	46%	30%	12%	12%
Social Restrictiveness	50%	30%	19%	1%
Benevolence	38%	16%	19%	27%
Mental Hygiene Ideology	21%	22%	27%	30%
Interpersonal Etiology	16%	28%	37%	19%

TABLE XII

Summary of Evaluations by Group Leaders

Factor	After Fifth Meeting				At Close of Program			
	Strongly Disagree	Disagree Mildly	Agree Mildly	Strongly Agree	Strongly Disagree	Disagree Mildly	Agree Mildly	Strongly Agree
Authoritarianism	33%	30%	21%	16%	31%	41%	23%	5%
Social Restrictiveness	35%	25%	25%	15%	30%	38%	27%	5%
Benevolence	20%	32%	38%	10%	10%	41%	41%	8%
Mental Hygiene Ideology	3%	31%	43%	23%	7%	30%	43%	20%
Interpersonal Etiology	6%	23%	41%	30%	6%	10%	68%	16%

TABLE XI

Various Intensities of Each Attitudinal Factor for P - Group Initially and at Close of Training Program.

Factor	Initial Test				Re-Test			
	Strongly Disagree	Disagree Mildly	Agree Mildly	Strongly Agree	Strongly Disagree	Disagree Mildly	Agree Mildly	Strongly Agree
Authoritarianism	50%	19%	17%	14%	50%	22%	18%	10%
Social Restrictiveness	52%	28%	13%	7%	52%	30%	12%	6%
Benevolence	6%	11%	25%	58%	7%	13%	24%	56%
Mental Hygiene Ideology	19%	24%	28%	29%	18%	23%	35%	24%
Interpersonal Etiology	19%	23%	34%	24%	16%	20%	40%	24%

TABLE XIII

Items Describing more than 50% of the Population of Drug Addicts as indicated by 66% or more of those responding on the Initial Administration of the Dynamics of Drug Addiction Scale.

Item	Percent of P - Group Initial Administration	Retest
3. Addicts generally show extreme ups and downs in their moods	66%	85%
8. "Clean" addicts return to addiction because they are sent back to their original environment.	73%	64%
10. Drug addicts can not put up with the ordinary tensions, pains or frustrations of life.	91%	91%
11. The drug addicts personality can be described as follows: He sees the world pretty much as it really is but disregards this in that he must have whatever he wants whenever he wants it regardless of the rights of others. Finally, he feels no pangs of conscience about his opposition to society.	66%	60%
15. Beneath it all, most addicts have an inferiority complex.	82%	82%
17. Though an addict may feel torn apart, inside, he refuses to face this and behaves in a, to him, gratifying but actually, self, destructive way.	82%	94%
18. The drug addict's idea of right and wrong goes against what the rest of society thinks is right and wrong.	73%	61%
19. For the most part, addicts come from homes in which love and affection and respect are absent.	66%	60%
22. Addicts commit crimes, steal and push, to get money to support their habit.	94%	94%

TABLE XIV

Items Describing more than 50% of the Population of Drug Addicts as indicated by 66% or more of those responding on the Retest of the Dynamics of Drug Addiction Scale.

Item	Percentage of P - Group Initial Administration	Retest
1. It is the kind of person you are, not so much the chemical effect of the drug, that determines whether or not you become addicted to a drug.	61%	76%
12. Generally speaking, drug addicts more closely resemble severely disturbed people than reasonably normal ones.	60%	69%
14. Addicts tend to call each other by nicknames.	64%	79%

Items Describing 50% or less of the Population of Drug Addicts as indicated by 66% or more of those responding on the Retest of the Dynamics of Drug Addiction Scale.

Item	Percentage of P - Group Initial Administration	Retest
24. An ex-addict will revert to addiction even if he does not return to his old environment.	64%	66%

4. Discussion of Results

Attitudes of the D - Group

Responses of the D - group to the Attitude Scale, indicate that 24% of the group agreed with the items reflecting an authoritarian attitude while 76% disagreed. The fact that this was divided 46% and 30% between strong and mild disagreement as compared with 50% and 19% for the P - group suggests slightly less disagreement with authoritarian items among members of the D - group.

For the factor of social restrictiveness, the findings are slightly reversed. In both the D - group and the P - group 20% agreed with items reflecting such attitudes. However, for the P - group the percentage agreeing strongly was 7% while for the D - group it was only 1%.

The most substantial differences between the groups are noted on the benevolence factor. While 83% of the P - group agreed with these items only 46% of the D - group expressed agreement. Similarly, 6% of the P - group disagreed strongly with the items but 38% of the D - group expressed this view. Taken in conjunction with the attitudes expressed on the authoritarian and social restrictiveness scale, the authoritarian attitudes of the D - group seem to emphasize less the restrictive factor found in the P - group.

The responses of the two groups to the items of the factor labeled mental hygiene ideology and interpersonal etiology are almost identical. For both factors, a wide range of intensity is noted among the respondents of both groups suggesting that the degree of committment toward a mental health approach is about equal.

a. The Evaluation of the P - Group by the Group Leaders

The summary of the group Leaders' evaluation (Table XIII) must be viewed with considerable caution. An inspection of this table reveals that authoritarian attitudes and social restrictiveness is more characteristic of

the P - group than their responses to the attitude questionnaire indicate. How deceptive this is became apparent when the individual ratings are examined. In some groups, as the group members felt more comfortable, more trusting, and hence less defensive, they began to voice some of their ideas and among them, authoriarian views, more openly. While such "confessions" may be in the interest of diminishing the authoritarianism in the long run, they also result in an increase in rating of authoritarianism on the scale. While this was not true of all groups, the presence of members in two groups who followed this path, diminshes the meaning of these summary scores.

In general, though, the group leaders felt that the attitudes of the group members shifted toward less social restrictiveness (from 40% agreeing to 32% agreeing). The benevolence factor remained the same while the belief in the ideology of mental hygiene and an interpersonal etiology tended to increase. The evaluations of the group leaders will be discussed in more detail in conjunction with the groups' reponses to the attitude questionnaire.

b. The Dynamics of Drug Addiction

The information presented in Tables XIV, XV and XVI can be combined into a comosite description of the addict population by the P - group. In general, items attributing drug addiction to any one factor decreased over the course of the program in terms of the percentage of the group marking them descriptive of the majority of the addict population. While still held as descriptive of a large proportion of addicts, environmental forces (item 19), social factors (item 21) and familial influences (item 8) were given less weight after the program than before. However, psychological influences (item 1) were seen in increasing importance while the possibility of the addict having a hereditary weakness (item 12) also gained some support.

Further comparisons of the first questionnaire on dynamics with its final administration indicates an increasing awareness or sensitivity to the character of the addict. He is seen as conscienceness at the start but not so at the end (items 11, 18). Concurrent with this is an increased awareness of the lability (item 3), conflicted and self-destructive aspects of the addicts life (item 17). In line with this, the addict tends to be seen as more motivated to seek help (item 7). Subsequent to the program a larger percentage of the group saw the addict as a disturbed person. (item 12). Before as after the training program, the addict remained as someone who is viewed as having deep seated feelings of inferiority (item 15), and inability to face the world (item 10) and driven to crime by his need for drugs (item 22).

c. Opinions About Addiction

The responses to the attitude scale before and after the training program will now be considered in more detail. A summary of the percentages of the P - group sharing each intensity of each of the five attitudinal factors is found in Table XII. These percentages are noted for both the initial responses of the group and the retesting at the close of the program.

Inspection of this data shows that shifts in attitudes were remarkably small, when one compares the size of the group holding a particular attitude before and after the training program. Thus, while the responses to the attitude scale do not yield to a formal statistical analysis, the changes noted being too subtle to register as statistically significant, interesting trends are noted and these will be discussed in detail. Furthermore, as was mentioned earlier, inasmuch as the group leaders made pre and post program evaluations along these same attitudinal dimensions, these evaluations will be considered in conjunction with the attitude scale.

1. Authoritarianism

At the start of the program, strong agreement with items reflecting an authoritarian viewpoint was noted in 14% of the respondents, mild agreement in 17%, while 19% expressed mild disagreement and 50% of the respondents expressed strong disagreement. At the close of the program, only 10% of the group expressed strong agreement with the authoritarian statements, 18% expressed mild agreement, and 22% expressed mild disagreement. 50% of the participants still expressed strong disagreement. With authoritarian attitudes expressed by only 31% of the group at the start, a substantial shift in attitudes along this factor would be unlikely. Yet, these data do suggest that there was a slight shift by those holding authoritarian views strongly to a milder, perhaps more moderate adherence of these attitudes.

The bulk of the items comprising the authoritarian factor failed to discriminate along this dimension within the group. Most of the items elicited mild or strong disagreement already before the program. Selecting an item from the authoritarian factor might exemplify this. Item #28 states: The best way to handle drug addicts in hospitals is to keep them behind locked doors. At the start of the program, 80% of the participants disagreed with this statement.

Inspection of the items of the authoritarian factors reveals that six statements, number 7, 11, 18, 37, 40, and 41 reflect the most change when one compares the percentage of the group agreeing and disagreeing with each item before and after the program.

These items reflect two rather important and related issues. First, they tap the extent to which the respondent needs to emphasize the differences between addicts and other people or "normal" people, and second, they tap the extent to which addicts are seen as human beings. The following shifts

in responses support this. A trend from strong agreement to mild agreement was noted in the responses to item 11: "there is something about addicts that makes it easy to tell them from normal people". This shift is supported by a trend toward disagreement with item #18: "A heart patient has just one thing wrong with him, while a drug addict is completely different from other patients". Disagreement with the viewpoint that addicts "are no longer really human", increased over the course of the study. This paralleled a change toward agreement with the opinion that a person from any walk of life can become an addict. Finally, the extent to which these trends are part of a subtle but meaningful change is given further support by the change in attitude as to the extent to which it is dangerous to relax ones vigil when working with addicts. The extent to which addicts are seen as a danger or threat to the participants in the program seems to have diminished.

Authoritarian attitudes and behavior seemed to have been more readily manifested in the group discussions than on the questionnaire. In some of the groups as has been indicated, authoritarian ideas and behavior were noted more blatently as the program progressed; in other group , evidence for it seemed to diminish. While it may be difficult to draw any conclusions from this, the changes noted suggest that the group leaders were able to note varied evidence for the presence of this trait and note some basis for it. Authoritarian attitudes were suspected when a group member expressed a need to be part of an authoritarian structure over the addicts with a punitive approach. Such an approach was rationalized as fulfilling a public service. Authoritarian attitudes were also noted in conjunction with an envy by some of the participants in the program of the addicts' dependent position. The notion was expressed that adicts are taken care of and do not have to work while decent people must work for a living. Authoritarian styles of behavior

were noted in that certain group members became rather monopolitistic vis-avis the discussion group or became excessively fearful of voicing opinions contrary to what the "authorities" espoused.

Several of the group leaders suspected, in their second evaluation, that much lip-service was given to disagreement with the authoritarian viewpoint. Judging from the behavior of the participant in the group discussion and utilizing intuitive, inferrential or vaguer impressionistic cues, authoritarian attitudes were noted by the group leaders in behavior in the group discussion meetings.

2. Social Restrictiveness

Items reflecting a socially restrictive approach to the problems of drug addiction found strong agreement among only 7% of the participants at the start of the study. This dropped to 6% at the end of the program. At the start, 13% agreed mildly with these items compared to 12% at the close. 52% remained in strong disagreement with items reflecting this approach while the number of those in mild disagreement increased from 28% to 30% over the course of the program. While, essentially, this reflects a remarkable consistency on the part of the respondents, a slight shift in attitude is hereby noted.

On both the pre and post program questionnaires, there was a high degree of disagreement with the items expressing socially restrictive attitudes towards drug addicts. The percentage of disagreement shifted only from 80 to 82%. Disagreement with such items as #34. "The law should allow a woman to divorce her husband as soon as he has been confined to an addict treatment facility" was almost unanimous before and after the program.

On the group discussions, the group leaders noted that when opinions in support of greater social restriction of addicts were voiced, they were usually coupled with the belief that a more punitive approach toward addicts

would decrease addiction as a problem. These ideas were expressed by those who criticized the tendency of the courts to place addicts on probation or to suspend their sentences too readily. One participant expressed the belief that in states where there are heavy penalties for drug sale and use there is no addiction. By and large, however, over the course of the program, the view was expressed that the task of rehabilitation would be made easier if society were less restrictive; if society would be more willing to open its doors to the rehabilitated returning ex-addict. Throughout the year then, the group leaders noted a consistent tendency toward disagreement with the socially restrictive approach.

3. Benevolence

At the start of the program, 6% of the group disagreed strongly and 11% of the group disagreed mildly with items reflecting an attitude of benevolence. At the close of the program, the figures were 7% and 13% respectively. At the start of the program strong agreement with these statements was expressed by 58% of the group with 25% indicating mild agreement. At the close of the program there figures were 56% and 24%. Thus, again the responses to the questionnaire items reflecting the "Benevolent" attitude toward addicts remained remarkably stable over the course of the program. The group disagreeing with the items increased slightly from 17% to 20%. Most frequently, benevolent attitudes were expressed in the group discussions in the context of viewing the addict as a "naughty child" in need of discipline from a kindly authority. As one participant put it, "I was spanked as a child when I did something wrong. This is what the addict needs."

4. Interpersonal Etiology

Strong agreement with items reflecting the notion that drug addiction grows out of complex social environmental and familial prablems was expressed by 24% of the participants at the start of the program.. Mild agreement was

noted among 34% while 19% expressed strong disagreement and 23% mild disagreement. At the close of the study 24% still were in strong agreement while the group expressing mild agreement increased to 40%. Strong disagreement and mild disagreement was expressed by 16% and 20% respectively. The shift toward mild agreement of these items is one of the larger opinion changes recorded in the study. The shift 58% to 64% agreeing with items that reflect this approach suggests a growing awareness of the complexity of the factors that cause addiction and a concomitantly more sympathetic view of the addict. Increasing disagreement with an item such as #13 "People who are successful in their work seldom become drug addicts" might be a reflection of the increased sophistication of the group. The causes of addiction are seen as complex, intricate and subtle.

5. Mental Hygiene Ideology

At the start of the program agreement with the ideology of the mental health field was expressed strongly by 29% and mildly by 28% of the participants. Strong disagreement were noted 19% while 24% disagreed mildly. At the close of the program 24% expressed strong agreement with items reflecting the mental health approach and 35% expressed mild agreement. Disagreement was expressed strongly by 23% and mildly by 18%.

Throughout the course of the program a shift seemed to have occurred away from strong agreement and away from disagreement toward mild agreement. This change reflecting about 7% of the group is the largest shift in attitude noted on the questionnaire.

A number of items here tap the extent to which drug addiction is seen as an illness, like any other illness. The trend for this item is primarily from a strong agreement with this view toward a more moderate agreement. Perhaps this indicates a cognizance of the uniqueness of drug addiction in

the context of it being viewed as an illness.

Of special interest are the changes in responses to three other items in this category. Over the course of the program there was a marked shift in the attitude as to whether addicts are willing to work. At the start there was mild disagreement with the statement #12 "most addicts are willing to work". The subsequent testing resulted in a shift to either mild or strong agreement with that statement. There was a further shift toward the belief that addicts would remain in an institution even if its doors are open. One rather curious shift occurred in response to item 17: "More tax money should be spent on the care and treatment of people with drug addiction". Strong agreement was evoked at the start of the program but mild disagreement at the close.

As with all the other factors, a wide variety of views were expressed within the group discussions. While in one group there were those who tended to voice strong agreement with the tenets of the mental health approach and with the idea that better self-understanding can help understanding of the addict. In other groups only lip-service was given to this approach. The disbelief with this approach and a greater concern with rules and regulations than with people was noted. While in one group the idea that addicts are like prisoners was expressed quite directly, in another group the limitations of the prison approach and an openmindedness to various approaches toward drug addiction was expressed.

6. Miscellaneous Items

A number of items which are not included in any of the five factors were included in the questionnaire as well. Those items reflecting shifts of interest will now be discussed.

Three items were included which tap the extent to which the respondent

is sensitive to the feelings of others as well as to his own feelings. To item #5: "If people took more interest in one another we would have no drug addiction", the responses shifted from strong disagreement to agreement. The responses to item #59: "It may be difficult to tell for sure, but probably most drug addicts are suffering in ways that most healthy persons know little about", shifted from strong agreement to mild agreement. The responses to yet another item #63 reflect a decreasing reluctance toward acceptance of psychiatric help by the respondent. Finally, the responses change to item #68 "Drug Addiction may be mild or severe and is very often curable" is of interest. The shift here is from strong agreement to mild disagreement.

V. Discussion

It was the purpose of this training program to enhance the knowledge and increase the sensitivity of the target population. It is of importance then who remains in the program after its inception and who drops out. It is obviously advantageous for a training program of this type to reach and hold as large a group as possible. Who remained and who dropped out of the program became an issue of immediate interest. The bulk of this discussion will concentrate on the group that participated in the program but some findings about the group that discontinued are of interest.

It is safe to conclude that those who dropped out of the program in its initial phase did so for a variety of motives. They were quite similar to their brothers who remained in the program in a number of ways. Their average age was similar and they were not found predominantly in any one agency or vocation. They came from each of the various departments or disciplines also represented in the large remaining group. Their general experience with the Department of Correction or an agency equalled, in time, the experience of the participating group but those who discontinued had spent on the average, half the amount of time in work with addicts compared to that of the group that remained.

Descriptively, the D - group semed to be slightly less authoritarian and less inclined toward a socially restrictive view of the addict. They also found less in sympathy with the items of the benevolence scale than the P - group members. A further finding is that the two groups do not differ in terms of their commitment to a mental health ideology and a belief in the importance of an interpersonal factor in understanding drug addiction. The D - group thus seems to be on the one hand less experienced in work with

addicts, but also slightly less authoritarian in its view of the problems of addiction. At the same time, they are less cooperative in a program that is geared toward a philosophy quite similar to theirs. This failure to cooperate is seen primarily in their discontinuing the program. It may also be noted in the sizeable number that either neglected to, refused to, or failed to, fill in the responses to the two items concerning work experience included on one of the questionnaires. This behavioral data does make the responses of the D - group to the attitude questionnaire somewhat suspect. This group may also be guilty of paying lip service to attitudes in the belief that this is what is wanted. The observations in this regard by the group leaders may well apply to this group too.

These findings point up the importance of reaching those who discontinued in the program. Had this group expressed more extreme authoritarian or restrictive views, their discontinuing would be more understandable. It would then become an issue for study and disposition in terms of the relationship of such attitudes to work performance. Under the present circumstances it is more likely that on the surface there is great reluctance to identify with authoritarian viewpoints but that in the course of the group discussions such view points are sired, discussed, and, in that sense, available for change.

