AN INQUIRY INTO THE RELATIVE EFFECTIVENESS OF SELECTED THERAPEUTIC COMMUNITIES IN THE TREATMENT OF NARCOTIC DEPENDENT PERSONS

Senior Honors Thesis
Submitted to Dr. Bart James

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Official and unofficial estimates of the number of persons dependent on narcotics vary widely. Similarly, estimates of the societal cost of this population are various.

There is, however, general agreement that people dependent on, or addicted to, narcotics pose a significant problem. The primary area of contention appears to be in the solution or solutions for the problem. Indeed, it would appear that one body of opinion holds that no solution does or can exist.

The purpose of this paper will be to examine one area of dependence treatment for its solution potential. This will be done within a framework of historical perspective of the problem, and with a view to the psychological and social factors which may contribute to dependence, to the extent that those factors may give insights for treatment effectiveness.

Current estimates of the addict population range from 250,000\(^1\) to 750,000\(^2\). Based on an average of 50 milligrams of pure heroin daily, at $1.15 per milligram, the cost of this addiction in property theft alone can be placed between $15,000,000,000 and 45,000,000,000 annually, depending on the population figure used. This assumes 60% of the funds for purchase are raised by theft and resale at 20% of actual value\(^3\).

Since there is reason to believe that the addict population may still be increasing by as much as 15% per year\(^4\), there is some urgency in finding an effective treatment mode.

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\(^1\) United States Department of Justice Drug Enforcement Administration, *Drug Enforcement*, fall, 1974, p. 46.
\(^3\) Drug Enforcement Administration, *op. cit.*, p. 46.
\(^4\) Cuskey, et al., *op. cit.*, p. 199.
Unfortunately, few treatment modes have been shown by thorough examination to have significantly better effectiveness than the Lexington Narcotic Hospital, with a 75% relapse rate in 1942¹.

Addiction to opium and its derivatives is not a new phenomenon. The opiate withdrawal syndrome, the chief determinant of dependence, was described in medical tracts as early as 1700². Used extensively in the Civil War as a pain-killer, included in patent medicines, and prescribed by doctors to ease tensions, opiates had approximately 250,000 addicts in the United States around 1900³.

At that time, there was relatively little public recognition of the existence of a problem. Without prohibitive laws, the availability of the drugs precluded heavy thefts for habit support. Concern for the addict was minimal, especially since he was perceived as being a foreigner or member of a minority race, e.g., Chinese or Negro⁴.

With the reform movement associated with the first two decades of America's twentieth century history came the Harrison Act of 1914. The reform movement leading to the Harrison Act had two bases: protection of the public from unlabeled patent medicines and fear of and/or resentment for the minority groups associated with addiction. It was the latter which led to possession's becoming a crime⁵.

Controversy involving the Harrison Act's enforcement and interpretation began shortly after its passage. Technically a revenue measure to be enforced by the Treasury Department, the act had no actual revenue provisions until enactment of the Rainey Amendments of 1919⁶. Section eight made possession of

¹ David F. Musto, *The American Disease*, p. 78.
² Ibid., p. 69.
³ Ibid., p. 5.
⁴ Ibid., p. 5.
⁵ Ibid., p. 11.
⁶ Ibid., p. 136.
narcotics through unauthorized channels illegal, with the burden of proof as to the source resting with the accused.\(^1\)

The question of legal maintenance of an addict's habit by his doctor occurred early in the Harrison Act's history. The Supreme Court, by a five-to-four decision, reversed a previous decision and held that such maintenance constituted bad faith on the part of the physician, and was therefore illegal. This was termed to be "...so plain...that no discussion of the subject is required."\(^2\)

The Federal Government's first serious attempt to cure narcotics addictions came in 1935, with the opening of the Lexington Narcotics Hospital. A similar facility was opened three years later in Fort Worth, Texas. In these facilities, some significant discoveries were made in the area of medical withdrawal from narcotics.\(^3\)

The previously mentioned lack of success at the Lexington facility has been attributed by some to a lack of genuine desire or even intention to cure addicts there. This body of opinion holds that the intention of Congress in enacting enabling legislation in 1929 to build these facilities was more to handle the overcrowding of federal prisons than to cure addicts.\(^4\) The April, 1928, population of federal prisons was 7,598 (2,300 of whom were narcotics law violators, with 1,600 considered addicts), while the stated cell capacity was only 3,738.\(^5\)

The few voluntary patients admitted to the Lexington facility left as soon as they had completed withdrawal.\(^6\) Preferring to use the facility for prisoners and probationers,

\(^1\) Ibid., p. 122.
\(^2\) 249 U.S. 96, 1919, as quoted by Musto, op. cit., p. 132.
\(^3\) Whitney N. Seymour, Jr., The Young Die Quietly, p. 83.
\(^4\) Musto, op. cit., p. 85.
\(^5\) Ibid., p. 204.
the Public Health Service admitted voluntary patients at Lexington only when and if space was available. The cure rate there through the nineteen-thirties was no higher than in prison.

The National Conference of Commissioners on Uniform State Laws proposed, in 1932, a Uniform Narcotic Drug Act. With minor alterations, this act was put into effect in all but four states. Under the model Uniform Act, the state laws provide penalties for unauthorized possession or use of narcotics, but the penalties section was left blank. Thus, the penalties in various states range from short imprisonment to life imprisonment, with death penalties in some cases. The majority of these laws have remained as the mainstay of narcotics control until this decade.