Those in the D - group, of course can not avail themselves of this opportunity. The danger is that while there is a denial of authoritarianism on the surface, it can still gain expression in work attitudes as it did in the group discussions of the P - group. In the absence of any other data on the D - group little more can be said about them. The fact that almost one third of the target population discontinued very early in the training

program warrants study. They dropped out too soon for it to be realistically related to dissatisfaction with the program. Judging from the group leaders' observations, this D - group may symbolize an attitude of distance - maintenance that characterizes other staff members to a lesser degree. Such attitudes can certainly challenge the success of attempts toward rehabilitation of the addict.

The findings with regard to the P - group will now be considered. Most obvious is the consistency with which the participants of the program responded. Whatever shifts have been described and are to be discussed, are small. The consistency of the responses attests to the reliability of the questionnaires. In spite of an attempt via the program to influence and change attitudes, the beliefs that participants held prior to the program were still by and large expressed by them after the program. It may be inferred from this that the attitudes measured by the scale represent generally firmly entrenched views probably rather deeply embedded in the personality of the respondent. At least they are held more tenaciously than a relatively short-term educational program can affect in a meaningful manner.

It must also be borne in mind that already at the start of the program a large number of participants expressed agreement with attitudes which were consistent with the direction and goals of the program. In that sense this was a highly selected group which, therefore, could not have changed much. The question must of course be raised as to the extent to which expressing attitudes to a questionnaire is indicative of the behavior of the respondent. This is a most complex issue and will be taken up in more detail in the course of this discussion. Certainly, unless attitude change is also reflected through performance of ones work, its study is of dubiou[illegible] [illegible]lue.

II. THE LECTURES - SYNOPSES AND DISCUSSION

This section of the Report will attempt to integrate, comment and elaborate on the content of the various lectures presented during the course of the Project. No effort will be made to present the lectures in their entirety because of their length, overlapping and necessary repetitiousness.

The lectures were designed to present, in an organized fashion, a reasonably comprehensive picture of the status of narcotics addiction today in relation to the community, law enforcement, and with respect to theory and rehabilitation techniques. This section, then will attempt to distill the essence of the lecture material and coordinate the efforts and products of all the speakers who contributed.

The lectures were presented under four topical areas:

A. The Community and Narcotics Addiction

B. Law Enforcement and the Addict

C. Theoretical Aspects of Narcotics Addiction

D. Rehabilitation of the Narcotics Addict

A. The Community and Narcotics Addiction

Dr. Efren Ramirez, the Coordinator of Addiction Services in New York City, was the first speaker. Dr. Ramirez's program represents New York City's most organized effort in the field of rehabilitation for the narcotics addict. One large segment of his program operates within the Rikers Island Penitentiary and, as such represents a genuine effort to combine Rehabilitation with Corrections -- an accommodation that many in the field feel is impossible. Dr. Bluestone, for example, was pessimistic about

such programs. Mr. Lang, the counsel for the New York State Narcotic Addiction Control Commission, was quite related in his remarks to the presentations of Drs. Ramirez and Bluestone. The fourth speaker, Mr. Preble, an anthropologist, was not so much concerned with formal treatment, legislation or program development, as he was with the addict in the street, and the interaction between him (the addict) and the community.

1. The Addict in the Street

Mr. Preble is presented first because he offered a picture of the addict, the street addict, in relation to his community. Mr. Preble makes a major differentiation among addicts as a function of their socio-economic status -- the class to which they belong. He points to the "ghetto" addict as the community problem in the drug addiction field and he suggests that this "type" is the target of all the legislation and programming to which the three other speakers addresses themselves.[6] In concert with Dr. Bluestone, Mr. Preble pointed out that the more affluent addict is not a community problem as is the less affluent person -- not because his illness is different -- but because he steals and preys on property. The point being that if he weren't such a "pain in the neck" to the community, the community probably would not be so concerned about him. He described the now familiar picture of the harried parasitic "junky" who steals, lies, cheats, prostitutes, and in general engages in anti-social behavior to sustain his habit. However, the most important aspect of his presentation revolved around the interplay between the addict and his community. As Mr. Preble describes it, you have the community on the one hand, morally aroused and firmly committed to the elimination of drugs and drug users; while on the other hand, the same community supports, sustains and furthers methods of distributing drugs to drug users. He illustrates this through reference to the common knowledge that you couldn't have the extensive drug traffic that we have in this country if it were not for the cooperation, participation and profit of many "respectable" citizens. This support, however, is not restricted to the highly placed and influential, but extends to the members of the very community that the addict preys on.

Mr. Preble cited the example of the ease with which addicts can peddle the harvest of their petty thievery such as radios, television sets, clothing, etc. A case in point was one bartender in particular, who in the midst of holding forth against the sins of junk and the loathsomeness of junkies spotted a neighborhood addict going by the bar. He interrupted himself, dashed out of the bar, and in full view of those before whom he had been upbraiding the addiction world, proceeded to place an order for a radio. Consciously, this bartender, and many other "respectable" members of the community would be the last to admit, or even worse, to be aware, that they were supporting and sustaining drugs and drug abusers.

Obviously, then any attack on narcotics use, and any concern with its elimination concerns much more than the addict. The pusher and the smuggler are obvious sources of concern, but the more subtle supports in society require our attention as well. Society at large then is both the victim and the perpetrator to a large extent of the addiction syndrome in the broadest sense. As such, Mr. Preble drew and supported the observation that addiction is not solely a symptom and illness of the individual but also of his culture or society.

2. The Addiction Services Agency

Dr. Ramirez addressed himself to the magnitude of the problem and the broad outline of his program. In his estimate, there are probably about seventy-five to one hundred thousand addicts in the country whose overall cost to the community runs from five hundred million to one billion dollars a year. These figures include goods and property stolen. Unfortunately, no two experts agree on these numbers and we have no statistics that can be relied on, but there is no question that the addiction problem involves a great many lives and does cost the nation a large sum of money. Dr. Ramirez then described the program he has initiated which in summary was:

Three phases in this process are identifiable. The first one we call induction, this phase lasts an average of two to three months (on the average it can be shorter or longer) and can be described simply as primarily a training program -- a training process that engages a raw, usually unmotivated, addict in the street (wherever the street may happen to be)....

The now "clean" addict is then challenged to make a demonstratable commitment to long term treatment leading up to his eventual rehabilitation; this second phase of the process which we call treatment must be carried out in a therapeutic community for a large majority of addicts. In general, treatment consists of the organization of a total guidance program which attempts to regulate all aspects of the patients existence....

In Dr. Ramirez's experience the treatment process may last for an average of between six to eight months, perhaps a little longer. The principles of total milieu therapy must be applied in order to achieve the correction of psychopathic attitudes, and to re-inforce productive attitudes both in the patients and in the staff

who work with these patients. It carries the patient from the point of commitment to long term rehabilitation. The stage where his overall consistent behavior with peers, with staff members, with relatives and neighbors is such that the addict is regarded by all as a productive individual rather than a social parasite. When the patient is viewed as having received optimum help and is discharged, he enters into the last phase of process, which we call re-entry. The re-entry phase of the process may last up to a year and provides three main services; (1) evaluation, a chance to evaluate the effectiveness of Phase I, Induction, and Phase II, Treatment, through observation of the total behavior of the re-entry candidate in whatever milieu he finds himself; be it in a re-entry house, a half-way house, or in the open community with his family, friends, work situation, etc. That means that the patient will have a one year total observation follow-up. The second service provided by the re-entry phase of the process is the chances given an individual to enter a pool of trained parapsychiatric manpower. The pool of re-entry candidates, the ex-addicts, aid and complement the professional staff and others in different stages of Phases (I) Induction and (II) Treatment. The third service provided by re-entry is the all important opportunity provided the ex-addict to confirm his rehabilitation to his own satisfaction through a process of gradual confrontation with progressively demanding emotional, vocational and social areas of his own choosing....

Dr. Ramirez pointed out that in a prison setting, such as Rikers Island, the prisoners are under no obligation to attend his induction meetings, but do so voluntarily and in so doing make a first step toward rehabili-

tation. There is constant evaluation throughout the program and a given addict can be returned to a lower state in the program at any time, should his behavior warrant such a decision.

It should be pointed out that the Ramirez Program has much in common with other addict self-help programs such as Synanon, Daytop Village and Odyssey House; one difference is that the Ramirez Program is government sponsored and managed; however, with the exception of Odyssey House, all the programs, including the Ramirez Program are run with either minimal, or in the case of Synanon, no professional collaboration. This has important implications for the ultimate rehabilitation of the addict. At this point the Ramirez plan is new, promising and unevaluated, but at least in theory it holds out much hope.

3. The New York State Narcotics Addiction Control Commission

Mr. Lang is Counsel for the New York State Narcotics Addiction Control Commission, which has official statewide control and responsibility for the disposition of any apprehended or voluntarily committed addict. Mr. Lang talked about the enabling law and the products of the Commission to this date.

The Narcotic Control Act of 1966 is New York's first attempt to deal with this social problem which has massive implications in criminality....

The act is actually an amendment to the 1962 Metcalf Volker Bill which provides for the creation of a Narcotic Addiction Control Commission within the department of Mental Hygiene....

The Commission has broad powers encompassing the entire field of Narcotic Addiction. It has established an operative rehabilitation center and other facilities for the care, custody, treatment, rehabilitation and after-care of narcotic addicts certified to its custody. It has established and operated medical examination facilities to determine whether an alleged narcotic addict is in fact addicted....

The compulsory committment features of the law do not include barbiturates, amphetimines, marijuana, hallucinogens, L.S.D. and the like. "We feel we have a responsibility under the statute in the area of prevention and public education in dealing with the so-called soft drugs, however the compulsory commitment procedures are limited to the opiates. The Commission has the power to approve private, public and local facilities for the treatment of narcotic addicts." For example the New York City Program run by Dr. Ramirez is an approved and accredited treatment agency. Other recently accredited agencies are Daytop Village, Exodus House, and Odyssey House. Thus, the Commission has the power to assign and transfer addicts to facilities which it established or to other state, local or private agencies which have been approved by the Commission. The Commission has been empowered to conduct experimental programs involving the administration of addicting substances and can give grants to, and accept grants from, private and governmental units. In this regard the Commission is currently funding most of the private agencies in the field, and will shortly sign a contract with the Methadone Project which will involve some three million dollars....

In order to understand these sections, it is necessary to briefly outline both the prior law and the reason for its failure. Under the original Metcalf Volker Bill, an arrested addict who was not otherwise ineligible, and a high number were ineligible, could apply for civil commitment to the Mental Hygiene department in lieu of prosecution. If accepted, the charges would be held in abeyance during his rehabilitation and upon successful graduation from the program, and after a lapse of three years, the charges would be dropped. If the addict failed he would be returned to court for processing of the criminal charge. If an eligible addict desired treatment he had to surrender his right to bail as well as his right to a trial regarding his guilt or innocence.

In point of fact, the vast majority of addicts who are eligible for this program and its benefits did not even apply for it. Apparently, preferring a prison term to the alternative of meaningful treatment. The new statute mandates treatment for addicts. It provides that every person who is arrested and possibly addicted must undergo a medical examination to determine whether he is in fact addicted. If the person is found to be an addict, and he is convicted of a misdemeanor then the court must certify him to the custody of the Narcotic Addiction Control

Commission for an indefinite period of up to three years of sooner, the Commssion feels he is rehabilitated. The court has not other option....

Where the addict has been convicted of a felony, the court has the discretion of committing him to the custody of the Commission for an indefinite period. This time the period is five years, or he may be sentenced to state prison under the normal provisions of the penal law. Under Section 210 of the Mental Hygiene Law, the statute provides that with certain limited exceptions an addict who seeks treatment may apply for civil certification in lieu of criminal prosecution. This means that if the application is granted the criminal charges will be immediately dismissed, there will be nothing hanging over his head and he will be civilly certified to the custody of the Commission for up to three years....

The advantages of the new provisions are quite evident. First, if we recognize the addict, in euphemistic terms, as a sick person, recognize also that like other sick people he cannot dictate his own treatment. Second, once the initial proceedings are terminated the courts no longer have jurisdiction. Thus, the addicts are no longer exposed to the unhealthy prospect of being returned to court to be tried on a stale charge. Mr. Lang also emphasized that the program does not call for automatic confinement for three or five years. The addict is certified or sentenced to the custody of the Commission and the Commission determines the best program for him, the regime best suited to his needs, and best suited to the needs of the

community. There is, in addiction, heavy emphasis on urine testing, and if a person in an outpatient status shows that he is reusing or that he's becoming readdicted, he of course, could be reinstitutionalized....

There is nothing really unique about the individual treatment programs that the Commission is going to be involved in; but what is unique, is the vast numbers of addicts who will be involved in this program....

An important aspect of the program is its flexibility; the granting to the Commission complete flexibility as to how to handle the individual. As you know most programs having anything to do with penology, in the past have usually remanded the individual to jail for a period of time, then parole. Or placed him on probation and if he slipped, then to jail. In this program you have wide ranges of facilities ranging from correction, to mental hygiene, to the Commission's own institutions or to open facilities such as Daytop, or maintenance programs. You then have the ability to gear your program to the needs of the individual, the needs of the addict. Mr. Lang noted that not all addicts are alike, and consequently, he sees this potential for differential assignment as a most important breakthrough in the treatment of deviant behavior. Mr. Lang is of the opinion that this type of approach will ultimately have a profound effect on the field of penology and indeed on dealing with all socially deviant behavior. He envisions, perhaps a decade from now, an end to the fragmentation that we currently have of mentally ill, socially disordered, criminally convicted, youthful

offenders, narcotic addicts and alcoholics. In place of the current overlap a division of rehabilitative services in the state whereby these types of character disorders or deviant behaviors can be handled in a flexible and appropriate way -- socially, psychologically, and medically.

One other important aspect in regard to the committment program is something that has received the most controversy, and that is the involuntary civil committment of the narcotic addict. In point of fact, there was a civil committment provision in the old Metcalf Volker Bill that was never enforced and what the current Bill provides is that any person desirous of having an addict certified to the Commission, or if the addict himself so wishes, may apply to a Supreme or County Court where the addict resides (or where he may be found) for purposes of certification to the custody of the Commission. This involved, of course, a sworn petition establishing probable cause. The individual cannot be summarily picked up off the street and just thrown into some kind of center, the proceeding must be initiated by a court petition. If there is a finding of addiction by the court and subsequently, possibly by jury, the addict is civilly committed to the custody of the Commission.

There is a difference between a civil and a criminal certification: The criminal certification, that is for addicts who are convicted of crimes is a sentence, that is his sentence. The civil certification is not a criminal proceeding at all but civil and, therefore, the addict who is involved in a civil proceeding forfeits no civil rights

and cannot be assigned or transferred to a correctional institution. Those are the two basic differences although the treatment programs in large measure would be the same....

The remainder of Mr. Lang's remarks concerned themselves with evidence of implementation and operations of the Commission. Dr. Irwin Gould discussed Mr. Lang's presentation as follows:

"I don't think that he has to belabor the point with an audience such as this that the charge that the Commission is confronted with, the job it has in front of it, is a huge and overwhelming one, and my personal experience with the Commission has been punctuated by one major notion -- try. Try and experiment, and try to take advantage of every existing modality that is available. So it is much too soon to have any definitive word in yet, but it seems to me, just from the point of view of common sense and logic, that this kind of undertaking, this kind of a massive effort if nothing else, is reflective of an alteration in the community awareness, and the readiness on the part of at least a very large and significant element of the community to look upon addiction in a more hopeful light. And I can't help but contrast it with the almost total absence now of the idea we used to hear so much about: The best treatment for addiction is the legal dispensing of drugs. This change in attitude, I think, is probably one of the most concrete achievements that can be associated with the existence of the Commission today. Legalization was really another way of saying 'we give up' and the Commission is a very definite way of saying we may very well be able to do something about it."

4. One Professional View of Addiction

Although Dr. Bluestone was not originally a scheduled speaker, but a substitute for Dr. Carl Easton, he proved to be one of the most provocative. Where Mr. Lang, Dr. Ramirez and all subsequent participants were messengers of hope, guarded optimism and effort, Dr. Bluestone was the messenger of doom, abject pessimism and futility. Dr. Bluestone is a psychiatrist who is most familiar with community work having recently retired from the New York City Community Mental Health Board. His speech is being quoted almost in its entirety because it represents an extensively held but rarely articulated position. The fact that a man of Dr. Bluestone's credentials and background had the candor to present it, is to his credit. When we talk of the need to alter attitudes towards the drug addict, we don't always say what these attitudes are. Dr. Bluestone does. When we add to this the fact that evidence of his position was reflected among large numbers of the target population, we begin to get a better idea of the magnitude of the responsibility training programs have before them. Further, when we examine the forthcoming paper, we may, perhaps also have a better understanding of why, up to this point the professional establishment has failed with the addict, and the ex-addict as a rehabilitation agent is proving to be so much more effective.

Dr. Bluestone:

"I worked for the City government for a number of years in the Correction Department and in a Mental Health agency. Before that I worked for the State government for a number of years with its Correction Agency and the Mental Health Agency. I have been more or less involved with narcotic programming up to about a year ago. I am in the very

fortunate position now of having nothing to do with it, which maybe gives me the freedom to express some views about some of the programs that have been, and some of the programs that are, and some of the programs that are contemplated.

My general feeling ab·.t these programs is that they are grossly inapplicable to large numbers of people, and the proponents of many of them talk as if they have the word from God, that they are destined on earth to treat narcotic addicts.

The only way a drug addict could be treated in this City, at one time, was in this institution (Rikers Island). People could sign themselves into Rikers Island as a voluntary inmate and then become, I guess, detoxified by whatever method was used here. So we are sitting in the original place, as far as this City is concerned, in treating drug addiction.

After World War II, as everybody knows, there was a tremendous increase in the number of drug addicts in the country, particularly in New York City. The characteristics of drug addiction changed, there arose a much younger group of drug addicts, there were less of the middle aged, medically addicted people and many more street addicts taking heroin. In addiction, a lot of crime got connected with the taking of drugs in recent years. Many people became concerned about drug addicts being inarticulate and disenfanchised people, and many people were concerned about the political implications in drug addiction. A whole series of things started to happen when drug addiction became a major social problem which it did after the Second World War.

In Program #1 there was an unfortunate interlude across the way on North Brother Island where there was a program for the treatment of

adolescent narcotic addicts. This enterprise was fraught with much difficulty. A lot of drugs supposedly came on to the island and a lot of people were very very unhappy with the program. The Columbia School of Public Health was asked to evaluate this program. I do not know if anybody ever read this report, I do not know if it has ever been published, I doubt it. If it has been published, it has disappeared from circulation altogether. I have never gotten my hands on the report about what was wrong with that program. But I heard second hand about various things that were going on that should not have been going on, I think it was possibly a somewhat maligned program and I have since met some of the doctors that worked there. They had some very good people working in that program who continued to work in the City service. The program then, was never really evaluated.

Another program that was started in New York was the program of Metropolitan Hospital. This is a City sponsored program. Supposedly a research program. The City went shopping around for some medical school affiliated hospital to develop a treatment program. This program is still going on. The emphasis is on detoxification and supposedly rehabilitation follow-up treatment which they are trying to develop. This program also has run into great difficulties.

The first phase of the program, the detoxification phase has been very successful; detoxification programs have been successful in general, in prisons and any other place. It is very simple to get people off drugs for the moment. They do it relatively painfully or relatively painlessly, and this is not difficult to accomplish. What happens is that people sign

in, go through the medical phase of the treatment and leave. Leave against medical advice, sign out and so get lost to the program. It has therefore been very difficult to document any long term treatment results, for any large numbers. My guess is that of the people who go through that program, some numbers do not take drugs anymore.

But this is also true of this institution, which by the wildest stretch of the imagination is not a treatment institution. Yet we keep reading about the high rate of recidivism in a place like Rikers Island. Let's say 90% of the drug addicts come back which means 10% of the people don't come back, which is probably as good a percentage if you want to use gross numbers as some of the medical treatment facilities are able to produce.

There is a hospital downtown on Second Avenue, Manhattan General Hospital, whose program was a much less pretentious one on paper, and in practice, than the Metropolitan Hospital program. It was financed by City money, but the actual staffing and costs of the Manhattan General program were somewhat less than the Metropolitan program. However, it was never considered to be a major teaching or research institution to start with. They have done a reasonably good job, if you see their goals in a very modest light, that is if you see their goas as relatively, painlessly getting people off drugs. They do this quite successfully. However, if you see their goals as long term treatment results, I'm unconvinced that they are any better than Lexington Hospital or Rikers Island or any of the other institutions to which people go to and......come out of again.

This is the extent of the major programs in the city; the Metropolitan Hospital program, the Manhattan General program, and programs, I use the

word very loosely, in the prisons. I say that because I don't think a prison can treat anybody. I think that a prison, I'm beginning to think more and more like the correction officers who I fought with for years and years, who kept telling me: 'you've got rocks in your head if you think you can treat anybody in prison.' I agree with them now, of course. A prison cannot go in two directions at the same time, and have two contradictory missions: One, punishment and custody, and one, supposedly, treatment. Impossible! These are irreconcilable goals.

In any event, we reviewed the existing programs which were Rikers Island Programs, such as it was, the Metropolitan Program, such as it was, and the Manhattan General Program. This, as I recall, was the substance of the Narcotic Program in the City and we looked at various different kinds of possible programs.

One of the most interesting, not in terms of numbers, but in terms of heat and passion -- was the whole idea of -- should Narcotic Addicts readily and easily get drugs from a clinical kind of set up, or should we continue on with very repressive measures to control durgs. Our committee felt -- since it was a medical committee primarily -- very strongly that at least some investigation should be done to consider the possiblity of making drugs available to some addicts under some conditions. Some time after that, I think right before our report was published, Vincent Dole was working down at Rockefeller Institute and reported some interesting results. He's a man with a very excellent reputation as an investigator and not a fly-by-night psychopathic character like so frequently turns up amongst physicians who work with addicts. The City became interested in this, and

Dr. Dole got the money from the City Government to expand his program and he did some work at Manhattan General Hospital. Many people get very confused about this. They think that Dr. Dole's program is the major aspect of the Manhattan General Program which of course it is not. He gave, as you know, large doses of methadone to drug addicts and, according to his report, these people didn't have any yen to take heroin anymore. He got them into school programs, and educational programs and they then were maintained on methadone.

Dr. Dole, of course, was accused of substituting one addiction for another addiction: But by his definition of addiction, he said that this was not what he was doing. And his definition is as acceptable, I guess, as anybody elses: Somebody is an addict if he steals to get drugs, and somebody is a patient if a doctor prescribes medicine for him. Which is not too bad a way to define it. It may sound silly, but any other definition anyone else will make will sound equally silly, I am sure. In any event, Dr. Dole started to give people methadone and many people did very well. However, this is a very small number, maybe 100 or 200 cases did well with this method of treatment.

Now where are the controls in this program? People say to Dr. Nyswander, Dr. Dole's partner: 'You're giving junkies methadone, you're doing all these other things, you've got rehabilitation, you've got this and that and the other thing and you've got your warm and wonderful personality involved with these people.' And her answer is, I hope I'm quoting her correctly, her answer is that she had done all the things that she did before and had no good success. She doesn't do anything different, except now her patients get methadone; before they didn't.

So these people wound up with a program, very clearly labled a "research program" to investigate the possiblities of giving one drug under controlled medical conditions to take care of a group of addicts. This was one of the things our group was interested in seeing happen.

There are some reports written up about the Methadone Program. The Medical Association had one three years ago. Dr. Nyswander had three articles in the District Branch Bulletin of the American Psychiatric Association. The public press has written this stuff up at great length. The use of Methadone is one of the on-going research programs in New York City.

I think that the catch in this program, as is the catch in so many other programs, is that while 100 or 200 or 300 people did better with this method of treatment, maybe 100 or 200 or 300 people can do better by coming to Rikers Island prison alone. If you get the right hundred people you can cure them by putting them on this Island for a little while. We have some churches around where the preacher gets up and exhorts the people and says don't you take any drugs at all anymore and a certain number of these people get well with this exhortation.

Robert Beard has this little place up on 100th and something street in Harlem. It's a very interesting place and you all ought to visit it sometime. It is a very fascinating way to spend a night. The activity starts about 12 o'clock at night and Beard exhorts people not to take drugs any more until 7 o'clock in the morning, and lo and behold, a group of 50 or 75 or 120 or larger numbers of people respond to this kind of approach. There is always a small number to whom this kind of treatment appeals.

In any event, one of the major emphases in our report was to get somebody interested, some reputable investigator, if possible, interested in looking into the possibility of giving drugs and seeing if something could be done. This has in fact taken place.

Another kind of program we looked into is the kind of program that Synanon runs. They used to have a place up in Connecticut. I guess it is closed. They had a big place out in California, I guess they still have it there. Fascinating, fascinating business, I tell you. Synanon is like prison without walls. You get the same kinds of things happening that happen in a prison, and it is a drug free prison. Synanon has managed to accomplish the same thing pretty well by having a walless prison and getting people off drugs pretty effectively. Everybody within the confines of this total institution called Synanon is free of drugs. I believe that.

The catch to this program, of course, is number one, it is extremely highly selective. There is a whole series of rituals one has to go through in order to get into the program; there is a whole series of rituals one goes through to stay in the program. So it is a highly selective program, which is alright. Every program is. However, the gentlemen who run this program say it is not highly selective. They take anybody. They do not. They only take the people who are willing to go through this whole business. So that is one thing that I do not believe is quite open and frank about the people who run Synanon. The other thing is, of course, that like any total institution, or any brainwashing procedure, or any prison, the change in behavior which takes place within the confines of the walls is lost as soon as somebody gets out of the

at the time, experienced much grief over this program. So we have program number two, the artificial society type program, one might say, or the prison without walls type program, Synanon and Daytop. These functioning programs do serve a useful purpose.

Then the whole question came up of civil committment. Lovely. I went out to Corona, California, where they started a program in a country club that had been built in the early 1930's California passed a civil committment law which enabled them to send addicts to Corona. When I was out there, inspecting the program, they had not released anybody yet, except a lot of people got out on a writ. Actually there was some question about the constitutionality of the whole business. Nobody ever finished the program, at least they had not when I last was there a few years ago. These fellows were civilly committed and it struck me that the program was depriving a lot of people of their rights as citizens, depriving them of the right to be tried for a crime and put in a regular prison rather than to be sequestered in another prison without having the benefit of a trial. However, New York State went along the same general lines and passed a civil committment law last year, which started a civil committment program with all kinds of provisions.

Essentially, people can go into "prisons" called hospitals, after committing crimes or they can voluntarily go in, or somebody can put the finger on them and send them in. There are a few things that concern me about the state program. One is the legal matter of civil rights. The other is a medical question, and that is, does an institution become a hospital because you write hospital on the door, or does it have to have some other qualifications to become a hospital? It is inconceivable that

there could be enough staff to have a hospital treatment program for the supposedly fifty thousand addicts, if there are that many in the state. There just are not enough people to do the job. Questions of security have already come up.

Addicts have gone into these hospitals and have walked right out again. Then everybody gets worried. As matters stand now these hospitals are more like prisons. It is a very complicated business. The program remains to be evaluated.

In any event, our state programs seem to have gone in three general directions: One is along the lines of investigating the giving of narcotics or substitutive narcotics to addicts - an interesting program; the other is the development of the closed society type, like Daytop and Synanon programs; the third is the civil committment of vast numbers of human beings into various institutions. There are a lot of good people connected with the State program as you well know, however, I have my doubts about the legal and medical aspects of this type of program.

There is one other thing I would like to make a couple of comments about. It is very fashionable now to use ex-addicts in the various programs. I had lunch with one of Dr. Ramirez's assistants a couple of weeks ago and he was telling me about one of the problems that they are having -- and there are lots of them. One problem is where are the ex-addicts going to come from. There is a great shortage of ex-addicts. Suddenly the demand has made ex-addicts fashionable, like short skirts for ladies, only not so pleasant. In any event the great fashion now, is ex-addicts.

We have ex-addicts in some programs getting paid sixteen or eighteen thousand dollars a year. I went home after this lunch and said to my son who is starting out in college, 'you become an ex-addict, you can do it in one year, and can make sixteen thousand dollars a year; you get addicted, then unaddicted and become a certified, bonified ex-addict, then you get a great place in the program.' These ex-addicts are involved, I am sure Dr. Ramirez told you, in various phases of treatment.

The ex-addict programs are Synanon and Daytop. The program is geared to the ex-addict moving up in the hierarchy, treating the addict who becomes the ex-addict, and so forth and so on. There is a great demand for ex-addicts. The State program now, too, is getting right on the band wagon signing up all the ex-addicts it can.

If I sound somewhat cynical, I do not mean to be. I am just skeptical. I believe there are addicts now and there are going to be addicts in the future. Let these fellows be, and let us do something worthwhile with our own profession instead of playing foolish, make-believe games. If we think our foolish games can help one hundred or two hundred people, great. I think they can. I think any psychiatrist can help a hundred people or any clergyman can help a hundred people or any madman can help a hundred people or any ex-addict can help a hundred people. Anybody can help a small number of people. We know that in the mental health field, we have all kinds of competent, incompetent, less competent, more competent people, and they all manage to do something good for somebody sometime. But we should not get carried away. So I think we ought to take our psychiatric talent, and our correctional talent, and

our medical talent and do something which we know something about -- and not play all these foolish games. In which case there will be some addicts on the street, and some crimes commited which go on now anyway."

This concluded Dr. Bluestone's formal address. However, in response to a question about the co-existence of Correction and Rehabilitation, Dr. Bluestone came very much to the heart of a central issue that this project was concerned with. Namely, can rehabilitation take place within a correctional setting? There is no question that there was extensive doubt in the minds of many of the participating personnel. So another question was raised. Is it enough to try to train personnel in corrections institutions, or must the nature of the corrections institution be changed. Dr. Bluestone's reply is quite eloquent:

"This is not restricted to drug addiction by any means and it is a very serious matter. The issue was touched upon at some length in the President's report on crime in a free society, which I trust everybody read. The President's Commission addressed itself to this question about whether correctional institions should be custodial institutions or rehabilitation institutions. The President's Commission report made a big plea for rehabilitation. Unfortunately, they left out one important aspect of prison work and this is something that they should have considered. That is the punishment function of a prison. People, as you know, in this State at least, are sentenced to let's say five to ten years as punishment for the crime of armed robbery. It is punishment to go to prison. The emphasis in prisons is to keep people from escaping. If somebody escapes everybody is aware of it; but if somebody does not get rehabilitated nobody is going to know the difference.

Therefore, in prisons the emphasis has to be on 'do not let the prisoner get away.' So an atmosphere is created, of necessity which is repressive. Its goal, its function, its reason for being, is not to let people get out before society has said that they can. In this atmosphere, it seems to me almost inconceivable that what I consider to be treatment can take place.

Now all people, I think who have written seriously on the subject of crime and correction have addressed themselves to this issue. Read any textbook on criminology and you will see this issue discussed. Some of the European Countries have answered the question in an interesting way. In Denmark, for example, if somebody is sentenced to a crime for which they get, let us say four years, they get two years of punishment in which they are locked up and they do get punished. They are not allowed any freedom. They they get moved out to some open type institution, where they can come and go pretty much as they want, and where they get treated. At least they realistically tackle this issue by separating a treatment function from a custodial function.

I do not think, for instance, that the State hospital system did anything that I would call treatment until they started to open up their doors. Once they started to open up the doors and did not see themselves as custodial institutions anymore, the atmosphere then became conducive to treatment. This is not to say that people do not get better in prisons... I think that a prison gets ten, twenty, or thirty percent of their people better. Some people walk into a prison, see the bars there and are so unhappy about the whole thing that they never allow themselves to go back to the situation that led to their imprisonment. There is no question that

wit, tongue-in-cheek style, and general delivery. But after I get finished being amused with it, I am frankly disturbed. It is a tough problem and I think Dr. Bluestone is going to the end of the continuim rather than illustrating the difficulties of the problem, or the challenges that it represents. The social sciences have been confronted with frustration, and sense of defeat, and sense of impotence, ever since they have attempted to do something in the drug area.

But I for one cannot see the equation between failure up to this point, and justification for giving up one's efforts toward a solution of the problem. So I will go along with Dr. Bluestone, it is rough, it is tough, it is complex and on more occasions than not, it would seem that it is totally pointless. But I still am of the conviction that with the Riversides, with the Synanons, with the Daytops, with the Bernsteins and even with the Beards, that out of this whole mix, constructive things do get extracted, important things do become learned. Applications are derived and not necessarily, solely and exclusively restricted to the field of addiction. As a matter of fact, I think one of the major contributions that have been derived from all the work done on addiction is the enlightenment that has resulted -- not so much about drug addiction -- but the mechanics of personality, the operation of pathology, and various and sundry means and ways people function under given circumstances. A concluding note: As long as we are working with people, as long as we are directly and forthrightly addressing ourselves to a generally agreed pathological state, the worst that can happen is that we are going to learn something. If we turn our back and simply say there is no point in even looking,

we can be sure of one thing, we certainly will not learn anything and we certainly will not do anything. This way there is just the chance that we might. I prefer a little bit of optimism to all of the pessimism. Above all nihilism will get us nowhere toward resolving the drug addiction problem."

5. Summary

When we review the four lectures in this section, certain things manifest themselves. The community, in contrast to ten short years ago is very much committed to doing something about narcotics addiction. Committed in deed not word. The reality of the Ramirez Program and the Narcotic Addiction Control Commission bear witness to this. That these programs are costly, there is no question; that the Ramirez plan is grandiose and based on an oversimplified behavioral conception of personality organization is generally agreed; that the Commission was ill equipped to initiate a service program when they did is acknowledged; and that the New York City Department of Corrections treats addicts like prisoners cannot be argued. Yet, all these criticisms, notwithstanding, we have these programs and we have the New York City Department of Corrections co-sponsoring this project. We can only point out that it took the community a long time to get involved and because of this, existing programs have a deep responsibility to be open to constructive criticism and suggestion, and prepared to modify and refine their procedures. Should these conditions not obtain then the current community involvement and support could quickly turn to indifference and apathy once again.

B. Law Enforcement and the Addict

This section of the program was organized with an eye to following the typical course of the average addict once he became indentified. It is in the nature of the disability of addiction, and how society has chosen to perceive and respond to it, that the life of an addict and the law are so intimately entwined. As Inspector Ira Bluth of the New York City Police Department puts it: "The addict gets along best with the Narcotics Bureau because it is part of his milieu - which is a sub-culture into intself. The addict has his own type of life-style which is completely dependent on heroin, and the police, of course, are part of this game. Arrest is a calculated and expected risk."

It is really quite interesting that although every participant in the program made a point of acknowledging that narcotic addiction is basically an emotional illness, society's initial contact with it is invariably through the policeman. He is then remanded to the courts as described by Judge Arthur Markewich of the Supreme Court of the State of New York, where his disposition is determined by the specifics of the law. Following his court appearance, he is either sent to jail or remanded to the jurisdiction of the New York State Narcotics Control Commission. In most states it is almost exclusively the former.

Once in prison his primary supervision comes from Corrections Officers who by virtue of this fact, become one of the most significant groups in the management and rehabilitation of the addict.

In order to obtain a clearer picture of the uniformed Corrections Officer's role, attitudes and perceptions, a round table discussion was organized. This discussion proved to be the most dynamic and dramatic segment of the entire program, as we shall see. The remaining two sessions concerned themselves with the role of the psychiatrist in court and the function of parole.

1. The Policeman's View of the Addict

According to Inspector Bluth, the police department comes into contact with addicts only when they violate the law through illegally selling drugs, illegally possessing drugs or by committing non-narcotic crimes. This is by way of clarifying that simply being an addict is not a violation of the law; however, possession of drugs, even in one's blood stream, without a prescription is. Most of Inspector Bluth's remarks were procedural, statistical and reflective of the police department's picture of the addict garnered through many years of experience. As one would expect the overwhelming number of crimes committed by addicts are crimes against property such as burglary, forgery of prescriptions, criminally receiving stolen property, possession of burglar tools, unlawful entry and grand larceny other than motor vehicles. This is naturally explained through the addicts constant need for money for drugs. Consequently, addicts rarely commit crimes against people or crimes of violence.

The policeman's view of the addict is worth quoting in that it varies little with the general consensus view.

A. The typical addict is introverted, has difficulty relating with his peers and has a low threshold of frustration.

B. An addict is wary of the establishment including representatives of all official agencies.

C. The addict is knowledgable about the law, but has no love for it. Frequently, addicts resist arrest with assault. Heroin is a depressant but its users are not always docile.

A few years ago the addict was found almost exlusively in the lower socio-economic areas of the city but now the problem of addiction has spread to the middle and upper income groups. The majority of addicts are in the twenty to thirty-nine year old group. Addiction suddenly disappears in the forties. Why? The inspector feels that the death and prison theories are invalid. He accepts the "maturing out" theory (see section on Theoretical Aspects), but he does not know why.