Passage of the Boggs Act in 1951 created mandatory minimum sentences for narcotic offenders, removing much of the discretion previously allowed judges. A significant part of the atmosphere in which this Act was passed was the hysteria of the McCarthy era. Immediately prior to the Congress' consideration of the measure, the Federal Bureau of Narcotics claimed to have linked much of the drug traffic to Communist China.

The primary thrust of the Federal Government's efforts to remedy narcotic dependence remained couched in punitive measures until 1963. It was then that the President's Advisory Commission on Narcotic Drug Abuse recommended for the first time that laws be amended to allow the type of treatment prescribed for addicts to be determined primarily by the medical rather than the legal profession.

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1 Cuskey, et al., op. cit., p. 200.
2 Ibid., p. 200.
3 Edwin M. Schur, Narcotic Addiction in Britain and America, p. 49.
4 Musto, op. cit., p. 230f.
5 National Commission, op. cit., p. 239.
The Drug Abuse Control amendments of 1965 created the Bureau of Drug Abuse Control within the Health, Education and Welfare Department. In 1966, the Narcotic Addict Rehabilitation Act established machinery for civil commitment of certain addicted prisoners, and, in some cases, addicts before trial or sentencing. The emphasis of these two legislative efforts denoted a major change of attitude toward narcotic offenders.

It was during this period of time that serious searches for methods to cure addiction got under way. Synanon House was established in California in 1958 by an ex-alcoholic and a group of ex-addicts. Methadone maintenance programs and narcotic antagonist experiments began in the sixties.

As these programs began reporting some successes, public support for further legal changes increased. Official sanction for cooperation between the medical and legal professions in the drug abuse area came with the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Under the provisions of this act, all but one of the mandatory minimum sentences for drug offenses were removed, and recognition was given to the differences of degree of harm of various drugs. The provision which may eventually be most significant is that for various money authorizations for rehabilitation centers and research.

The gravity of the situation has continued and increased through the last two decades. In 1955, there were an estimated 60,000 narcotics addicts in the U.S. In 1965, U.S. narcotics officials thought the addiction problem was under control, since there were only 57,000 'known' addicts in the country. By 1968 this figure had doubled, and by the early

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1 Musto, op. cit., p. 239.
3 Schur, op. cit., p. 43.
seventies the alarming possibility of reaching a million narcotics addicts was seen.

Approximately 50% of all urban crime is believed now to be narcotics related, and as many as two-thirds of the prisoners in metropolitan jails may be addicts. In 1970, New York City's Board of Education estimated that as many as 7% of their high school students were seriously involved in drugs. There is a strong possibility that as many as 6.5% of all U.S. factory workers may be narcotics addicts.

Most recent analyses of the narcotics addiction problem appear to view it as having sociological and/or psychological roots. The myth that anyone trying heroin automatically becomes addicted has been exploded by the knowledge that as few as 25% of heroin users actually become dependent.

A number of generalizations may be made concerning the social characteristics of the narcotics addict, based on several surveys made in the study of narcotics addiction. The vast majority of addicts have not completed high school, a large amount not reaching ninth grade. Most left high school between their sophomore and junior years, when they became old enough to do so legally. Despite normal intelligence, the majority displayed behavioral problems in classroom situations.

Most persons dependent on narcotics are less than thirty years of age, and have been dependent for several years. Many had initial heroin use between the ages of eighteen and twenty, with dependence occurring a few years later.

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1 Cuskey, et al., op. cit., p. 199.
2 Seymour, op. cit., p. 15.
3 Judianne Densen-Gerber, We Mainline Dreams, p. 370.
5 National Commission, op. cit., p. 144.
6 Ibid., p. 168.
Most had first obtained public notice, in the form of arrests or warnings, within five years of the onset of dependence\(^1\). However, with the exception of crimes committed solely for the purpose of obtaining drugs, addicts have no higher incidence of criminal activities than non-addicts\(^2\).

Contrary to the common belief that most addicts are passive and without motivation, most addicts on the street work harder and longer hours promoting their drugs than most full time employees\(^3\).

The majority of addicts were raised and still reside in an inner city area. Most live in an environment characterized by economic deprivation and family instability. Most remain single; many who have married have already divorced\(^4\).

Similarly, many studies have been made which give generalizations on the psychological characteristics common among narcotics addicts. One of the more significant findings is that while narcotics can exacerbate existing psychopathology, their ability to do so is dependent on the pre-existence of psychological maladjustment prior to the onset of drug use or dependence\(^5\).

Thus, it may be concluded, findings of similarities in the psychological make up of drug dependent persons may have some significance in the area of dependence causality, since the dependence itself can be eliminated as a possible causative factor in these observed similarities.

The following characteristics are nearly universal for addicts: being uncomfortable with and alienated from self, constant felt need to maintain control over frustrations and hostilities, lack of stable social relationships, and low

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\(^1\) Ibid., p. 167.
\(^3\) Stephen Pittel, quoted in Psychology Today, May, 1975, p. 22f.
\(^5\) Ibid., p. 172.
self esteem, perpetuated by perceived inadequacies. In addition, most addicts are immature, emotionally labile, resentful of authority, passive-aggressive, socially isolated, and ridden with feelings of sexual inadequacy\(^1\). Most addicts have histories of psychopathology manifest in some form of deviant behavior prior to the onset of drug use\(^2\).

Passive or active suicidal tendencies are common with addicts. Statistically, they are 25 to 50 times as likely to commit suicide as non-addicts\(^3\).

Transactional analysis describes the addict as having a 'life script' which enjoins him from feeling normal joy and happiness. This is reported to come at least partially from an alienation from the body, i.e., always taking pills to deaden pain without questioning the source of the pain and/or having a parental injunction against experiencing pleasant body sensations\(^4\).

Many of the characteristics noted above for this group are not unique to the narcotics addict, but are also manifest in the polydrug abuser. It has been observed that the polydrug abuser (one who frequently uses drugs from two or more of the following categories: CNS stimulants, CNS depressants, hallucinogens, opiates, cocaine, and/or others) is statistically more likely to be neurotic, high in state anxiety, and high in sensation seeking than non-drug users\(^5\). This carry-over may be important in seeking causative factors.

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1 Ibid., p. 169f.
2 Ibid., p. 180f.
3 Cuskey, et al., op. cit., p. 199.
4 Claude M. Steiner, *Scripts People Live*, p. 94.
5 Dean S. Kilpatrick, Patricia Suther, and John Roitzach, "Personality Correlates of Polydrug Abuse," *Psychological Reports*, February, 1976, p. 311f.
Unfortunately, these studies of sociological and psychological characteristics of addicts have one inherent flaw. That is that they are limited to the group actually studied, i.e., those who have been arrested, convicted, hospitalized, or voluntarily placed in treatment, and these are definitely a minority of the actual addict population.

There is persuasive evidence to suggest that the portion of the addict population that has been arrested is heavily weighted toward lower socio-economic groups. Thus, many common stereotypes of drug addicts, which are 'supported' by several studies of addicts, may be of questionable accuracy.

One such stereotype is that drug dependent persons usually come from broken or inadequate homes. This has frequently been shown in studies of addicts in treatment. However, at least one recent study of adolescents with 'prevalent' drug involvements showed the vast majority of subjects to have mutually accepting, intact homes.

Because of this 'weighting' of lower socio-economic groups in the studies, other stereotyped characteristics, such as education level and employment status may be suspect also. Other factors that may have a bearing on the likelihood of arrest should be considered.

Some speculations of the nature of the unmeasured addict population tend to view it as a youth counter-culture. Current information does indicate an increase in the proportion of known addicts who are under the age of eighteen.

Some observers believe that youthful drug involvement is primarily a function of peer group identity and/or pressure. Such peer groups are believed to have their cohesions based on "us kids" versus "those adults" attitudes. It has been noted

1 National Commission, op. cit., p. 166.
2 Governor Raymond Shafer, statement before Special Subcommittee of House Committee on Government Operations, Hearings, p. 427.
6 Fritz Redl, Drugs: For and Against, p. 120.
that narcotic addiction among adolescents appears to be much more 'contagious' than among adults.\(^1\) The idea of peer group identity would seem to be consistent with this.

The idea that peer group demands and expectations could be causative of narcotics involvement in adolescents who need not be psychopathological is not new. It has been observed for some time that in the cultural shaping of adolescents' personalities rebellion against parents and parental values is normal. It has also been noted that the felt need to conform to peer standards is frequently extreme in adolescents.\(^2\)

It may be inferred from the above view that the use of drugs can serve as an important function of peer group cohesion for some adolescents. This would be primarily for its value in increasing the cultural hostilities between generations.

It is theorized in transactional analysis that adolescent drug users have at least partial motivation in causing 'law and order' defenders to overreact into an untenable position.\(^3\) The current controversy over marihuana, with over 200,000 persons imprisoned, could be viewed as symptomatic of this.\(^4\)

One study of young drug-involved persons not located by arrest or treatment mode found a number of characteristics in the subject group which were contrary to those in incarcerated samples. Some of these included above average intelligence (WAIS median 119), high school completion by the vast majority, and having been raised through adolescence by both parents.

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\(^1\) Densen-Gerber, \textit{op. cit.}, p. 24.

\(^2\) Nathan W. Ackerman, \textit{The Psychodynamics of Family Life}, p. 209.

\(^3\) Claude Steiner, \textit{Games Alcoholics Play}, p. 101.

\(^4\) Michael Aldrich, \textit{Drugs: For and Against}, p. 86.
in an intact home for nearly two-thirds of the subjects. Also contrary to studies of incarcerated addicts is the fact that the median income for the subjects' families during the senior year of the subject's high school was $13,000 to 15,000, with 90% reporting that their fathers were executives or professionals, and only 1% reporting their fathers as unemployed.

There are some characteristics which appear to remain consistent with both portions of the drug dependent population. For example, nearly all of the subjects in the above study have a profound sense of loneliness and isolation, and the majority have no regular sexual partner. Also noteworthy is the fact that 60% report having seen a mental health professional, although only 10% relate that this was for drug related problems.

So it is necessary to take cognizance of the fact that there remain many facets of the sociological and psychological make up of narcotic dependence that are unknown. It is also necessary to be aware that many items considered to be 'known' may be subject to change at some point. Individuals studying aspects of prevention of drug dependence especially would be well advised to be aware of this.

In studying treatment modes, however, the writer will hope that studies involving characteristics of addicts who are in treatment are germane, while being aware of their weaknesses.

The use of therapeutic communities for drug dependence treatment could be said to date back to Lexington in 1935, although the modern concept began in 1958 with Synanon House in California. The basic change in approach that has evolved

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2 Ibid., p. 889.
3 Ibid., p. 884.
4 Ibid., p. 885.
appears to be in the area of therapy given for underlying psychological maladjustments in addition to the original formula of detoxify and detain.