Bluth corrects several fallacies that concern the start of addiction.

A. Pushers do not lurk around schools to inveigle students to try heroin. It is dangerous and there is little market there. In 1966, the police statistics show only one per cent of drug users arrested were under sixteen.

B. Pushers do not spread addiction; the addict himself increases the spread of addiction which is due to a combination of medical, sociological and psychological factors. Addicts are always trying to induce someone to try herion.

C. Bluth denies that the Narcotics Bureau harasses the addict and in so doing make him reluctant to come to addiction treatment centers. He states that his people are cognizant of the difficulties involving voluntary treatment and bend over backward in trying to cooperate. He states that consideration is given to those carrying identfication cards to indicate they are involved in such treatment.

D. There is no average bag of heroin due to differences in processing (cutting with adulterants) and that police analysis indicates that most bags currently contain one or at most two grains of heroin or twenty per cent heroin compared with two to three grains some years ago.

E. Bluth denies that the police attitude is that of the punitive approach to addiction. The police merely enforce the laws that are enacted by the legislatures. This they do objectively. Arresting the addict is doing a service by affording him an opportunity for rehabilitation which he ordinarily would not avail himself of due to lack of motivation. He concluded that the police must play a part in this socio-medical situation because heroin addiction and illicit traffic are interdependent.

2. The Judges View of the Addict

Judge Markwich presented a very complete review of the current status of the New York State law as it affects the addict. He pointed out that the passage and enforcement of the new penal and mental hygiene laws clearly indicate the direction the courts are following in their philosophy concerning drug addiction.

The old penal code emphasized concentrating the attack on the seller. It was reasoned that once the seller was removed from the environment by incarceration, that would be one less source contributing to the illicit drug supply. For example, there was a mandatory minimum term of six months for any second narcotics conviction under the old law. The new penal law views narcotic usage and control as a far more difficult type of problem for the courts to handle and emphasized the emotional and psychological difficulties which are at the root of the problem.

The rehabilitative aspects of drug control seem to offer a better chance for a solution than the punitive approach. Nowhere in the new provisions is found a minimum sentence; additional punishment may be meted out to the seller at the discretion of the court.

How the New Mental Hygience Laws Operate - The court's attitude is strictly dictated by the new Mental Hygiene Laws, it is obligated to follow the law with practically no freedom of choice. Consequently, a knowledge of these laws and how they operate is essential to this dicussion.

Section 201 - The definition of an addict is one who is, or in imminent danger of becoming addicted. The words imminent danger are important because it is finally decided by the opinion of the doctors of the court.

Section 204 - Describes powers and duties of the Council on Drug Addiction. Establish rehabilitation centers and other facilties, establish provisions for examination of suspected addicts, and establish facilities for treatment, rehabilitation and care, etc.

Section 206 - This is important because it states that a justice of the Supreme Court or a judge of the County Court may certify to the care, custody and control of the Commission a person who is an addict within the meaning of the law, except if there is a pending criminal charge, or if the addict is already enrolled in an approved program. This petition may be made by anyone who has grounds for belief that the respondent is, or is liable to become an addict. And this person (anyone including a policeman or even the respondent himself, may petition the court for the respondent to be examined.

The court can issue an order for examination or a direct warrant if it is felt that the person will run away. The Commission is to provide examination facilities and then report to the court. If the court is satisfied that the respondent is an addict, he is informed of his rights and to have counsel. If he waves his right for a hearing, the court may make a finding that he is an addict and commit him directly to the Commission for up to three years unless sooner discharged by reason of rehabilitation. If there is a hearing, it must be held in five days as a full adversary proceeding with all the protection under the law. If desired, the hearing is private and the papers are sealed and can only be examined on petition. After a hearing before the judge, he may apply within thirty days to a Supreme Court Justice other than the one who certified him to the Commission to a jury trial - not on the advisability of sending him to the Commission, but on question of the facts involved as to whether or not he is an addict. Up to now, all jury proceedings have decided that the commitment stands. There is no loss of civil rights on a civil commitment such as conviction of a felony.

Section 207 - This section is more involved with criminality. Every person arrested on any kind of narcotics charge has to be examined. If there is any information that the defendent of that criminal cae is an addict, he must be examined and a report be made to court.

The examiner is to get all records made by police officers or persons having the defendant or respondent in charge including Corrections Officers. They fill out form CRI which indicates their basis for belief that the person is an addict. However, none of this information or the doctor's report may be used if the case goes to trial. If the person is out on bail and fails to report for examination, he may be remanded without bail for the purpose of the examination. In most cases, the examinations can actually be held on the basis of objective signs alone without the necessity of the man's history.

Section 208 - If the person is an addict and is convicted of a misdemeanor he has the opportunity of a hearing as to the fact of his addiction, and if found to be an addict he must be sent on this misdemeanor conviction to the Narcotic Addiction Control Commission for a period of up to three years. If it is a judgment of conviction, there is no suspended sentence. If it is a felony charge, the Court has the discretion either for the regular sentence or commitment to the Commission for a period up to five years. The same thing applies to a youthful offender as the three year term. This provides the opportunity to work with addicts and to see whether they can be cured.

Section 210 - An addict can get treatment with the consent of the District Attorney (a civil commitment instead of the indictment against him). Many addicts desired this. The attitude of the

DA has changed, and it is more difficult to get this treatment. There are various safeguards on this; a previous felony conviction, previous commitment to Narcotic Addiction Control Commission, a charge punishable with either death or life imprisonment, in a felony case, requires the consent of the District Attorney.

In the beginning, the two hundred ten cases were conducted as mass proceedings. This is no longer the case. A false claim of addiction can come up when a person is being indicted for a felony. He hopes to get a plea of a misdemeanor and gets three years in a hospital instead of the felony sentence or gets the indictment dismissed if the DA consents to a two hundred ten (no criminal record).

The Judge commented that the criticism leveled at this operation as ineffectual did not realize the difficulties in curing addiction, and that they do not understand what the treatment involves (psychiatric and emotional). But there are legitimate criticisms also - there is not enough staff, so examinations are not timely, or often even made. The flood of applicants emphasized the insufficient facilities and personnel.

The Judge assumes the law constitutional but mentions that the Civil Liberties Union has a case declaring the law unconstitutional now pending. He assumes the view that if you do this for the purpose of protecting the public generally by compulsory treatment, it is probably constitutional. There are many views on the subject. The Judge feels that because they want to share their degradation, they spread addiction. If the program, that is the NACC, does not work, there is time enough to

abolish it, and it is not harming the unfortunate addict. As far as the Judge's experience in judging an alleged addict in a hearing, the Judge stated that as the law stands, he has little or no freedom of choice. He personally views the addict as mentally sick and anything that might free the addict of his addiction is worthwhile.

CONTINUED

1 OF 2

3. A Round Table Discussion with Corrections Personnel

This round table discussion is actually the second of two. Originally, only one was scheduled but due to the inability of a speaker to appear, the second was organized. Interestingly, this resulted from a polling of the audience when it was learned that the schedule had to be changed. Given the option among several speakers, they voted almost unanimously for the round table. The proceedings of this second conference will be quoted almost in its entirety because, like the Bluestone lecture, it yields a most thorough, direct and revealing picture of what is operating within a representative correctional setting. In addition, it documents areas of concern, friction and philosophy that anyone interested in training, personnel practices or rehabilitation in the field of corrections would be concerned.

The actual names of participants, with the exception of the discussion leader, will not be used since this was one of the agreed conditions among the participants. Job titles will be used instead. It should be further noted that the reported round table was expanded by popular request to include mental health workers and a female corrections officer.

Dr. Gould: The participants in the round table today are Deputy Warden (DW)________, Captain (Capt.),________, Corrections Officers (CO,________, and________, Miss (CO)________, in addition there is Social Worker (SW),________, Psychologist (Psych.),________, and myself as leader.

I think we'd like to pick up where we were two weeks ago when the group was much smaller and continue our discussion. At that time as you

will recall, there was some feeling that it would be interesting and worthwhile if some people joined us who were not involved in the discussion at that time, and the particular people that were requested were representatives of the mental health disciplines and a female corrections officer. We have these people today. So how do Corrections Officers talk to psychologists and social workers. How do female corrections officers talk to male corrections officers and what do we all want to talk to each other about.

CO________: I'd like to begin by asking about protection. I think that the DW made a comment before we actually got together here about correctional officers and mental health people talking together and what were we going to do about protection.

Dr. Gould: Protection of what, of whom --

CO______: I don't know but I just had a feeling that there might be some danger in people coming together and talking together who usually do not.

Dr. Gould: Why did we want mental health personnel here.

Psych.______: I'd like to maybe start something rolling, in terms of what I feel have been some kinds of traditional stereotypes that distinguish mental health people and correction officers, and I think these stereotypes involve feelings in regard to authority and the uses to which authority is put. Now I think that correction officers feel that authority is a good thing and the use and exercise of authority is a good thing. I think they tend to sometimes feel that we do not, mental health people that is, do not agree with this. My personal feeling is that authority as such, really cannot be discussed because it is not so much that we are against authority or against the exercise or use of authority, but that

we tend to break authority down into two different kinds of ways in which authority can be applied. I think that this was touched on a little bit last week. Authority applied and used in the interest of the person over whom the authority is being exercised I think is one thing. On the other hand, authority used in the interests of the people exercising the authority at the expense of the people the authority is being exercised over is something else. So rather than talking about yes authority or no authority can we kind of maybe go from there?

Dr. Gould: Yes, I think that any discussion such as we are trying to get under way today has to involve the various participants' understanding of authority and the application of authority. I think as I was listening to you it occurred to me that perhaps one of the better ways of getting answers would be to set up an as if situation. Suppose we act as if we had a particular prisoner under consideration or a particular group of prisoners under consideration and for one reason or another everybody sitting at this table is involved in the rehabilitation planning for this person as long as they are in this institution.

If that is so, then we all want to get an idea of how we see this person or persons, what we think should be done for this person or persons, and how we should go about doing it. Let me suggest that a prisoner or -- no let me defer to Mr. (SW). I assume that in your capacity as a social worker in this institution, you have an idea of the background of someone, some of the issues concerned, what he is here for and so on and so forth. Would you present the prisoner to the rehabilitation panel.

SW_____: Embarrassed, mumbling and incoherent --

Dr. Gould: He was just clarifying the burden I just placed on him. He is organizing himself.

SW_____: O.K. we have a person whose been in the institution approximately one week. He has no family on the outside, at least no family that is going to be available to him when he is released from the institution. So therefore it is difficult for him to establish plans regarding any program for himself. He was referred to the institution, he was adjudicated by the court and sentenced for an indefinite sentence. This complicates the matter; it produces more anxiety since he does not know when he is going home, he does not have a program to establish for himself. He is in the institution one week and he is having problems with some of the inmates in the QUAD, the conflict is over racial issues.

Dr. Gould: If such a situation were in fact to exist would it come to your attention.

DW_____: No, to the Captain.

SW_____: I would like to go one step further. Due to this racial conflict he finds himself in the minority position among his peers in the QUAD. He is faced with anxiety, perhaps he is being threatened in some way by his peers in the QUAD and he resorted to cutting his wrist. Now this is brought to the attention of the officer in the QUAD and then he is referred to our board.

Dr. Gould: All right let us take it in that sequence. Will you take it from there.

Capt._____: The officer would let the supervisory officer know what it is about. Now what the supervisory officer would have to do is....

Dr. Gould: Capt. let me interrupt. Which one of the officers on the panel was directly involved with this.

Capt._____: Oh, let us say Mr. (CO) was the housing area officer at the same time of the incident and it was brought to his attention and he in turn reported it to me.

Dr. Gould: And now it is turned over to (Capt._____)

Capt._____: The first thing we do is, of course, get medical attention. Whatever medical attention he would have to have. The next thing a referral would be made to one of the mental health people. I would refer him to Dr. (Psych_____) but there are a few more things I have to do before I can do that.

In my interview with him let us assume that the fact came out that he was concerned that he had no one outside and there was no reformatory sentence, and that the average stay under the state parole board is a bit longer, I would get in touch with say Mr._____ who is the vocational counsellor and try to work up a positive program for this boy. In other words, he, as a job counsellor, would try to get him a job. He would also go along in trying to get him a place to live in the community. Now there is something else involved here. Self mutilation itself is an infraction against the rules. Now we might also ask that the psychiatrist give us an evaluation of whether this person was mentally competent to stand trial or not and whether we would want it. Not in all cases do we do this. We do as far as their mental competency is concerned but sometimes we will not try this person, but we would look into the background of it. Another thing that we would have to take into consideration is where do we house this person? Where do we house this person until we have a definite designation of his mental health.

Dr. Gould: Who would be involved in this decision?

Capt._____: Well in my place I would, because I am the classification officer with the counsel of the mental health staff. (At this point a psychiatrist from the audience volunteered to participate in the round table and was invited to do so. She is a female psychiatrist)

Dr. Psych._____: In adolescence, spells of cutting up occur rarely on the outside. I had lately about six boys cut up superficially and I think that is done as a means of getting attention and getting what they want. It is not a real suicidal attempt, it is more of a gesture.

Dr. Gould: Let me interrupt for a moment. On the assumption that Capt._____ has approached you now for a consultation and you are talking to him and he is talking to you, what is this dialogue like?

Capt._____: Well I might say to her: Do you think the boy should stand trial?

Dr. Psych._____: The other day the Deputy came up with a boy who he knows is very disturbed and he was cut up. He said look I do not want an infraction board. Now if a boy is really disturbed you do not want to submit him to that judgment again.

DW_____: And we went along with mental health. The two boys that were cut up we did not have any infraction charges brought against them because one of them was directly under Dr. Psych._____ care and he is continuing under her care and we did not think at this time that it would serve any purpose to push charges.

Dr. Psych._____: Now as a matter of fact, I want to add one thing and I will keep quiet. That one boy seemed very disturbed to me. But I did not

make a diagnosis of a schizophrenic reaction. He came to the infraction board without any medical consultation and it apparently had such a bad effect on him that he got much worse. Maybe he would have gotten worse anyhow. He is a hospital patient now, and it was not until after the infraction board that I realized that he was really psychotic. He didn't seem to be psychotic before. So I think we have to keep that in mind.

Dr. Gould: All right, so to the point that we have gone we have been sticking to the vehicle of the implementation of authority.

DW.______: There is another level of authority there. You mentioned the fact that this was an ethnic fight. Now any kind of ethnic fight makes me very nervous. Because I have had experiences where we have had a fight in block two at eight o'clock in the morning and a near riot in block eight as a result of this fight. So whenever we have such a fight we will investigate very thoroughly to see if there is going to be a carry-over. It may be necessary to keep a whole group of men working overtime all through the night because once a riot gets started it takes weeks before you can quiet the prison down. So it pays to stick everybody for overtime for twenty-four hours, if necessary, until things are quieted down to make sure, and we have people circulating the blocks during this time.

But any kind of an ethnic fight is a thing that we should be very careful of. Two people fighting who are white or are Negro or are Spanish, are of no concern to us, this is merely a fight, but as soon as there is a break in the relationships then we become very nervous about it and it becomes a matter for top administration's concern.

Dr. Gould: What's being pointed out is that there are several levels of concern. There is the concern of the individual corrections officer with the immediate behavior among those people under his immediate supervision. The next level of concern would be on the disposition of this behavior or the person committing this behavior. Then there would be the medical concern with regard to the health or the emotional stability of this individual, and finally there is the institutional concern; the ramifications or implication that this has in terms of institutional management.

CO______: I had the opportunity to talk to this person after, well in this case he went to the board and was found not capable of standing trial. But I wonder what the people feel about the question of the difficulties that he was having in the institution. If they are mainly due to the racial difficulties that people themselves set up. In other words I gather from what he has told me and from what we seem to know, that there is racial prejudice here and racial disturbances and fights do occur. I wonder what, not only what can be done for this individual but what does the panel feel can be done about this problem in institutions.

Dr. Gould: So in effect, what you are saying is now that the situation has developed, now that the situation has been handled and in effect stabilized what do we understand about it. What do we know about it. What do we learn from it and how can we manage it in long term considerations.

CO_____: I have found out from some of my inmates that there is an unwritten law that says the Negroes will stay here and the whites here and the colored here. They must not mingle and if they mingle it may be taken

out among themselves. Now I do not know who makes these laws and I was just wondering about it in terms of this discussion.

Dr. Gould: How do you feel about that.

CO_____: Well I will tell you I think that -- I do not feel terrible about it because I feel that -- let me ask you when was the last time we had a riot that you know of, more or less these people take care of these things themselves. You will find, if you have a predominance of any race in a specific spot, I can give you an example. As you walk along inside the institution, while people walk to the mess hall -- to the mess hall in groups you can always tell which is the predominant group in the area, and that will be the people in front of the line. If the block is predominantly white, the white people will be in the front of the line, if it is predominantly Puerto Rican, the Puerto Ricans will be in the front of the line and this holds true in nine out of ten cases.

SW_____: It even appears to be this way when people eat together in the restaurant among us. The Negroes eat together and the whites eat together.

Capt._____: Well I do not think so.

SW_____: There seems to be the same carry over.

Capt._____: I think personnel are very integrated. I do not believe that they stay by themselves.

SW_____: Well perhaps then we could deal with it. You seem to be saying that they handle this problem by themselves but from my information it seems to be something that is not really handled. They do it but they don't really enjoy doing it when you talk to them individually.

(Mixed discussion from the floor)

Capt._____: It is not a matter of enjoying doing it or not enjoying doing it. We are living in a society that forms a social structure and this is it. This social structure here consists very simply of three groups. White, Negro and Puerto Rican. Now there was a time in this institution some years back, when things were very quiet, they broke this down into light Negro and dark Negro and light Puerto Rican and dark Puerto Rican just to make things a little tougher for themselves.

They lead a very, very boring life and they try to maintain the purity of their groups. When any inmate violates the purity of their groups he is blackballed, when he is blackballed that means he is an outlaw in the block. In a block of four hundred people he will not have a single inmate who will talk to him. This is the kind of guy who blows his top. This is the guy that you will probably get after he has been beat up or after he has cut himself up just to get out of the block. He is definitely manipulating the institution to get out of the block because it is an intolerable situation. But there is nothing you can do about the social structure, I have tried.