The need for such facilities in the United States was pointed out as early as 1920: 1

Over 95 per cent of all drug addicts treated at Riverside Hospital, from the beginning of service until now have shown by their acts a non-appreciation of the service, and have repeatedly attempted to be discharged before the end of treatment, or have in some way interfered with its prosecution while there.

(Recommended) such cases as are of a truly residential character (be) detained in institutions that can provide custodial care, for that is the most important therapeutic agent necessary in taking them off the drug.

The fact that withdrawal by itself does not cure drug addiction was known as early as 1930 2. However, long time lapses between medical knowledge and its instrumentation in public policy have characterized addiction treatment throughout its American history 3.

There are now a large number of therapeutic communities throughout the country which use various methods to treat narcotics addiction. They appear to have two main areas of similarity in treatment. One is the requirement that the client show some commitment to change himself. The other is a mental shock given by role models which forces the patient to realize he is missing happiness in life 4.

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2 Musto, op. cit., p. 85.
Most of these programs, in attempting to change behavior patterns, use some combination of two therapy modes. The first of these is confrontation, or encounter group therapy. In this community members discuss each other's past drug history, and it is here that community values are introduced to the new members and reinforced for others. The other therapy mode is largely a form of milieu therapy, in which a hierarchial structure is used to reinforce responsible behavior and give negative reinforcement for undesirable behavior.

Four specific programs will be detailed here, in order to compare and contrast the treatment techniques used. Generalizations used at a later point for all therapeutic communities will not be drawn solely from these four, although illustrations from them may relate to such generalizations. No attempt is made to choose four programs which are specifically representative of all therapeutic communities, nor is there any claim that the four detailed show the entire range of differences to be found in all communities.

Synanon House, the first of the modern therapeutic communities, was started in 1958 in Santa Monica, California, by Charles Dederich and a group of ex-addicts. It is a private institution made up entirely of voluntary clients, and it has no professional staff. It is one of the institutions most selective of its clientel, and it is one of the strictest in terms of internal discipline.

Dederich, a former alcoholic, held a series of discussions in his livingroom with a group of former narcotics addicts. In these discussions, he perceived that drug addicts were more responsive to group therapy than alcoholics, and the residential facility in Santa Monica was an outgrowth of his livingroom discussions.

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2 Ibid., p. 318.
3 Seymour, op. cit., p. 92.
Synanon is a completely drug-free community, and withdrawal is accomplished there without the use of medication. Postwithdrawal treatment consists primarily of work assignments and group therapy sessions conducted by an ex-addict, usually a former patient.

Synanon's treatment program is written into three stages: living and working inside the house, living in the house and working outside the house (usually in one of Synanon's own private enterprises), and living and working outside the house. A resident's position in these stages largely denotes his progress and privileges.

Work details, in addition to facilitating the maintenance of the house, are used to develop the addict's self-respect and sense of worth. Intellectual pursuits are also encouraged, along with continued adult education.

One of the primary dynamics of Synanon is its autocratic family structure. Once accepted, the client is immediately incorporated into this structure, through which he receives a constant flow of criticisms, orders, rewards and subtle behavior controls. Positions in this structure depend on position in the stages.

Privileges are structured to increase with responsibilities. Upon entrance, the addict must completely cut himself off from the outside world. At this time he is assigned a 'wizard' an experienced community member to give him advice and support. The cutting off of outside communications includes visitors, telephone calls, and any unsupervised trips outside the premises. Mail is censored. These rules generally last two to three months, then begin a gradual relaxation.

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2 Seymour, op. cit., p. 93.
3 Eddy, op. cit., p. 9.
4 Ibid., p. 9.
5 Seymour, op. cit., p. 93f.
In actual practice, the rehabilitated addict usually does not leave Synanon to re-enter the outside world, but rather remains in the community in some paid capacity. The intention at Synanon appears less to be to motivate clients to cope in society than to incorporate them as functioning, permanent members of the Synanon community.

Characteristics which distinguish Synanon from most other therapeutic communities include its extremely narrow screening process to pick those applicants with the most motivation for self-improvement, and its use of ex-addicts, to the exclusion of all others, in staff positions. Synanon has served as the original model from which many other programs were fashioned, and it has itself expanded with new branches until it now holds over 1,500 addicts.

Eagleville Hospital, in Eagleville, Pennsylvania, is a private, non-profit hospital. It was originally established in 1909 by Philadelphia's Jewish Community as a sanitorium for victims of lung diseases, especially tuberculosis.

By the sixties, the need for such a sanitorium had vastly diminished. By that time, however, the association between alcohol and tuberculosis had long been noted. In treating tuberculosis, the staff had obtained a great deal of experience in the treatment of alcoholics. Conversion to an alcoholism treatment center was completed in 1965.

In the late sixties, similarities between alcoholism and drug addiction were noted. Also, it was noted that many dependent persons had both problems. As drug addiction became of increasing concern to the local community, Eagleville Hospital moved to include addicts in the treatment program. Drug

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2 Seymour, *op. cit.*, p. 93.
3 All information concerning Eagleville Hospital was obtained from Cuskey, et al., *op. cit.*, p. 229ff.
addicts generally comprise 33 to 40% of Eagleville's resident population, and approximately 95% of them are dependent on heroin.

As an accredited hospital, Eagleville receives funding from insurance payments, as well as private sources and health aid program funds, including Medicaid, through the Commonwealth of Pennsylvania. It charges at least nominal fees of all residents.

Staff is comprised almost exclusively of medical professionals, with little or no employment of ex-addicts in treatment roles. Medical services are provided around the clock. The treatment mode is drug-free, with medical detoxification available. The clientele is comprised of voluntary patients, referrals from other agencies, and referrals from correctional systems.

The program is structured as a sixty day inpatient treatment, supplemented by the candidate program, and outpatient counseling which is available after program completion. Halfway houses in the area are also available for use by program graduates.

The entire program is divided into four phases, the first three of which are strictly inpatient. The first phase (seven to ten days) is for orientation to the program and detoxification when necessary.

The second phase is the most intensive, with full time therapy. Following phase one, all residents are assigned to groups of ten to twelve. The residents stay in the same groups, with mixed alcoholics and addicts, throughout their inpatient treatment. The first two phases of the program are its nucleus, taking a total of sixty days.

Phase three is the candidate program, which does not have a structured time element. During this phase residents participate in therapy groups and work assignments on the grounds equal amounts of time.
Phase four is the out-patient phase for those who have completed candidacy. During this phase clients may live and/or work outside the premises while still receiving counseling from Eagleville or one of the halfway houses. Clients are encouraged to participate in this phase for at least a year, and they are not considered discharged from therapy otherwise.

The primary thrust of therapy is against personality 'inadequacies' resulting from family and/or peer group difficulties. Individual counseling is used, along with group sessions, which are frequently marathons lasting up to forty hours.

The inpatient capacity allowed for addicts is 120, with some expansion planned. Annually, an average of 300 to 350 addicts go through some portion of the program each year.

Several characteristics distinguish the Eagleville program from most other therapeutic communities. It is nearly unique in that there is no screening for motivation. The combining of addicts and alcoholics in the same treatment groups is also quite unusual. The medical-professional make up of the staff differs from most other programs.

Phoenix House, with fifteen facilities throughout New York City, was begun by former addicts in 1967. It is primarily financed by city and state funding, although it receives welfare checks turned over by some of its residents.

The program is largely patterned after Synanon - it is also voluntary and is run by ex-addicts. The primary aspects of therapy at Phoenix are work therapy and encounter groups.

The work therapy consists of rigorous physical work to teach responsibility and release energy. Responsibilities in the assigned work gradually increase throughout the program, which can take up to two years.

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2 Ibid., p. 49.
3 Seymour, op. cit., p. 95.
The encounter groups, which are held three times per week, are described as "sometimes brutal." They are all led by ex-addicts, and they appear to be the key element for progress at Phoenix\(^1\).

The total residential capacity at Phoenix exceeds 1,500, or about the same as Synanon. Phoenix' approach to treatment varies from that of Synanon in only a few areas. There is some use of medical and psychiatric personnel on a consultation basis, along with some professional teachers. And, although nearly half of the program graduates remain there as employees, Phoenix makes no effort to form a separate, intact culture.

Odyssey House was begun in New York City by Judianne Densen-Gerber in 1966\(^2\). While doing her residency for psychiatry at Metropolitan Hospital, Dr. Densen-Gerber began the project as a research program.

The program was categorized as maintenance testing, which meant that addicts who requested to be taken off the maintenance drug could not obtain permission to do so. It was as a result of a confrontation with a group of such addicts that Dr. Densen-Gerber began her own program, which was incorporated (non-profit) in 1967.

Odyssey is a private institution which serves voluntary and court-referred clients. Nearly all funding comes from private donations, although some government allocations are received\(^3\).

The treatment mode is drug-free, and detoxification is available for adolescents. Adults are expected to be previously detoxified, or to have reduced their habits prior to entrance to a point where detoxification will not be required.

Odyssey staff is of both ex-addicts and professional psychiatrists\(^4\). Full-time medical personnel are also employed.

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1 Campbell, *op. cit.*, p. 51.
2 Except as noted otherwise, information on the Odyssey House program was obtained from Densen-Gerber, *op. cit.*
3 Campbell, *op. cit.*, p. 51.
4 Seymour, *op. cit.*, p. 95.
Treatment at Odyssey is divided into several stages and can take up to twenty-four months to complete. Agreement among peers, ex-addicts, and professionals is necessary for each promotion through the stages.

Before actual treatment begins, there is a pre-treatment phase. This begins when the addict applies for admission, or is referred to the institution. A team of ex-addicts must determine, from such factors as being on time for the interview, displaying a cooperative attitude and having his level of addiction lowered, whether the client has at least minimal motivation for treatment. If so, he will be sponsored for admission to the facility by a Level IV resident.

Within twenty-four hours of admission to the community, the resident is given an "inquiry in." This is an open-ended meeting, conducted by the House Coordinator, with representatives from all levels of the community. The purposes of this meeting are to give the resident a constructive feeling of belonging, to acquaint the residents with the new member, and to obtain a background history.

A copy of the inquiry, with the comments of the residents present, is appended to the patient's chart, and he becomes a candidate-in. Within twenty-four hours, he is given a complete physical, with blood and serological testing, an EKG, TB skin testing, a chest x-ray, and urinalysis. Female residents are also given a PAP test.

Within the first seventy-two hours of his candidacy-in, the resident is also given a complete psychiatric evaluation by a qualified psychiatrist. This, with the physical, is also attached to the chart.

The candidate-in is supervised by a Level III resident. He receives four and a half hours a week of group therapy, and he is responsible for most of the manual labor in the community. He has no voice in shaping policy in the community.