At one time I had a complaint from a captain here that our garbage gang was all Negro, this was six or seven years back. Well, I ordered the gang integrated, in other words what they call salt and pepper and the inmates themselves complained about this, they wanted their own people with them to do their work comfortably. When they were working with someone else they just were not comfortable. This is an uncomfortable situation to begin with and when we force them to do things that they

do not want to do, they do not like it. Now there are very few inmates in this place who want to be housed with people from other areas. We house them indiscriminately, but once they go out of their cells and into the block they will automatically segregate themselves into these three groups, and there is nothing we can do about it, or should because we could have a rather rough situation if we did.

Psych.____: I wonder, because it has been my experience that it is like almost unconsciously tolerating something you feel is not my responsibility because this is what they want. But when I see these people in groups they talk about their feelings about this racial segregation and it comes out that they really do not like it, but they are playing along with their fears. They do not like this conflict, but they are doing it because of the need for belonging and the need for acceptance, the need for a scapegoat, you know, so when you get to talk to them about their feelings it is not something that they really enjoy, in many cases. It serves a purpose for them but on the other hand it seems that this is something that they really do not look forward to.

SW____: Or is this an expression of problems that they brought with them into the institution that are related to the reasons why they came to the institution in the first place. So that concern with the why's and wherefore's of this kind of behavior may very well be just as much a concern with helping them to live differently outside of the institution.

CO____: Now I wanted to say this much, now you face it that, now you say the white, the Negro, the Puerto Rican, they have been segregated on the outside, so when they come within these walls, let us say they are not

going to segregate, they are going to mingle with their peers. Now the individual that might complain to you by himself that he resents -- say a white boy would come to you and tell you that he resents being with the white boys and he wants to join up with the Negroes or the colored gangs.

He cannot do it because it will be as though he was turning his back on his own, let us say it will create a problem for him, so he has to go along. Well his only outlet is to complain to somebody and you are it. But there is nothing that you can do about it. Our society segregates us on the outside and when you come within -- they segregate themselves. So there is nothing you can do.

Dr. Gould: So you see to be saying we cannot do anything about it here.

Floor: Well I think you're dealing with a different class. I believe so.

Dr. Gould: Let us keep it limited to the participants.

CO____: I would like to give you an experience that I had as a military policeman at Brooklyn Army Terminal. We took twelve white officers of three different ethnic groups -- Jewish, Irish and Italian. We took them into the officer's club. They had never met before and within an hour all of them had moved into separate groups, as soon as they found out.

Dr. Gould: So what seems to be being described is number one, that there is often times a conflict between what the individual may desire as opposed to what the group may very well impose on him. Now the other point that I think warrants our consideration is that much has been said about this segregating procedure being self-imposed, self-managed and organized by the various inmates and that they are comfortable in doing

this and this is the way things are kept smooth. Now this raises a question, a very basic question in rehabilitation and change. I would like to put the question to the panel. Does anybody ever comfortably change? And because it is uncomfortable to change is that a reason that would justify supporting the status quo or going along with the impulse not to change.

SW_____: I think here again the question is authority and its exercise and in the interest of whom. Now I think it is in the interests of the institution to have a smooth, uneventful, comfortable running organization with as few problems as possible. But on the other hand it may be in the interests of the inmate in the institution for it not to be so smooth and so comfortable and so uncomplicated.

Psych_____: Well this is the point I was trying to bring up just recently. Now it seems to me that we are dealing with a natural phenomena. That of a sub-culture being developed, and I think that it could be developed anywhere in any environment no matter whether it be an institution, whether it be in society, or on whatever level you might want to think of. A sub-culture is a natural phenomena, it is not going to be eradicated. I do not know, and in fact, I do not think that the custodial authorities can eradicate or do away with the sub-culture entirely because I think if they did another one would develop along different lines perhaps. But still you would have a sub-culture and it would have its pros and it would have its cons.

The question that comes to my mind at this point is -- is it therapeutically desirable to correct the environment for the individual,

or would it be better to confront the individual with his problems and help him analyze his problems. That is, to talk about his problems within this subculture and see how the individual can cope with this sub-culture. Perhaps his methods of coping with this sub-culture are wrong. The thought that brings me to this is that on the outside, if one were to go for therapy or for consultation it would be rather ironic for a psychologist or psychiatrist to say well, we are going to perhaps place you in the army or move you to California to solve all your problems. You have to deal with the individual where he sits, with the roots he has already created for himself. So you have to have the individual change or understand his particular problem, so could not that be applied right here?

Dr. Gould: Anybody want to react to that? It is an interesting notion.

CO_____: The prison is an unnatural environment as it is. By creating a situation such as this we make it a much more unnatural environment because when the inmate leaves here he goes right back into a culture that has prejudice. You cannot eliminate it here and let him go back into it there, and expect any kind of positive results from this. The cure has to take place outside, if it takes place outside we will follow inside. We are only reacting to the structure that is outside right now.

Psych._____: I think that the point that (CO) made was very well taken. I think this is an essential point in working with someone in therapy. In other words, you have these problems in reality that are effecting you. Now how are you going to cope with them or how have you coped with them You know you cannot change everything in reality, you cannot be this way. It is not going to be perhaps that beneficial for the person. Then again

you are also faced with a limited amount of people in treatment and you have a problem dealing in pure relationships, and part of that problem is the need to form a sort of structure amongst themselves. There is a need for a scapegoat, there is a need for one class as opposed to another.

Dr. Gould: All right then what you are suggesting is the possible innovation of a structure or an approach that would attempt to come to grips with the existing situation. A point I would like to throw out to the group is this. Going back to (CO's) point about the ultimate necessity for the individual to cope with his problems; that the essential burden for living lies within the individual, and it is inherent upon him to make the best of his lot. Why should we have a prison or any other institution if it is entirely up to the individual. If all you are going to do in effect, is say it is your baby, carry it, why should he be here.

CO_____: I think the prisoners are very much aware of it. There are some houses that will have just Puerto Rican doormen, some who just have colored doormen, for some reason or another certain stores will have it that way. There was a demonstration once in front of Chock-full-of-Nuts and some white boys demonstrated so they could get in.

Dr. Gould: But would you comment on the point I just made. Why should we have a prison if the entire burden of adaptation and adjustment is going to be seen as the responsibility of the individual. Why the institution?

(Discussion from floor)

CO_____: The individual when he is born into this world is handed a set of rules and regulations whithin which he must abide. He cannot violate them; if he violates them the society into which he is born wants some place to put him. He becomes a deviant factor. That is what you have prisons for.

Dr. Gould: So we have a prison just to punish. (CO) says to rehabilitate. Captain you want to say something.

Capt._____: When we first started society in this country we did not have prisons, we had corporal punishment. There were certain standards set up by law. The society we live in now says a man gets a criminal commitment and he comes to jail. I do not think the man comes for punishment; I think we are trying to do a job of rehabilitation but society wants a certain amount of punishment too. Now it is all right to say well why do you need prisons? You take a fellow and you put him in an abnormal society and you expect him to function normally. Are you not doing that in prison. Maybe someday we will have something else to take the place of prisons. But in the meantime let us get some suggestions. Now (SW) said something about, well maybe they do not like their structure, but let us be realistic about it. You do not even have enough mental health people here to touch the surface, to see anybody anymore than on a referral basis. How much individual psychiatric treatment goes on here? How many groups do we have? What work are we doing with these inmates?

Dr. Gould: Good, so we come back to one of the questions that this panel at one point considered worthy of consideration, namely, the coordination of correction and rehabilitation. The perception, or the role or the function of the corrections officer as an agent of rehabilitation. How do we make

mental health personnel? How do we use what we have got? This is what we have got. This is the responsibility we are charged with. How do we use ourselves to better implement and better accomplish the ostensible goals we have. It is generally agreed today, nobody is put into prison to punish them. All the bleeding hearts say we are putting you in prison to help you change -- to rehabilitate you. How do we do it? We have about five minutes to try to figure it out. How do we do it? How would we use ourselves?

CO_____: Well you can call prison what you like. It is still a punishment. The mere fact that you are taken out of your society and put into an unnatural society is punishment. The mere fact that all choice is taken away from you while you are an inmate here -- you cannot order your meals or your clothes or your awakening time -- this is punishment.

Dr. Gould: You cannot do it in the army, you cannot do it in a hospital either, many hospitals that is.

CO_____: All right, there are restrictive institutions, which are part of society, a prison and an army is part of society. These things have been developed by society to protect society.

Dr. Gould: How do you make the institution that was developed initially to punish -- how do we make it an agent of change?

DW_____: We want to make it an agent of change, but first we must face the fact that it is primarily an agent of punishment.

Dr. Gould: We do.

DW_____: Within that we can do some changing.

Dr. Gould: What changing? How?

DW_____: Well this is what we do not know. I do not think anybody knows.

CO_____: Dr. Gould what you are asking for is very unrealistic. Let me tell you why. First of all....

Dr. Gould: One of the luxuries of this panel is that we can be as unrealistic as we want.

Capt._____: It is a monumental budgetary problem. On this Island alonewe have five thousand people. In the three disciplines that we have here, you do not have nearly enough personnel to do it. If you want an ideal condition, I can talk to you about having an institution of not more than one hundred people with maybe almost a one to one relationship between mental health and custodial people. And this is an idealistic picture.

But the society we come from is much more interested in keeping people out of here than treating the people who are in here and you are never going to get the budgetary funds to set up an idealistic condition, so what are you confronted with? You are confronted with an overburdened staff, too many inmates, and you can talk until you are blue in the face and you are not going to do the job under these conditions. You can only touch the surface and just help to keep everything calm.

Another thing you have to deal with is this. Society has a law. The law says a man has a criminal commitment. There are certain codes and ethics that are set up. They say if a man commits the crime of grand larceny that he is to be sent to a reformatory for a three year sentence under the auspices of the parole board, and these are the things that have to be done, and we are given this to live with, and we have to make the best

of it. But if you want to talk about idealistic conditions, let us start right out with budgetary funds and break down into small institutions and beautiful areas and give all the therapeutic help we can. And it just is not going to work like that because you are never going to get the money.

SW_____: Suppose we take what we have, for instance, I do not know, I think this part is part of my own interest in the problem of peer relationships and prejudice and the program that they set up, but I think also it is an indicator of the emotional problems that they individually are going through reflected in groups, so what do you think one could do with this problem in, for instance, in a quad or housing area.

Dr. Gould: What do you think?

SW_____: Well I think, first of all, that perhaps there could be some discussion between the officer and mental health people. Get together and talk about what is happening.

Dr. Gould: You have three minutes, you are a mental health person, Capt._____ is a uniformed person.

Capt._____: Hey (SW) what are we going to do about the fact that, how are we going to break down the structure, that when we go to the mess hall in this particular block the whites are the dominant factor and they are up in the front of the line and if one of them steps out of line and talks to a Puerto Rican, he is considered a freak. Now I have been mulling this over and I think it is a monumental task. Can you help me in this?

Mark: Is this just in one quad?

Capt._____: No! No! I'm talking about two thousand inmates in the adult division.

SW_____: This seems to be through a program that is set up not just for two thousand people but in each individual quad. I wonder if there is any way that you feel perhaps some program can be set up. That mental health people can work in this type of milieu therapy arrangement with some responsibility to talk to inmates about what is going on. About their feelings about this program. And include officers in this also.

Capt._____: Fine. Do you think by doing this that this is a realistic approach and do you think we have enough hours in the day to do it?

SW_____: Do you think this would be allowed first of all?

Capt._____: Why not, I have already seen the Warden and he gave me the go ahead to work with you.

(At this point one psychologist from the audience imposed himself and grew very excited)

Psych.II_____: No, I just feel that the whole thing is ridiculous. What is realistic is playing games and acting out. I just.....

Capt._____: Look that is a downright misrepresentation of the facts. I personally suggested an integration of blocks and was told that the Warden was against it. So what you are saying is not accurate.

CO_____: But we are playing, this is an act.

(Discussion from the floor and very heated I might add)

Capt._____: We are talking here for the panel. Now I would like to hear you expound on some ways of doing it.

Psych.II._____: You are giving all kinds of excuses that it is societies' fault and everybody else's fault. Do not make waves. What about gangs that are assigned just Negroes or whites or Puerto Ricans, but not all of them.

Capt._____: I have been a classification officer in the penitentiary. I have never ever assigned along ethnic lines.

Psych.II.____: I do not care what you have done. It is done now.

Capt._____: By whom?

Psych.II.____: By whoever assigns the inmates.

Capt._____: I assign inmates and I defy you, I defy you to come over to my place and I will show you every roster and you show me that to be true.

Psych. II.____: I will show you every adult unit.

Capt._____: I can only talk for myself and I defy you to come over and show me that....

Psych.II.____: I was not accusing you, I was accusing the institution.

Capt._____: So it is a question of -- maybe what Psych. II is saying is that maybe, this is a lot of bullshit. Is this something that we maybe really want and want to take responsibility in looking at and doing something about, or are we just talking.

Psych.____: Do you honestly think -- I want to put out a question to you and Psych. II. Do you honestly think that you can get a group of these people in the auditorium or wherever you wish under any conditions you want and let them tell you their feelings and that you will break this up. You will break this structure up. I would love to see it be done.

Psych. II.____: You do not want the structure broken up.

Capt._____: My dear man let us be perfectly realistic about it. You will go home at four o'clock. I would not want to be that officer in that cell block by himself on a four to twelve shift with three hundred angry inmates.

Psych.II.____: Let us not call this rehabilitation, let us call it what it is.

Capt._____: We are trying Mister and we are trying very hard. I am as much interested in rehabilitation and I think more than you will ever be.

Psych.II.____: Could be, but the point is, the way it is being done it is not rehabilitation, it is words.

Capt._____: Many nights I stay here late and I....

(Discussion from floor)

....I never see you here Psych. II.____.

Dr. Gould: May I interrupt -- what are you learning? All right permit me to sum up. The question came from the floor what are we learning. The inference being we are not learning anything from displays such as we are witnessing this afternoon. I could not disagree more strongly. What we are learning, if we are willing to listen, if we are willing to hear, are the following things: We are learning that when you come to learn about drug addiction or anything else, there is much more involved than having some learned people get up on a podium and talk to you about the fancy psychodynamics of an individual.

You are learning that there are a group of people involved in a very complex enterprise, namely, the rehabilitation of individuals who have committed crimes against society. You are learning that there are many people with intense feelings, good faith, and a sense of commitment to the job they are charged with. You are learning that the good guys and, we are the good guys, can get frustrated like the bad guys. And you are learning that the good guys can be brought almost to a point of physical violence like the bad guys, and you are learning, most importantly, I think, what the first and most immediate need is -- communication, talk!

I think the most important thing that has happened here today is that an honest exchange finally took place and it exposes the crying need for more honest exchange. And if the question were put to me that I put to the panel -- what can we do about this? I would say -- doctor cure thyself. And before I did anything about the inmate, before I did anything about rearranging living facilities, or classifications, I would sit down with my colleagues, no matter what kind of clothing they were wearing or what kind of office they sat in and I would talk. And I would talk regularly, and I would talk intensively, and I am sure that in time just like an Italian eventually gets to comfortably have a beer with a Jew, and the Negro eventually gets to comfortably have a beer with a white man. I think it is even possible for a psychologist, or a psychiatrist, or a social worker to comfortably have a beer with a correction officer.

And one last point -- I cannot help it I am a psychologist -- so I have to make an interpretation. I think it is very interesting that the essential vehicle of the discussion revolved around prejudice. And I think it is an important point to make -- that it seems we were talking about racial prejudice. And like so often it is not the racial prejudice that is at issue. It is the racial prejudice that hides what _is_ at issue. The prejudice that finally came out was the inter-disciplinary prejudice, and I am sure that much that goes on within the inmate population under the guise of racial prejudice is masking something else. But until you can talk about the racial prejudice as we did today, you do not get to what is underneath it, but as you notice, and I hope you learned -- if you talk about something long enough you eventually get to what the issue really is. If you talk about it long enough and patiently enough, that is. Thank you.

4. Summary

Following the round table just reported, there was a significant drop in attendance. In spite of the fact that it was accorded a standing ovation and all participants loudly complimented and thanked. It was afterward that the reaction set in and attendance fell off. It was temporary and returned to the average level, in time.

Here then, are many of the issues. Can they be dealt with? Do we have the courage to come to grips with them? Do we really want change? These are the questions that must be asked and this one round table, it would appear, contains indications of what might be done, how it might be done and why it should be done.

C. Theoretical Aspects of Drug Addiction

In this section an effort will be made to present a comprehensive picture of the addict; a view from a theoretical, dynamic, pharmocological and family point of view. Where previous sections were concerned with society's or the community's vantage point here we are attempting to look at addiction from the frame of reference of the concerned social scientist. Here we are really posing the question, "what is a drug addict?" In theory, the answer to this question should logically lead to a basis for formulating treatment and rehabilitation programs.

1. Some Theoretical Considerations

The first speaker in this series was Dr. Charles Winick. Dr. Winick began by observing, "it has been said by a number of different people that there is nothing so practical as a good theory." In this field, however, in addition to being a phrase that is meaningful, it is also urgent. This is so because, depending on what your theory of narcotic addiction is, your approach to treatment will obviously follow. There has been, in the last six or seven years, a great deal of agitation and reexamination of theories which had previously been taken for granted, and this is especially true of the theories in the fields of psychiatry, psychology and psychoanalysis.

Dr. Winick then proceeded to enumerate some of the various existing and new theories of addiction. These, he broadly characterized into Person theories, Chemical theories and Sociological theories. He noted that prior to the introduction of the methadone maintenance programs, about ten years ago, there was a reasonably general acceptance of the concept that narcotic addiction is in fact a severe emotional disability. This emotional disability loosely clustered under what is known as a passive dependent personality or oral character. Further, that the addict came from a home with an over protective, rejecting mother and a weak or absent father. This he cited as a kind of Person theory. A

theory that posited that we would have to know how to change such a person before we could do anything about his addiction.

Winick then went on to essentially reject the Person theory and present other ways of viewing the problem. The major problem basic to all of Dr. Winick's succeeding presentation was that in rejecting Person theories you are left with the uncomfortable impression that perhaps addicts are not persons; not governed by the same internal and external conditions as are the rest of us; and that there is really little that can be done short of substituting one drug for another, as with methadone, or letting the illness run its course, as in his maturing out hypothesis.

His first reference in developing his position was the work of Dr. Marie Nyswander. He cites Dr. Nyswander as an analyst with long experience in the addiction field, as an authority for rejecting a psychodynamic position. Nyswander's position is essentially a biological one. She hypothesizes, as a result of her "success" with methadone maintenance that addiction is a metabolic disorder resulting from the intake of heroin. Or, perhaps, that the intake of heroin is in response to a metabolic deficiency. One should note that in all the excellent physiological research that has come out of Lexington, Kentucky, not one bit of evidence exists to support her theory. The fact that Winick is impressed that a psychoanalyst, Nyswander, comes up with a non-Person theory seems to be a rather thin basis for enthusiasm.