If, after at least a week, the candidate-in can obtain a treatment staff sponsor, he is entitled to a "probe." If he is unsponsored, he is entitled to a probe by default at six weeks.
The purpose of the probe is for the candidate-in to prove to the residents and staff that he has an understanding of the house's concept and a commitment to live by it. If the candidate-in passes the probe (the vote by residents and staff present must be unanimous) he then begins the actual treatment phase at Level I.

Treatment is sixteen hours per day. This includes work responsibilities, which are still largely manual at Level I. The primary emphasis at this level is to convince the resident that positive change will occur.

At Level II vocational skills are fostered, and work assignments gradually shift from manual to clerical. Self-discipline is developed in the completion of tasks with decreasing amounts of supervision. Supervised family visits in the house are permitted for the first time.

At Level III the resident begins taking on responsibility for others. In therapy sessions he is sometimes given the role of co-leader. He is allowed to travel alone on house business and receives unopened mail.

Level IV is the beginning of the re-entry phase. It is usually reached after ten months to a year of treatment.

At this point the resident will gradually increase his time spent outside the house, at speaking engagements or informally representing the house. With permission, he may now leave the house for personal reasons or on business. He may also occasionally spend a night out.

A Level IV resident accompanies the Induction Supervisor to raw-addict intakes, and he may be a co-leader at an inquiry-in. At this level he begins to formulate a detailed plan for functioning in the outside world.

At this stage the patient may put his plan together and meet with a group consisting of peers, representatives of the next higher level and staff. In this meeting, the "inquiry out," he may be voted to the candidate-out stage, if his plans seem complete and realistic.
The candidate-out lives and works outside the program. He must hold employment outside the field of drug addiction. His involvement with Odyssey House is diminished to weekly candidate-out group sessions and unscheduled urine drops. For the first time, he may obtain individual counseling.

Finally, the patient must pass his "probe-out" meeting. Once he does so, he is considered discharged to outpatient status. He is then independent of the program, except for participation in the five-year follow-up studies, and occasional urinalysis. He will participate in monthly outpatient group sessions for two to three years.

Since its inception, Odyssey House has grown to thirty-three locations in six states. The addicts who have been treated there number in the thousands.

This program differs from most others in several respects. Its synchronization of medical professionals and ex-addicts appears to be unique. The insistence on immediate, complete physical and psychiatric evaluations is unusual.

The intensity of professional psychotherapy seems higher than with other programs. Also the level of expectations and demands placed on the addict, even to receive treatment, seems higher.

The requirement for daily urine testing of all residents and staff is unique, as is the thorough follow-up activity for program graduates.

A comparison of therapeutic communities with other methods for dependence treatment is difficult for two reasons. There is a severe lack of comparable data, and the types of clientele served may differ widely enough to invalidate direct comparisons.

In 1914 Charles B. Towns advertised that several thousand addicts had been through his hospital's five-day treatment plan, with a 'cure rate' of over 90%. This statistic was

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1 Seymour, op. cit., p. 95f.
arrived at by the fact that less than 10% of his patients returned for further treatments. Mr. Towns may have paved the way for current record-keeping in treatment facilities.

Precisely what determines "success" or "improvement" through a drug program has stirred some controversy. The writer, while recognizing the importance of employment levels and rearrest rates for the topic, will arbitrarily limit comparisons to the abstinence from narcotics use after leaving the program, either by discharge or premature exit.

As recently as January, 1975, the Special Assistant to the Secretary of the Health, Education and Welfare Department stated:

So far, there has been relatively little research on the efficacy of various treatment approaches to heroin addiction and, for all practical purposes, none in other areas of drug abuse. Defining appropriate evaluation criteria is a major problem. Current criteria for evaluating treatment vary almost as much as the treatment approaches themselves, and the few studies which are now available reflect these differences.

One of the few representative studies made on drug-free after-care programs (including therapeutic communities) over a one year period involved over 1,000 patients. Only thirteen were found to have abstained completely from illegal drugs.

A different study of over 1,000 opiate addicts compared the retention rates of various types of programs. (Here, the underlying assumption that those who prematurely exit the programs will return to drugs may be partially borne out by the statistical fact that 90% of those who do so are dead or

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1 Musto, op. cit., p. 88.
3 Ibid., p. 117.
imprisoned within a year. In it the retention rate after one year of methadone maintenance programs was 65%; drug-free outpatient programs had 46%, and therapeutic communities had 29%. Other comparative studies use numerical values placed on the 'rated improvement' of the addict. Here, the lack of follow-up studies makes the statistics apply to only those on whom data are available, or less than one-third. And then, the improvement figures are admittedly "completely subjective."

A lower rate of retention or success by therapeutic communities relative to other treatment modes may not necessarily indicate weaknesses in that type of program, even if the data are complete and reliable. This assertion is based on the tendancy to refer the more 'hardened' addicts to such programs, because they are thought to be more appropriate for such clients.

Further, there may be other valid reasons to believe that higher levels of client retention in other types of programs would not necessarily indicate proportionately higher indices of cure. It may be speculated that in some of these programs there are factors which would motivate a client's staying in treatment longer, without becoming or staying drug-free.

In methadone maintenance, for example, the addict is not required to go through abrupt withdrawal. Since the client is generally given methadone at no charge, eliminating the risks involved in seeking street drugs, it would appear reasonable to conclude that the patient would have a positive motivation for continuing treatment. The final phase of

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1 Seymour, op. cit., p. 94.
2 Brown, op. cit., p. 117.
4 Drug Enforcement Administration, op. cit., p. 174.
the methadone programs, in which the client is withdrawn from methadone, would seem to be more comparable to therapeutic communities. However, this phase of treatment has not occurred in methadone programs in statistically significant numbers of cases.