He next cites Winkler's work which postulates that narcotics work on the central nervous system in such a way as to quell, or suppress sexual and aggressive drives and in so doing relieve the individual of these discomforting, internal stimuli. Accordingly, people who have trouble in expressing or responding to pain, aggression and sex would become drug addicts. This, Winick categorizes as a psychiatric theory. What he overlooks is that this formulation, though true, is essentially mechanical. That is, it tells us what people, possibly, are bothered by; the cite in the body that mediates these stimuli; and the substance that neutralizes the stimuli. However, he overlooks the fact that such complex phenomena as <u>one's reaction</u> to pain, the construct of aggression, and the complex that is related to the sexual drive, are hardly sub-cortical, autonomic phenomena uninfluenced by one's psychodynamics.

So to this point Winick has presented a most superficial notion of a Person theory which he rejects and in its place suggests a biological theory for which there is no evidence, and a psychiatric theory that does no more than explain the mechanical effects of a narcotic.

He then went on to describe the very real possibility that addicts, rather than being exclusively dependent on heroin, are in fact "polydependent" on a number of substances. These substances ranging from heroin to alcohol, to other kinds of drugs. One application of this notion, according to Winick, is the utilization of alcohol as a substitute for narcotics. He cited that this has been done

in his jazz musicians' clinic for a number of years and has not led to the development of alcoholics in place of narcotic addicts. Here again, there is insufficient evidence in terms of the total content of the program and verifiable follow-up. What really needs clarifying is not the issue of "poly-dependency" that is acceptable, but rather the notion of poly-dependency as a basis for seeing Winkler's formulation as less relevant; "the psychoanalytic formulation as far less relevant;" and the necessity for our treatment and rehabilitation procedure to be all different. It would seem quite the contrary. If anything, the evidence of poly-dependency does nothing more than underscore heroin or any other substance as a symptom. It is only if you are in the business of symptom relief, rather than attack on an illness, that these points mean anything. Winick certainly made an important point at the outset when he noted a theory is important since it will determine the nature of treatment. So far he rejects the one theory that contains elements of treatment, i.e., Person theories, and in their place substitutes mechanical or symptom-oriented theories. The result can only be what we have had so far -- symptom relief for the addict with very little evidence or rehabilitation or cure.

Winick's next major discussion point was his "Maturing Out Hypothesis" which has had great attention paid to it. Very briefly, the maturing out concept suggests that for perhaps eighty per cent of the narcotic addicts the whole phenomenon, the life cycle of

their addiction is a time limited one and that it is a function of their age. At the age of onset of the addiction the younger they are when they begin, the longer the addiction will last; the older they are when they begin, the shorter their period of addiction will be. By period of addiction, he does not mean one period of addiction, he means the total period in their lifetime during which they will be drug users. He suggested in his two reports on the subject that for about eighty per cent of narcotic users the age of the mid-thirties is essentially the age when this phenomenon, this maturing out occurs. He has developed a simple equation that enables us to predict how long a given narcotic addict will continue to use drugs, once we know the age at onset of his drug use.

From this hypothesis Winick raises some very interesting questions. Since 1962 when his original article on maturing out appeared, there have been five large scale follow-up investigations of narcotic addicts and they have all confirmed this findings. That is, they all found that once the period of the mid-thirties are reached, narcotic addicts stop using drugs regardless of whether they are in or out of a treatment or a rehabilitation situation. So this finding essentially has confirmed his hypothesis but it has also confirmed a more ominous aspect of his hypothesis; namely, that if this is so, that is, the maturing out hypothesis is so, then there is very little, or relatively little that we can do for the majority of young addicts.

This is so because the disease or the illness seemingly has a life cycle of its own almost regardless of whatever intercession or rehabilitation we engage in. He says this is ominous because its implications are very disturbing. If indeed there is relatively little that we can do for the younger narcotic addicts, then what about this should modify our policy? Should we give them drugs for the average of eight years which he concluded was the life span of a typical addict? Should we establish special facilities for young men and women in their twenties who will be taking drugs anyhow? There are a number of disagreeable questions of this sort which might be raised but which he thinks are quite central in terms of the theoretical approach which we take to addiction.

At any rate he mentions this because it suggests that for the great majority of addicts, the phenomenon is a time bound one and it is something that we can look forward to the end of during an addict's fourth decade of life.

Dr. Winick's presentation of "old" and "new" formulations then shifted into the sociological area. The old view was contained in the "delinquency opportunity theory."

Very briefly this theory suggested that we all live in a culture, and we all have certain modes of conduct, or we all have certain values, but not all of us necessarily have the same access to the valued things in our society. One may walk past a store and see something he likes; he may reach in his pocket for money;

he goes in the store, buys it, goes home with it. Now the poor person who sees the same object in the store has been trained and conditioned by television and advertising to feel that he too should buy that object if he wants it or get that object. He looks in his pocket, he has no money and he looks around and realizes that there doesn't seem to be any traditional job situation that will help him to get the money to buy the object. Therefore, he will look around him and realize that there are illegitimate means ofaccess to money, various forms of crime and that he has access to these illegitimate means of activity. In the process he will become a thief or a burglar.

The opportunity theory of Clausen and Olin suggests that for many young people, becoming a thief or a robber is not something that they feel they can easily do. Rather, they withdraw even from the sub-world of the small time criminal. They withdraw to the world of drug use with its own language and sub-groups and select activities and skills that must be mastered, and with the many satisfactions that it provides, because it is a twenty- four hour job to get drugs.

Although, Winick did not make the point, right here one would have to ask what kind of person turns to crime and what kind does not. Does one have different metabolic rates than the other? He most probably has less tolerance for the experience of pain, the pain of worrying if he will be caught. He most probably has

greater problems with aggression -- if we equate aggression with crimes against property. But, and most significantly, once he is an addict, as our crime statistics tell us, this form of aggression is no longer a problem. Obviously, then, the Person theories rejected earlier perhaps have relevance.

The new Sociological theory Winick presented grew out of the incidence of addiction in higher socio-economic stratas of society. The new theory loosely revolves around the ancient concept of "Rites of Passage." These were rituals associated with the passage of an individual from one significant life stage to another. In so doing, new roles are defined and different kinds of behaviors are called for. As a result of this upheaval and dislocation, narcotics are often resorted to as a way of avoiding the pressures and demands of the new stage of life that the person is entering. The theory suggests that by joining a new sub-culture, that is a drug culture, that does not subscribe to the mores of the larger culture, one can escape from the rigors of their "new role."

Dr. Winick closed with the observation that we have looked at a half-dozen theoretical dimensions of narcotic addiction. Each of these is currently subjected to reexamination as a result of our new opportunities for experience with narcotic addiction. Now for the first time, we have a chance to see which of our perceived ideas have merit and which do not, and the disagreements that he has described.

"Actually I think it is a sign of health, a sign of ferment in a new and growing field. It is good that we do not take for granted what we have been told; it is good that we are honestly collecting data and revising theories in the light of these data and it is good that we feel free to confront one another and say where and how we disagree. It is only through the kind of confrontation and through the kind of dialogue that a series such as this provides an opportunity for that progress to be achieved. It is only through this sort of free and honest reexamination of what we believe, that we will be able to make progress in what we all, I am sure, agree is unfortunately a very thorny and difficult, but very urgent problem for all of us."

2. Issues in Personality Development

The next speaker in the Program was Dr. Lewis Wolberg. His presentation is in dramatic contrast to that of Dr. Winick. Where Dr. Winick dealt very little with the individual, Dr. Wolberg dealt with him exclusively. Although Dr. Wolberg did not couch his remarks as reflective of any particular theory, it is quite clear that they grow out of an electric psycho-dynamic view of personality development.

Dr. Wolberg sees the drug addict as one of a class of people, all of whom suffer from a basic defect in development. His essential position revolves around the resolution of an individual's independence and dependence strivings.

A well adjusted individual has to be able to relate to others without undue aggression, protectionism, withdrawal or dependency. He has to be able to relate to himself without undue grandiosity, without masochism and with the ability to isolate his past from his present. In short, he must be able to live according to the reality of the situation. These are very complex personality operations and an individual who has not built up experiences and structures to enable him to relate in this way will be disturbed. The drug addict is such an individual.

The foregoing products grow out of one's upbringing and Wolberg sees this process as one where an infant's helplessness and dependency are gradually replaced by feelings of independence. Under optimal conditions, a loving mother makes the child feel wanted as a person; a supportive father figure engenders an atmosphere of discipline, order and security in the home. In this atmosphere, the child grows up with the dictates

of the family and society around him. As he grows, he is able gradually to slough off his dependency so that by the time adolescence rolls around there is both a good measure of dependency and independency. It is this balance that enables him to develop mechanisms and defenses that help him take up his responsibilities that will make for good adjustment.

There are many things that can happen that can serve to prevent this. Among these things are a sick or harried mother, or one who is neurotic and overconcerned. Or a father may be too passive, too tired, too hostile and bitter, or absent either in body or spirit, or both.

Most directly the impact on the individual of these conditions is usually that his dependency remains too high, has never been resolved, and he is therefore in chronic search of dependency figures -- none of whom are ever capable of satisfying his insatiable needs. A person can disguise these strivings in many pseudo-independent ways, but the drive is always for an idealized parental figure. However, it always fails; his needs are too great and his ability to trust is nonexistent. So he is looking for an all giving mother and an all protecting father.

Dr. Wolberg pointed out how the Corrections Officer will be seen as such an idealized figure, one who will not be trusted. So we can see why disappointment is inevitably present along with frustration, consequent resentment, and deep seated hostility. This combination of dependency and resentment often yields one or several of the following possibilities:

1. The person can resort to an act of violence toward the dependency object or a scapegoat (e.g., riots, prejudice, work strikes).

2. He can throw rage back onto himself masochistically (e.g. suicide, self-mutilation, seeking punishment).

3. He can develop physiological symptoms which can involve organ systems (e.g., paralyses, ulcers, tics, etc.).

4. He can go into a deep depression due to a feedback or resentment on himself.

Another consequence of the development picture cited earlier is the effect it has on a sexual identification. The combination of a low level of independence and assertiveness often leads to feelings of being less manly or unmanly or homosexual and is often compensated for with fierce competiveness and compulsive masculinity. Women, on the other hand, will tend to blame everything on the fact that they are not men. In response, they try to control and become overbearing and even assume a masculine stance, which may become converted into open homosexuality. (Notice the incidence of homosexuality among addicts, both male and female)

As a result of the three things, low self-esteem, devalued self-image and high dependency, compensating mechanisms, such as ambition, power drives and perfectionism are developed. Unfortunately, these compensations are usually in such excess that they fail, and the individual only succeeds in feeling even more inadequate than before.

Dr. Wolberg then described what is available to an individual when his environmental resources fail, the kinds of adaptations he can make. He grouped these into four levels of defense which consist of manipulation of the environment, manipulation of people, manipulation of one's psychological mechanisms, and finally manipulation of one's physiology in the form of regressive or psychotic defenses.

In the first level of defense, that of manipulating the environment, a person may seek peace by changing his job, his wife, his school and so on. Or he may begin taking drugs in order to cope with his anxiety,

particularly where he tends to identify with people in a sub-culture group -- even if it is an out group -- a group that will condone drug usage (Winick's new sociology theory). This may lead to an abatement of anxiety. He will find peace in a drug stupor that he previously was looking for in an idealized parental object (note the frequency with which a pusher is referred to as mother). On the other hand if he is very angry the drug will put him at peace, he will have no need to compete or worry about his failing masculinity. His devalued self-image does not bother him and he can return into day dreams to build himself up. The drug then, fits into his adaptional scheme. It supplies him with everything that life has failed to supply him with. That is why it is so hard for him to give it up.

The family structure in this situation is often as follows:

1. The mother is dominant -- she does not want the child to break away from her and as a result he is infantilized. The child then experiences the horrible combination and hate.

2. There is no father around and, as a result, there is no model on which to establish a male identification, something both a boy and a girl need, that is two parents. Further, there is little supervision at home, as well as little family cohesiveness. In all this, there is little opportunity for an individual to develop his own resources and break away from the dependency on the family. It is this conflict that may result in his finding solace in drugs.

The second level of defense wherein the individual concentrates on manipulating people in order to fill his needs draws upon his potential personality assets which he may pathologically exploit.

The third defense level is what we would classify as neurotic. Here the individual manipulates his intrapsychic resources. He buries things through repression and suppression. He projects certain of his needs and fears onto the environment, developing such symptoms as phobias, compulsions and rituals.

Finally, there is the most serious mode of adaptation, the psychotic or regressive defense. Here the individual distorts reality through hallucinations, delusions and the development of a wide range of psychotic symptoms. What is important is that the addict attempts to hold himself at the first line of defense, drugs, and the second, namely detachment. It is of interest to note that a reasonable number of addicted adults and adolescents, ten and thirty per cent respectively, are schizophrenics who try to avoid pyschosis through drug use.

We can see then that a diffuse personality difficulty is involved in drug addiction and consequently why the rehabilitation of this group is so difficult.

3. The Nature of LSD, Methadone, and Cyclazozine

Dr. Laskowitz

Any consideration of drug abuse today requires consideration of drugs other than the narcotics. Dr. David Laskowitz addressed himself to just that consideration, namely, the attributes, effects and significance of three drugs; methadone, LSD and cyclazozine. However, a large part of Dr. Laskowitz's lecture was actually more concerned with rehabilitation than with theory. Therefore, his presentation will be reviewed for its relevance, both in this and the section on rehabilitation.

Dr. Laskowitz began by stating that any drug which has a powerful positive effect has a potential to induce psychological addiction. The three drugs: Methadone, LSD and cyclazozine have as a common denominator the fact that all three have been used as a treatment modality; and both methadone and LSD when used indiscriminately have created mental health problems.

The Uses and Abuses of LSD

Although there are certain well established stereotyped responses to LSD ingestion, there are also a wide range of individual variations which are dependent on such factors as:

1. The prior personality of the user
2. The expectations for the substance
3. The prevailing mood at intake
4. The setting in which it is taken

Whatever the effects might be, the drug has an effective duration of from eight to twelve hours and that effect is invariably intense and often

capable of satisfying an individual for a lifetime. The drug is an extremely potent substance that induces experiences in the alteration of one's body image; sensory shifts; loss of a sense of boundaries; loss of control which generates acute panic; and a great deal of tension discharging acts such as hysterical crying.

Epidemiology

LSD usage has changed from almost exclusive usage by the intellectual elite. Although there are no accurate statistics, it is estimated that anywhere from two to fifteen per cent of our college students are using it, and the general age range of users is from twenty to thirty-five. There has been a rapid diffusion of LSD use to the lower socio-economic classes which has created another problem since there are different motivations for use in each social group. The danger in lower social groups results from their multi-habituation and sub-culturally approved acting out.

In general, there are considered to be five motivating reasons for the use of LSD. They are:

1. A philosphic-religious experience
2. Facilitate a breakdown in interpersonal inhibitions with little evidence of lasting value
3. Loss of social inhibitions - usually to aid sexual acting out
4. Achieve a sense of aesthetic change
5. Insight

Dr. Laskowitz made it quite clear that although these are some of the conscious reasons for usage, it is rare indeed that these goals are

ever achieved to any lasting degree. This is not to say that LSD is without constructive use for therapeutic purposes but more accurately that it should never be resorted to outside of strict medical supervision.

The speaker then went on to describe the major modes of therapeutic use LSD has been put to:

1. Psycholytic - Here the purpose is to dissolve the barriers that hold back repressed materials. The drug is used in small doses in conjunction with psychoanalytic treatment. The reaction must be controlled through the use of Phenothiazines and Barbiturates.

2. Psychodelic - Here the drug is used in massive amounts on a one administration basis. The person loses all control and experiences a sense of nothingness. It is a drastic and dramatic technique and we do not yet have reliable results as to its effectiveness.

3. Hypnodelic - Here hypnosis is induced while the drug is taking effect and in theory the patient becomes more amenable to post-hypnotic suggestion. Here again we have no reliable data, yet, as to the outcomes.

Methadone

Methadone is a fairly new drug. It was synthesized in Germany, as was heroin, in 1946. It has and continues to be used as a standard detoxifying agent in practically every institution where morphine substitues are used.

It is similar to morphine except for one very important aspect, that is its time action. Methadone abstinence is not apparent until 48 hours after the last dose. Consequently, being "strung out" on methadone is of a lower intensity than it is on heroin, and the abstinence syndrome lasts

much longer. It can last for as long as two weeks and does not reach a peak in two or three days as is the case with heroin. These characteristics make it useful as a substitute drug during withdrawal in order to make it a more manageable and less painful experience.

How this drug has been utilized in rehabilitation will be described in the next section.

Cyclazozine

Cyclazozine has been grouped with the hallucinogetics although it is considered to be much less potent than LSD or Mescaline. Essentially, it is a narcotic antagonist and as such competes with, and displaces this class of drugs at the receptor site in the central nervous system. Here again, as with methadone, its application in rehabilitation will be detailed in the next section.

4. Group Principles and the Impulse Disorder

Dr. Schwartz

Dr. Schwartz concerned himself with group counseling and the impulse disorder. He dealt with the subject in terms of what group counseling is, what a group experience is, and some of the central dynamics of an impulse disordered person. However, the nature of his paper had even greater significance in that it revolved around the essential need to experience genuine interaction, communication and giving and taking within a group setting. He, as much as any speaker, came closest to the essential nature of this program when he spoke of the need to create the possibilities for interaction, with resultant changes in attitudes and behavior among people.

As Dr. Schwartz put it, group procedures, in his opinion, were the techniques of choice for best reaching the impulse disordered person. However, specific modifications of existing techniques are necessary and these alterations are a function of the kind of person an impulse disordered individual is. In his view, such a person is one who does, rather than thinks or feels. In effect, he is someone who attempts to shortcircuit the entire internal apparatus. That apparatus which is geared to letting us be truly aware of what we are either contemplating, reacting to, being aware of or about to do. In short, the impulse disordered person is one who has little tolerance for the tension that arises from internal conflict. The problem then, is to get him to stop doing long enough, so that he can think and feel. But the consequence is the development of anxiety and the necessity for its management. The group seems peculiarly

suited for both of these tasks. This is so because interaction is central to group function, and it is the interactions which can channelize the drive for activity and at the same time provide an acceptable releasing device for that anxiety.