One relatively new mode of addiction treatment which has yet to be compared to therapeutic communities is the use of narcotic antagonists. The basic approach of such programs is to block the effects of narcotics by use of cyclazocine of naloxone, and thus de-condition the addict. The effectiveness of such programs in reaching the point of detoxification has been described as "limited," and the drugs have been shown to produce some unpleasant side-effects. Thus, the writer will consider this mode to be in the early experimental stage, while possibly worthy of more study when more fully developed.

The individual therapeutic communities described above have had varying degrees of success. Examining these in light of the noted program differences may be of some value in an evaluation of treatment methods.

Synanon has enjoyed a reputation of good results, but the administration does not release statistics. The rationale given for withholding such information is that records of failures would give new admittees excuses to fail. However, external observation has led to the conclusion that Synanon probably has only a 10% retention rate after a year. Thus, the likelihood of a good cure rate seems small.

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2 Cuskey, et al., op. cit., p. 200.
3 Eddy, op. cit., p. 9f.
The study of Eagleville shows general physical and psychological improvement among its patients, as well as a steady decline in the incidence of illicit drug use among the inpatients while in treatment. However, the majority of those entering the program do not complete it\(^1\). Again, this raises a serious question as to the proportion actually cured.

Phoenix House has also had less than perfect results. By 1970, 45% of the 1,700 addicts who had entered treatment had left the program prematurely. Seventy-nine had actually completed the program; two were known to have returned to drugs, forty-two were on the staff at Phoenix, seventeen were on staffs of other treatment facilities, and eighteen had regular outside jobs\(^2\). While the proportion of those staying drug-free after program completion is statistically high, it is almost insignificant in comparison to the number leaving prematurely.

Odyssey House is the only program studied which shows evidence of a high cure rate. It has had over 1,000 known cures, that is, addicts who stay drug-free on a long-term basis after treatment\(^3\).

The proportion of cures to admittees also appears to be high. Of all persons admitted for treatment, 70% stay drug-free on a long-term basis after treatment\(^4\). After the resident completes six weeks of treatment, the statistical chances of his being cured on a long-term basis increase to 80%\(^5\).

While these figures come from the Odyssey House administration, it would appear that the program has more authoritative ability to make such statements than most programs.

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\(^1\) Cuskey, et al., *op. cit.*, p. 231.
\(^2\) Campbell, *op. cit.*, p. 51.
\(^3\) Densen-Gerber, *op. cit.*, p. 33.
This is because, as previously noted, Odyssey House is the only known program with a thorough after-care program study which lasts for years after treatment.

The writer will attempt to draw several conclusions in the area of treatment effectiveness, with speculations into possible causal relationships for differing success rates. These will include what applications of program differences may contribute significantly to the cure rate differences, why therapeutic communities generally have low cure rates, and inferences as to program changes which may improve future effectiveness. A general view of the need for consistent performance criteria and further study will also be given.

One germane assessment of the lack of success generally among therapeutic communities is as follows:

They have all had some highly publicized and enthusiastic successes. The amount, however, cannot be determined because these places are usually manned and often directed by ex-addicts full of messianic and even authoritarian zeal, but little formal training and not much gift or patience for precise record-keeping. They rely heavily on faith, exhortation and on discipline and on group therapy, in which may face some excruciating exercises in 'facing the truth about himself.'

The disappointing results generally of therapeutic communities, and specifically those of Phoenix and Synanon, seem to lead to the conclusion that messianic zeal, reliance on faith and discipline and group therapy by untrained staff do not lead to adequate success rates.

Two programs detailed above, Odyssey and Eagleville, use trained professionals on their staff. Several distinctions which may be relevant to success differences may be noted between these two programs.

Odyssey uses ex-addicts on its staff, while Eagleville does not. They do receive formalized training, but they are nonetheless ex-addicts. They comprise the majority of persons with whom clients come in contact in the early treatment stages.

1 Cuskey, et al., op. cit., p. 201.
Also, while both staffs have trained professionals, the emphasis at Eagleville appears to be more inclined to medical than psychological treatment in comparison to Odyssey. A larger part of Odyssey's staff lives on the premises than Eagleville's.

While both programs use urinalysis, the attitude toward positive testing seems appreciably different. Eagleville is somewhat tolerant of one or two positive tests. At Odyssey, a resident is dismissed from the program the first time his urine tests positive, and he must apply for readmission to the program at the beginning. Also, Odyssey requires all staff members to submit to such testing, while Eagleville does not.

There are also several characteristics distinguishing Odyssey from most other therapeutic communities from which inferences may be made for success differences. The area of urine testing again seems relevant.

While some other agencies use urinalysis, usually sporadically, most do not. The idea of including staff in daily testing, unique at Odyssey, could be of significance, especially in facilities which use ex-addicts on staff. In 1975, the executive director of Bridge Over Troubled Waters died of a narcotic overdose.¹

The use of psychiatric evaluations early in treatment is another aspect of the program whose difference from other programs may be significant. Many others have no personnel with training in psychology or psychiatry. Nearly all of those making any use of such services do so only on a conferral basis.

The structuring of specific treatment phases at Odyssey seems more detailed than at other facilities. Criteria for advancement in these phases seem more specific. Some programs,

such as Eagleville, use length of time in treatment as the primary, if not only, criterion for advancement through some or all treatment phases. Other programs use no differentiated phases of their treatment.