When the foregoing is contrasted with the one to one situation, we immediately see that the group provides for greater action or activity. In its very nature, it is less contemplative, and, as such, less prone to mobilize anxiety in unmanageable proportions. The group contains forces for change in larger number than the one to one simply by virtue of the numerical reality. In addition, and most important, these forces for change are not exclusively mediated through an authority figure, as in one to one. The latter poses an invitation for rebellion for anyone with an authority problem and most impulse-disordered persons have this difficulty. Allied to the authority issue is the identity issue. The group, because it is composed of peer figures as well as an authority figure makes a positive and constructive identification seem less impossible. And finally, the group permits a person to get out from under the spotlight from time to time and thus provides a safety valve for his anxiety level.

So then what Dr. Schwartz was saying is if you are dealing with people who have little tolerance for anxiety, are in a chronic state of rebellion and motoric activity, provide a structure that has elasticity, wider boundaries for movement, less direct challenge and the potential for obtaining support from an acceptable source.

Having opted for the group, the next question is what kind of a group should it be? It should be a group where confrontation occurs. Not because you want to "nail" somebody, but because you realize the first step in change is the acknowledgment that something is wrong. This is vital for the impulse disorder, in particular, because one of the reasons he runs so much is in order to escape the reality that something is wrong with him. Another quality in the group should be giving and taking because the impulse-disordered person has always been essentially a taker. Again, this is more easily accomplished in group because, and here Dr. Schwartz was refreshingly candid, "most of you, me too, because most of us have contempt for the guy on the bottom of that line. Most of us do not want to exchange anything with him, most of us do not feel he has anything we want or that we could take from him.... Unfortunately, our contempt for the inmate is parallel. All human behavior is reciprocal, is bilateral, is interactive .... there is always a piece of contempt that feeds back."

The potential for exchange is indeed limited in an atmosphere of contempt but the group process permits a different kind of atmosphere to grow because of its composition. In this atmosphere there is an opportunity for an alternation in roles. One can, at varying times, be a giver, receiver, submitter, director, helper, exchanger, etc. It is a long time before this can take place in one to one with a severely damaged and undeveloped person.

In addition to being confrontational and reciprocal, the group provides a greater opportunity for freedom and honesty as it exists amongst

peers than can exist between the authority figure and inmate. They have allies against the authority; they have support for the courage to try something new; they have a sense of belonging to one another, a kind of homogeneity, a kind of cohesiveness. Because of all this, it is harder to escape in a group. Yet there are moments when the spotlight is not on you that can be moments of reflection. "That may be the moment for feeling and thinking."

These essentially were the highlights of Dr. Schwartz's address but it should be noted that there was much more in the elaboration and full content that cannot be presented here. Suffice to say this address, in particular, was unique in that it talked to both inmate and personnel needs and set forth structures both directly and by implication that would go far toward filling these needs.

5. Family Dynamics of the Narcotic Addict

Mr. Youcha

Where Dr. Wolberg gave a gross theoretical overview of the various ways that people adopt to the stresses of life, Mr. Youcha restricted himself to the specifics of the mother-child relationship of the potential addict. To be more accurate, the kind of mothering that invariably results in psychopathology, one manifestation of which can be addiction.

His initial observations were related to the abusers of hallucinogenic drugs due to the severe rise in its incidence. In comparing these people with heroin addicts, he has observed that they have a more intact family background, less gross pathology, less incidence of divorce, death of the father, separation and serious illness in the parents. However, the real difference is in style rather than degree. The LSD user's family is more subtle and better able to hide difficulty and serious problems in the marriage. As a result, Youcha sees the difference between the two youngsters, i.e., the heroin user and the LSD user as follows: The potential heroin addict cannot cope with the eruption of very intense emotions, the forbidden impulses of murder, incest homosexuality, etc. He knows what he is struggling against, it is close to the surface.

The potential LSD user is not in touch, he is out of contact, repressed, dissociated and he turns to an hallucinogen in a desperate attempt to make contact with his inner affectual life. There is a very clear split with a schizoid quality to the user of the hallucinogen. In effect, Youcha makes the excellent point that the substance an individual resorts to can be seen as a self-diagnosis. Amphetemines, or pep pills are sought out to

counteract depressive moods; barbituates, or downs counteract hyperactive states; LSD and other hallucinogens induce sensation contact and intensity of feeling where there is apathy, constriction and inhibition. Finally, heroin and other narcotics or pain killers soothe, ease, and relieve the intensity and anxiety associated with getting too close to things while being unable to cope with them. In any event, it is clear from the remarks of Wolberg, Schwartz, Youcha, Ramirez, Preble, Laskowitz and Bluestone that the nature of the problem lies in the dynamics of the individual; not in his metabolism.

Moving to the main area of Youcha's address, the mother-child relationship in the history of the addict, it is necessary to keep in mind that these are generalities and reflect a distillation of data so that we come up with the most extreme qualities. In fact, there is an entire range of these variables operating within the total addict population. However, viewing it in this way gives us a clearer and more defined picture.

There are two basic patterns of pathological mothering, one can be referred to as fusion and the other as exclusion. Consistent with Wolberg, Youcha noted that all human life starts in a state of fusion and it is only after many years, many crises and much growth, that healthy separation occurs. This growth process, it should be noted, not only brings about crises in the child, but in the parent as well. That is, every step by the child toward maturity is experienced with anxiety by both the parent and the child. This is for all parents not just parents of sick kids. What produces the pathology is a matter of degree, not kind.

When the anxiety associated with a given natural step toward separation and individuation is too great, that step is blocked. The fusing mother does not let these steps occur because she is too terrified by her child's growth since she equates the growth with loss. In the process she prevents the child from developing his own sense of self or to develop his own inner resources.

In contrast to the fusing mother, is the excluding mother, one who has rejected the child from the very outset. They most likely never wanted the child and could never feel a sense of unity with the child. In both groups there is a severe ego defect in the mother and that is the inability to perceive, discern, and delineate the separate identifiable qualities and characteristics of the child. The child is viewed as an object or thing; he is invisible to the parent and consequently invisible to himself. In Wolberg's terms the potential for self-esteem is indeed limited. However, to treat a child this way, one must have been treated this way himself. The point being that the parent is quite disturbed.

The fusing mother is unable to repress these cravings for love and affection; she remains a chronic infant in search of the breast.

The excluding mother has managed to repress these urgings for tenderness and warmth; she denies their existence. A consequence of this is she must not recognize these needs in herself or in others, especially her child.

Each of these mothers relates to her child in a specific way. The fusing mother merges with the child, "one bubble merges into the other

bubble." So they relate by identifying with the object, in this instance it is the child. They are the child and the child is they. As a result they intrude into the inner life of the child and the child becomes submerged to the parent. Any attempt by the child to surface or separate is thwarted. As a result the child is prevented from developing and learning any of the necessary skills in living. This is why you see a certain group of addicts who stay very close to home -- or who, after a hospital stay invariably return to the home environment. They get very anxious when you try to get them to do something new, and always it is the anxiety associated with separation.

As a child in this kind of a relationship grows, the fusion enables the mother to go on as always. He is still a baby and part of her so she can be as seductive and provocative as she likes. The fact that the child is stimulated never occurs to her. As a result, he now is in the throes of impulses and stimulation he cannot handle. Guilt ensues, anxiety develops, he cannot leave and he cannot stay -- heroin resolves it all. With it, he can remain -- remain and not feel a thing. It is for this reason that most addiction starts in adolescence. Notice, all through this, the mother has been nurturing the child's dependency. And this is the problem, for when that child's dependent needs never cease, the mother is simply incapable of fulfilling them. Then you have rejection that is overt, and the message to the child is you are not to ask anything openly of me, nor are you to function independently. "The demand is for him not to be but to be there." Any experience with addicts demonstrates how well they fill this demand.

For the most part, the typical addict mother is the fusing mother, the excluding mother is more often found in relation to schizophrenia.

In reviewing Youcha's paper, we find much of value. We find an elaboration of many of the more abstract positions contained in Wolberg's paper and many clues with regard to the nature of addicts and in addition many directions for rehabilitation.

D. Rehabilitation of the Narcotics Addict

In this, the last section of the program, we come to the application of all that has preceded it. Knowing what we know about narcotic addicts and narcotic addiction, what do we do with it? The major applications of all this knowledge has been made in a number of different types of programs. Broadly speaking, they can be subsumed under the labels of traditional, chemical substitute, correctional, spiritual and addict self-help.

1. The Medical Model

This section will be represented more in terms of the various procedures than the individual presentations. The traditional approach to narcotics rehabilitation is essentially a medical model and is best exemplified by the work at the U.S. Public Hospitals at Lexington, Ky., Fort Worth, Texas and Riverside Hospital in New York City. It is a model that has been primarily symptom-oriented. The essential steps in the process are medical detoxification through the use of methadone, physical rehabilitation through rest and nutrition, occupational therapy, sometimes psychotherapy, and discharge to the community with minimal after care services.

The Riverside Hospital follow-up study as reported by Dr. Bilmes, indicated that the program was a total failure from the point of view of rehabilitation. The 1958 Riverside Hospital study of patients admitted in 1955 indicated the following: 11 dead, 85% back in another institution; Only 4% (eight people out of 247) are now clean and none of these people had really been addicted in 1955. Out of the original 247 in the three years, half of their time had been spent in institutions and the other

half of the time, the study concluded, the patients were taking drugs two-thirds of that time.

These findings when combined with the equally dismal records of the Public Health hospitals certainly indicate that the traditional medical approach is not very adequate.

2. The Use of Chemical Substitutes

One approach that has received a great deal of attention recently is that of utilizing a chemical substance as a substitute for heroin. The two major substances currently in use are methadone and cyclazozine.

a. Methadone

The Dole-Nyswander Methadone procedure as described by Dr. Laskowitz involves the use of stabilizing doses of methadone averaging to 100 mgms. The rationale being to establish a sufficiently high methadone blood level so as to neutralize any heroin that may be administered. The program in a hospital has basically four phases:

1. In-patient phase - about six weeks in duration. The methadone level is built up slowly so as to avoid any possibility of toxic effects.

2. The period can last anywhere from six weeks to six months. Here the transitional crisis is trying to be bridged and an attempt is made toward vocational stabilization.

3. At this point, the patient has presumably gotten a job and things have gotten more consolidated and the patient is involved in pursuits not involving the drug sub-culture.

4. The final phase involves reintegrating the patient back into society and gradually having his dependency on methadone eliminated.

Hard core addicts have been selected for this program, all of whom have had at least 4 years experience mainlining. Their results, although not documented, indicate that they hold on to 85% of their patients which is indeed impressive. Seventy per cent of their people are working; however many of the jobs are either in the hospital or somewhere else in the

program. Sixty percent never took heroin after the first dose of methadone (this is highly dubious). In any event, they do seem to have people who are functioning.

The goals of the program are to knock out narcotics hunger through cross dependence. They use the social-competence theory. As Dr. Winich has indicated Dole-Nyswander think we have been unduly interested in pathology. They theorize that unlike the psychoanalytic model where we want to undo the pathology and get into character reconstruction, there is an alternative. That is to build up ego strength in a very literal way and achieve effective results. They feel that by getting their people to work out the problems of everyday life, they can gain self-esteem.

The program seems promising but the problem to this point is that there is no independent documentation and as best as we know, there is nobody who has gone through the program who is currently able to function without methadone.

b. Cyclazozine

Cyclazozine is a competitive antagonist to the opiates. Theoretically, there is a receptor site in the brain that would prefer cyclazozine to morphine. If cyclazozine is taken first, the morphine would have no place to go; if it is taken after the opiate the latter would be displaced and withdrawal could occur.

The conditioning model is one of the bases for cyclazozine therapy. One way that relapse has been explained is through conditioning theory. The setting etc. has been identified as the stimulus that sets off the response of withdrawal symptoms and craving after an addict has been drug

free for some time. The logic behind the program is that extinction of the use of heroin will occur since its intake in the presence of cyclazozine will have no effect.

Currently, the cyclazozine program has two units, one inpatient and the other outpatient. At present, the program is small (12 people) and it is the program policy to get people out of the inpatient unit as soon as possible. The population that they are working with is very different from that of the Dole-Nyswander project. They are middle class addicts, as opposed to those from the lower socio-economic levels in the latter procedure.

Their selection criteria is biased toward the middle class addict. They were looking for addicts who had some ego strength because their process involves taking a substance that frustrates getting high.

The goals of the two programs are quite different. Methadone procedures involve keeping someone drug dependent, perhaps for a lifetime; cyclazozine therapy has its goal drug abstinence of all kinds as soon as possible. In the past two years, they have had five patients off cyclazozine and off all drugs. Here again, time is too short and there is no cross validation data but it would seem that both of these essentially chemical approaches have a meaningful place in drug addiction rehabilitation.

3. The Correctional Approach

The correctional approach, as Dr. Bluestone noted, is the oldest and most extensively used rehabilitation method for the addict. This derives partially from the condition of the laws' perception of the addict and the community's need to punish. Needless to say, punishment has not cured many addicts, if anything it has done the opposite since punishment supports many of the masochistic needs of the addict. It is doubtful if extensive rehabilitation of any class of offenders could really take place in our correctional facilities as they are now organized. In this regard, Dr. Bluestone was quite right.

However, the introduction of plans such as that of Dr. Ramirez, adequate in-service training for personnel and more of a trend toward more open facilities might very well alter our current experience.

4. The Spiritual Approach

The spiritual approach to narcotics rehabilitation is really the label that has been given to the community trying to help itself. Historically, these efforts have usually polarized themselves around a community church and, as such, have one denominational leader or another at their head. The round table discussion in the current project had representatives from just such organizations. They range in type and program from Father Pitcaithly's Good Samaritan House to that of the Reverend Loencia Rosado. The former is essentially a community mental health center that utilizes the services of the mental health team as well as the spiritual guidance of ministers of all faiths. The Reverend Rosado's approach is quite evangelical and appeals to right and wrong, good and bad. In addition, there is much exhortation and maternalism, her's is very definitely a religious approach. The others, for the most part, do things very much as the lay community does. The utilize the services of the professional community and those of the ex-addict but in addition they do something unique -- they go, or are at, where the addict and his family is. In many ways, the church based effort is the oldest and most consistent effort at narcotics rehabilitation we know of. However, their results are not that impressive either. Again, further testimony to the difficulty and complexity of the problem.

5. Addict Self-Help Procedures

The final and newest approach to narcotics rehabilitation is the addict self-help program. This is the newest, the most dramatic and to this point, most promising. The originator of the approach was Charles Diederich of Synanon, which is the oldest and most famous of the various self-help programs. The essential notion involved is that of the therapeutic community and the peer helping the peer. The concept Dr. Schwartz elaborated on. The details and specifics are as contained in Dr. Ramirez' remarks. There are, of course, variations from one program to another but in the large they are more alike than different.

Here, as with the other modalities, you have minimal statistics, unreliable reports and many claims that often are more in the eyes of the beholder than in fact. However, there is no question that they have something here. Perhaps with the passage of time, greater opportunities for their study, and more organized research, we will be able to evaluate this approach and the others more definitively.

E. Summary

The foregoing section, represents an attempt to depict the essence of the material that was presented to the target population in the form of lectures and round tables. An attempt was made to present a broad spectrum of the status, law, theory and rehabilitation as it relates to drug addiction. The information is extensive, complex and oftentimes confusing. It was hoped that in the presenting and sharing of this body of knowledge, opinion and attitude, that the involved personnel would have an opportunity to learn, clarify and react. The major emphasis was on reacting toward the end that their own thoughts, perceptions, knowledge and most important, their attitudes could come into view. The next section then addresses itself to the outcome of the small group procedures.

III. The Small Group Procedure

In programs of this nature there are, in fact, two major sources of information and learning: One, the content of the lectures and two, the individuals who participate in the discussion groups. The untapped knowledge of the participants (i.e. those who listen to the lectures and then contribute to the discussions) is only latently evident until the "group experience" provides an atmosphere where it can emerge and be channeled.

The "group experience" is a powerful medium for the facilitation of communication among the participants. In this project there was evidence of this fact in that the correctional personnel gave the group a great deal of information regarding the care and treatment of addicts in prison while the mental health personnel showed an attitude of hope which was not always the case with the correctional people. The mental health personnel gave information about personality and the theories of drug addiction but it was not clear that their optimism was based on actual positive results they had with addicts in their own work, or whether their hopeful attitude was simply founded on a belief that "dynamic" psychology if applied is bound to produce results with addicts. If the latter were actually the case then it would appear that the "mental health" people have much to learn, for it is obvious that psychotherapy per se is not the answer for the rehabilitation of the addict - it is only one of many modalities that must be employed. The correctional personnel should learn more about the possibilities inherent in group work and other therapeutically oriented techniques.

An important aspect of heterogeneous groups such as those in this project, is that group members learn about each other first hand. This type of contact tends to reduce the suspiciousness and aloofness that exists between people who come into a group but who have had no previous contact as peers, only hierarchial contacts. For example, in one group a correction worker and the mental health person were peers with an ex-addict who had become a social worker. Thus, the members see that the ex-addict is human after all, and as a peer has many tenable ideas. The psychiatrist, in another group, talks with the social worker and the correctional worker as peers rather than as members of a hierarchy. The psychologist and the deputy warden begin to exchange views on a peer level.

It sometimes takes a longer time than was allocated in this project to break down certain hierarchial attitudes; to remove the fear individuals have that without these feelings the whole social system in which they work would break down. This fear must be allayed, and this sometimes takes the better part of a year. On some levels it is important for communication channels to be open within the hierarchial structure particularly as these pertain to the development of skills. Untoward feelings between supervisor and supervisee and between members of various work catagories and disciplines must be broken and dissipated if staff operations are to function smoothly. The group is an excellent medium in which these untoward attitudes can be changed so that meaningful dialogue begins to take place.

The composition of the groups was about half correctional people and half mental health people (considering the rehabilitation workers

to be mental health oriented), so that each group contained two subgroups. Inasmuch as this was a voluntary program, members were self-selecting on the basis of their interest and as has been our experience in several other educational programs, there were two or three people who were visibly emotionally disturbed. In one group this caused considerable difficulty. When a group becomes bogged down attempting to cope with a disturbed member this is a distraction from the main task of the group. The task of providing an atmosphere where the members can exchange views, discuss ideas, air their disagreements and come to some conclusions; in this case the conclusions concerning the programs they think are best for the rehabilitation of the drug addict.

As a rule, personal feelings come out in groups about the fourth or fifth sessions and these groups seemed to follow this pattern. Both positive and negative feelings were expressed. In Dr. Radin's group, for example, open criticism of the leader and other members began to appear in the fourth session. Feelings that the drug addict "gets away with it" were often expressed by the correctional people; "the addict gets taken care of while others have to work hard for what they get." The addict is coddled by mental health people. At the same time it was recognized that the addict who was said to be an "impulse disorder" needs "control" both in prison and outside in the community.

In Mr. Tillmans' group both positive and negative feelings came to the fore during the fourth session: Members began to express their disenchantment with the Ramirez program and "with the succession of other programs they had seen come and go." Feelings of frustration were

expressed by almost all group members. The correction personnel voiced more ambivalent attitudes such as "feeling close" to the addict due to frequency of contact simultaneously with their conviction that "you can't change human nature."

While there is a disquieting effect from the hostility that emanates from "group experience" sessions there is also a cohesiveness which forms about the fifth or sixth session and this manifests itself in the supportiveness, the agreements, the conciliatory attitudes, the emergence of directions and suggestions and finally the decisions which arise after discussion. This phenomenon seems to have taken place in these groups.

There was considerable anxiety present in the participants at the beginning. Anxiety develops as a consequence of the introduction of new ideas, or with confrontations which challenge cherished attitudes and concepts, and with the introduction of problems inherent in handling conflicts which arise when authority is challenged. In the group, anxiety is dissipated in several ways: Through carthesis, through the expression of hostility, in supportive ways, in questioning and in seeking answers, and in defensive maneuvers. Anxiety is more severe when the educational program centers on the work role of the individual for this seems more threatening than, for example, discussion about one's childhood. The here-and-now, particularly as it relates to income and the economics of life will generate anxiety due to feelings of helplessness or inadequacy. Typical attitudes of control of anxiety in relation to work role were shown by several members - a psychiatrist in one group, for example, became a lecturer, and the deputy warden in another group became a co-leader

expressing "mental health platitudes" but nevertheless displaying authoritarian attitudes. The psychiatrist in one group withdrew and did not return.

One comment seems worth making and that is that the participants hope to get more from an educational effort of this kind than is possible; for example, they hope to acquire certain techniques to apply in practice and indeed perhaps they begin to explore certain possibilities. But there is a great distance between lecture and discussion and the actual learning and application of technical skill. The acquisition of skills takes time and the learning process is unique to each individual even though the kind of discussion and "content" to which each group member may be exposed is essentially the same. Learning proceeds according to certain laws and probably each individual must apply similar methods in order to integrate knowledge, nevertheless performance from individual to individual is unique and varies depending upon many variables, not the least of which are certain emotional factors. On a practical level one sees this hope for attaining technical skill in such attitudes as the expectation, for example, that Dr. Ramirez's program would show definitive results in a period of two years. Actual change can cause disequalibrium which is anxiety provoking to the individuals within a social system for it means that new learnings have to take place and new adjustments. A small example of such a change was recorded in Miss Mermelstein's group: One probation officer had approached the leader early in the program and had chastized her for using the word "feeling". "We have no feelings; you put people off by asking them how they feel about

this or that!" Later on, the leader noticed that this same probation officer was asking people how they felt about their jobs or about addicts. He was quite unaware at first about his own change in attitude and approach. He seemed freer and participated in the discussions with greater ease and talked much more frequently after he began to talk about "feelings."

The majority of participants appear to have gained considerable facility in communicating with others in the group as time went on..

A more detailed account of what the group meant to the participants is found in the Evaluation Report.

IV. Evaluation and Discussion

The target population is broken down into its various segments and described in Tables I, II, III and IV. There were a total of ninety-four persons who registered for the program, however, attendance ranged from a high of seventy-one to a low of forty-four. On the average there were sixty-three persons present at each session. The low point in attendance occurred following the second round table discussion when only forty-four persons were present.

The most obvious explanation for this fact would seem to revolve around the nature of the round table. This, undoubtedly was the most involving, emotion laden session of the entire program and apparently many of the registrants were not prepared to have this degree of stimulation engendered. In addition, there was the undesirable time lapse between sessions. It is simply too much to expect that people who are not generally used to emotional confrontation are going to be able to tolerate a long lapse in time once they are struggling with threatening thoughts, feelings and reactions.

It is for this reason that it would have been much more desirable to have an opportunity for the small group meetings to take place on a once a week basis throughout the program.

Examination of Tables I, II, III and IV yield some interesting facts. The first observation is that the Mental Health Personnel had the best attendance record of all groups. This might be expected since

these people are generally at home with this kind of material, academically conditioned, and rather experienced in dealing with emotionally laden material.

It may well be that the attendance of uniformed force underscores more than any other single datum, their need for this kind of experience on a regular basis. It would be most interesting to see what would occur if the small group procedure were to become a regular feature of in-service training on a weekly basis.

TABLE I

Department of Corrections Uniformed Force

Job Title	Number	Average Number of Sessions Attended*
Warden	1	1
Deputy Warden	3	13
Assistant Deputy Warden	2	12.5
Captain	6	16
Corrections Officer	23	13
	35	

*There were a total of nineteen sessions. One Deputy Warden attended two sessions, the other two attended eighteen and nineteen respectively. One Assistant Deputy Warden attended eight sessions, the other attended seventeen.

Five out of twenty-three Corrections Officers attended eighteen or nineteen sessions.

Table II

Department of Corrections Mental Health Personnel

Job Title	Number	Average Number of Sessions Attended*
Psychiatrist	3	17
Psychologist	7	19
Psychiatric Social Worker	9	19
Chaplain	1	16
Psychiatric Nurse	1	19
	21	

*The only Psychologists and Social Workers who missed any sessions were those who resigned their positions during the year (3).

TABLE III

Community Social Agency Personnel

Agency	Number	Average Number of Sessions Attended
Welfare	1	18
Salvation Army	4	3
Westchester County Community Mental Health Board	1	18
Village Haven	2	2
Start	4	8
Friendly Visitors	1	19
New York State Parole	5	7
Greenwich House	1	15
Students	2	19
Organization not Registered	3	10
	23	

A. Background of the Evaluation

The implementation of this comprehensive in-service training program for personnel in the field of narcotics addiction necessitated a closely related evaluation of the effect of the program. Both the program and its evaluation rest on a number of assumptions. These are: that the care, treatment and rehabilitation of narcotic addicts is more effective if the personnel responsible for these jobs is sensitive to the problems of addiction, and understand these problems, and that attitudes toward narcotic addicts and attitudes about addiction are open to change through education, information and group discussion. The evaluation of the training program was thus an attempt to assess changes in attitude and level of information of the personnel involved. Specifically, the assumption tested was that attitudes would change toward a greater understanding of the problems of the addict and toward a medical and rehabilitative treatment program rather than a punitive and incarcerative one.

In evaluating this training program, a number of unknown factors have to be acknowledged. These are the target population, the expectable effect of the program, the validity of the measures used for the evaluation and the influence of each of these upon the others.

The target population can best be described as heterogeneous, in terms of age, experience, level of involvement with addicts, degree of influence or authority in working with addicts, knowledge about addiction and attitude toward the addict. These factors may make changes due to the influence of the program difficult to tease out.

The nature of the program has been described in the foregoing sections of this report. The program itself is an experiment and hence its effectiveness is

under evaluation. Then, too, the measures used for this evaluation were specifically adapted for this purpose. Since they had never been used in this form previously, there is no data available against which to compare the responses of the group participating in this program.

If the training program were one of known effectiveness, and the measures used for evaluation had been demonstrated statistically valid and reliable for the kind of population participating, then changes or failures to change attitudes through the program might be related to the characteristics of the personnel. In that case the evaluation would lead to suggestions as to personnel selection. Comparisons of several types of programs could also be undertaken to determine what kind of program or what aspect of a program or what combination of lectures, group meetings and roundtable discussions yields the most favorable changes in attitude, participation and level of understanding by participants toward the addict. Here the evaluation is part of the program rather than this program being part of a larger research evaluation. Standards for comparison and control will have to be gleaned from information available within the program itself.

1. Evaluation Plan

The plan of this evaluation will be first, to describe the group participating in the program, and contrast it with those who dropped out of the program during its initial stage - the first five meetings. It is of interest to determine if those who dropped out of the program, those who could not be reached by the program, can be distinguished along any of the dimensions studied, from those who remained. Following this evaluation, the attitude and level of information of the participants will be considered in more detail.

TABLE IV

Description of the Target Population

	Group that Participated (P - group)	Group that Discontinued (D - group)
Number	48	20
Age		
mean age in years	42	40
age range	24-64	25-55
Sex		
men: women	34:14	14:6
Responded to		
"experience" questions	35	13
mean years of experience with Dept. or agency	6	6
range	0 - 26	1 - 10
Mean years of experience with addicts	6	3
range	0 - 26	1 - 10

were asked to indicate the length of time they had worked with the Department of Correction or agency and in the second, the length of time they had worked with drug addicts. Of the P - group, 27% failed to respond while 35% of the D - group did not respond to these items.

With regard to those who responded to the question about experience, the mean number of years with the Department of Correction or agency was 6 years for both groups. However, those who discontinued the program had less experience working with addicts. While those who remained had an average of six years of experience with addicts, those who dropped out indicated they only had three years of experience.

It may be concluded at this point that the D - group and the P - group had many characteristics in common. They were approximately the same age, came from the same disciplines or vocations and had the same amount of experience with the Department of Correction or their respective agencies. The latter is true if one measures experience simply as a function of time. Both groups were composed essentially of the same proportion of men to women. The D - group, however, had less experience in direct work with addicts. It would appear that many of them worked in other jobs or with other populations in the Department of Correction or their agency for an average of 3 years before beginning their work with addicts.

In general, the D - group was more reluctant to reveal the amount of previous experience.

A comparison of the responses to the attitude questionnaire for these two groups will be considered later.

There were thus 48 participants in the study who remained and responded to the two questionnaires prior to and after the program. They consisted of 34 men and 14 women. Their mean age was 42 years. They had been working in their professions or vocations as well as with drug addicts, on the average, for the past six years.

3. Methodology

Three measures were used to assess changes in attitude and level of information occurring during the training program. The Cohen-Struening Opinions About Mental Illness Scale was adopted for use specifically to measure opinions about narcotic addiction. Second, the Gould Dynamics of Drug Addiction Scale, designed to tap a level of information about addiction was adapted to tap the participants' knowledge of the personal and social factors contributing to addiction as well as testing adherence to stereotypic ideas about addicts. The third measure used was a rating scale, filled out by the leaders of the discussion groups in which each group member was rated on the same dimensions as are tapped by the Opinions About Mental Illness Scale.

a. The Opinions About Drug Addiction Scale

The Opinions About Mental Illness Scale measures attitudes toward mental illness and the mentally ill person. This scale was adapted to test attitudes toward narcotic addiction and narcotic addicts specifically by substituting the term "narcotic addiction" or "drug addiction" for "mental illness" in the appropriate items. For example, the item on the original scale which read, "Mental Illness is an illness like any other" was changed to "Drug addiction is an illness like any other". The adapted scale for use with personnel in the field of drug addiction is contained in the Appendix.[1] The instructions for the adapted scale were changed appropriately from their original form and respondents were asked to indicate their opinions for each item by checking one point along

a four point scale: strongly agree, agree mildly, disagree mildly and strongly disagree.

A factorial analysis of the items of the original scale yielded five factors: authoritarianism, social restrictiveness, benevolence, mental hygiene ideology, and interpersonal etiology. The items, altered to be appropriate for personnel working with drug addicts, comprising these five factors are listed in Tables VI, VII, VIII, IX, X. For most items, intensity of agreement with the item is seen as an indication that a particular attitude or opinion is active in the respondent. Several items are negatively correlated with a particular factor and in this case disagreement with the item is used as an indication of the operation of a particular attitude within the respondent.

The five factors can be amplified by paraphrasing their descriptive summary from Cohen and Struening.[2] For each factor the term "mental illness" or its equivalent has been changed to "drug addiction" or its equivalent. While this procedure may be questioned with respect to the validity of the original scale, the items do now have a relevance and a "face validity" with respect to drug addiction.

1. Appendix V

2 Cohen, J. and Struening, E. L., Opinions About Mental Illness in the Personnel of Two Large Mental Hospitals. J. Abn. Soc. Psychol. 1962, 64, 349-360.

TABLE V

Items Included in Authoritarian Factor

Number	Item
1.	Drug addiction results when people work too hard.
4.	Although addicts discharged from hospitals may seem all right, they should not be allowed to marry.
6.	It is easy to recognize someone who once was an addict.
7.	People who are drug addicts let their emotions control them: normal people think things out.
9.	When a person has a problem or a worry, it is best not to think about it, but keep busy with more pleasant things.
11.	There is something about addicts that makes it easy to tell them from normal people.
15.	People would not become addicts if they avoided bad thoughts.
18.	A heart patient has just one thing wrong with him, while a drug addict is completely different from other patients.
19.	Drug addicts come from homes where the parents took little interest in their children.
20.	Drug addicts should never be treated in the same hospital as people with physical illness.
28.	The best way to handle drug addicts in hospitals is to keep them behind locked doors.
33.	Every addiction treatment facility should be surrounded by a high fence and guards.
36.	Drug addiction is usually caused by some disease of the nervous system.
37.	Regardless of how you look at it, patients with severe drug addictions are no longer really human.
40.	College professors are more likely to become drug addicts than are business men.
41.	Although some drug addicts seem all right, it is dangerous to forget for a moment that they are drug addicts.
43.	One of the main causes of drug addiction is a lack of moral strength or will power.
46.	All addicts in a treatment facility should be prevented from having children by a painless operation.

TABLE VI

Items Included in Social Restrictiveness Factor

Number	Item
4.	Although addicts discharged from hospitals may seem all right, they should not be allowed to marry.
13.	The small children of addicts in hospitals should not be allowed to visit them.
22.	A woman would be foolish to marry a man who has been a drug addict even though he seems fully recovered.
24.	Addicts who have been treated in hospitals will never be their old selves again.
26.	Anyone who is in a hospital for drug addiction should not be allowed to vote.
34.	The law should allow a woman to divorce her husband as soon as he has been confined to an addict treatment facility.
38*.	Most women who were once addicts could be trusted as baby sitters.
39.	Drug addicts in hospitals do not care how they look.
44.	There is little that can be done for addicts in a treatment facility except to see that they are comfortable and well fed.
46.	All addicts in a treatment facility should be prevented from having children by a painless operation.

*/Negatively correlated.

TABLE VII

Items Included in Benevolence Factor

Number	Item
10.	Although they usually are not aware of it, many people become addicts to avoid the difficult problems of everyday life.
16.	Addicts in hospitals are in many ways like children.
17.	More tax money should be spent in the care and treatment of people with drug addiction.
21.	Anyone who tries hard to better himself deserves the respect of others.
25*	Drug addiction treatment centers seem more like prisons than like places where people can be cared for.
29*.	To become a patient in an addict treatment facility is to become a failure in life.
41.	Although some drug addicts seem all right, it is dangerous to forget for a moment that they are drug addicts.
44*.	There is little that can be done for addicts in a treatment facility except to see that they are comfortable and well fed.

*/ Negatively correlated.

TABLE VIII

Items Included in Mental Hygiene Ideology

Number	Item
2.	Drug addiction is an illness like any other.
12.	Most addicts are willing to work.
17.	More tax money should be spent in the care and treatment of people with drug addiction.
25.	Drug addiction treatment centers seem more like prisons than like places where people can be cared for.
38.	Most women who were once addicts could be trusted as baby sitters.
45.	Many drug addicts would remain in a treatment facility until they were well, even if the doors were unlocked.

TABLE IX

Items Included in Interpersonal Etiology Factor

Number	Item
5.	If Parents loved their children more, there would be less drug addiction.
10.	Although they usually are not aware of it, many people become addicts to avoid the difficult problems of everyday life.
14.	People who are successful in their work seldom become drug addicts.
19.	Drug addicts come from homes where the parents took little interest in their children.
23.	If the children of drug addicted parents were raised by normal parents, they would probably not become addicted.
27.	Drug addiction among many people is caused by the separation or divorce of their parents during childhood.
32.	If the children of normal parents were raised by drug addicted parents, they would probably become drug addicts.

The conception of drug addicts projected by the authoritarian factor is one which stresses their difference from and inferiority to normal people. Several items present popular and contradictory ideas about the causability of drug addiction. Some items reflect the characteristic submission to authority and "anti-intraceptiveness" of the authoritarian. "Bad" or "too much" thinking is seen as playing an etiological rold. The handling of the hospitalized addict advocated here, namely, high fence, guards, locked doors, bears the coercive authoritarian stamp.

The view that drug addicts both during and after hospitalization should be restricted for the protection of society and the particular family unit has been termed the social restrictiveness factor. Thus, addicts should not be allowed to marry after hospitalization, should be easily divorced upon hospitalization and their parental rights should be restricted. These items share the belief that the drug addict is a threat to society which must be met by some restriction in social functioning both during and after hospitalization. The outlook for their future is seen as hopeless.

The benevolent factor and the mental hygiene ideology factor are both "pro-drug addict", but they are so from rather different perspectives. Benevolence toward addicts arises from a moral point of view, a sort of Christian kindliness toward unfortunates. Addicts are seen not as failures in life but rather like children. Still, it is dangerous to forget for a moment that they are drug addicts. They are looked upon as an obligation of society and more than mere custodial care should be offered them. The prison-like atmosphere of addict treatment facilities is denied and a traditional view of self-improvement is advocated. The benevolent attitude consists of a kindly, pater-

nalistic view toward addicts, rooted in religion and humanism rather than science or professional dogma. It is encouraging and nurturant, but still acknowledges some fear of addicts.

An orientation toward addicts which is also positive but embodies the tenets of the creed of modern mental health professionals is involved in the mental hygiene ideology factor. The items here are more factually descriptive of the addict; e.g., they are willing to work, many would remain with unlocked doors, etc. Implicit in this conception is the idea that addicts are much like normal people, different perhaps from them in degree, but not in kind. The efficacy of treatment is strongly believed in as is the assumption by society of its obligations to the addict. Drug addict treatment facilities are seen as similar to prisons.

The factor of interpersonal etiology reflects quite strongly a belief that drug addiction arises from interpersonal experience, particularly deprivation of parental love and attention during childhood or more generally the mental health of parental surrogates. Somewhat less central is a belief that addiction is motivated by, for example, an avoidance of problems.

b. The Group Leaders' Rating Scale

After the fifth group meeting, and at the close of the program the leaders of the discussion groups were asked to rate each participant in their group on each of the five dimensions of the opinion scale. These dimensions, corresponding to the five factors and the definitions of each factor, described above were presented and discussed with the group leaders. Furthermore, the group leaders were requested, whenever possible, to amplify their judgement by giving

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