Odyssey appears to keep its residents isolated from outside influences more completely and for longer periods of time than other programs. Even programs in isolated communities such as Synanon usually allow residents to receive uncensored mail earlier.

These factors may give some inferences for factors which contribute to the generally low cure rates of therapeutic communities. Here it seems appropriate to synthesize these factors with information previously presented on the characteristics and history of addiction in order to speculate on how these difference factors may relate to cure rates.

It should be remembered that this country is still in its first decade consistently treating addiction at least partially as an illness, rather than a crime. A similar transition took place some time ago for mental illness, without instant answers.

Attempts at addict rehabilitation in prison have been described as hopeless. Perhaps it is important that the addict, especially when committed by a court, understands that his stay in the facility is for the purpose of treatment rather than punishment.

This could mean that programs which intentionally or unintentionally promote the addict's ownership of guilt for his addiction are counterproductive. While teaching responsibility for actions may be necessary, guilt for addiction per se probably is not.

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1 Seymour, *op. cit.*, p. 15.
This is not meant to argue that use of non-medical narcotics should be legalized, nor to excuse the addict's behavior while catering to his habit. While addiction itself may not be a disease, it nearly always is symptomatic of some form of illness. This much, at least, was consistent in all the samples of psychological characteristics of addicts.

The use of legal commitment to treatment programs following drug-related arrests appears to be one of the more effective ways to get an addict into treatment. Prison, as an alternative for addiction treatment, is a method of motivation that probably cannot yet be dispensed with.

One of the most important bodies of information thus far found is that the addict nearly always has psychopathology predating his drug use. The inference for causality here is very strong. Feelings of inadequacy, inability to form stable social relationships, resentment of authority, alienation from self, depression and unresolved anxiety appear to be a syndrome which drug dependence is frequently used to mask.

Programs whose primary centering of treatment is against the drug dependence are probably doomed to fail, just as a treatment for hepatitis which concentrates on the yellow skin rather than the liver is doomed to fail.

And, while there are characteristics frequently found in common among most addicts, they exist in varying degrees and combinations, for differing reasons. A psychological 'formula' for treating addicts on an assembly line is of doubtful value, although that is the impression obtained of some programs.

It is here that the individual psychiatric evaluations used at Odyssey House seem most important. While group therapy is used extensively, the groups are to some extent matched. And the group leader is professionally trained, rather than having only 'his own experience' to rely on. He is a full time employee of the facility, which probably adds to his familiarity with and interest in the client. Many times he also has his own experiences with addiction to draw on.
It probably should not come as a surprise that the best success record in treating a problem with roots in psychopathology is held by a facility which uses full psychiatric evaluation coupled with trained therapists.

One forceful example of the value of individual treatment is the situation with the addicted schizophrenic. As many as 20% of the addicts entering Odyssey are schizophrenic, and they are separated from other residents for therapy groups, because the strong confrontation used in the therapy of most addicts would tend to worsen a schizophrenic. Confrontation therapy, of varying degrees of hardness, is used in virtually all therapeutic communities. Those which depend on faith and zeal instead of using individual professional psychological evaluations are probably automatically damaging up to 20% of their clients.

The use of urinalysis is probably of some importance in treatment success, as is the application of the urinalysis. Sporadic urine testing, or none at all, in combination with a permissive attitude toward violations of the drug-free policy, is probably an important program weakness.

The addict in treatment usually has years of practice rationalizing his drug use. If he were able to overcome his habit on his own, it is unlikely that he would be in treatment. If he is motivated to stay in the program, then it seems logical to use that motivation in his favor. Definite knowledge that he will be caught and dismissed from treatment if he goes back to drugs even once would destroy the rationalization and help the client increase his own self-control.

There is also the question of the patient's respect for those who are supposed to be able to help him. If one addict knows that another is still using drugs and able to fool the authority figures, then that respect is damaged. Worse, if

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1 Densen-Gerber, op. cit., p. 198.
the addict entertains doubts about some of his ex-addict super-
visors as being drug-free, then the respect will greatly suffer.
This can be eliminated by inclusion of the staff in daily urin-
alysis.

Specific expectations for completion of various treatment
phases may also be of value in treatment. The more specific the
criteria, the less chance there is for the addict to rationalize
his lack of progress as personal discrimination against him. It
would also seem that the more clearly the addict understands
what is expected of him, the more likely he is to be able to
achieve progress.

Also, the differing amounts of privileges given those
who assume responsibility should probably be very visible. If
the added privileges have any motivational value, then clear
definitions of how those privileges are obtained should enhance
it.

The degree of isolation used at Odyssey for its residents
is probably of value. This would be for a variety of reasons.
First, the isolation, along with the urine testing, helps
assure that the addict is drug-free while in treatment. This is
absolutely essential, since the goal of remaining drug-free after
the termination of treatment is quite unlikely if the client is
not drug-free while in treatment.

Also, isolation from family and former acquaintances
helps the therapeutic process. The addict is no longer in assoc-
iation with the peer group which probably aided his addiction
process. Further, a lack of former friends with whom to interact
will probably aid the process of transference with the ananyst.

The final contribution of isolation is its value in
motivation. If the use of privileges can help motivate for change,
then one as significant as outside communication should be of
value.

In speculating as to program differences' contributions
to success differences, the final significant difference at
Odyssey is its aftercare system. This can continue five years.
The graduate of a drug program has usually spent at least a year in it, in many cases more. The last time he was on his own, he probably perceived himself as an inadequate human being, unworthy of many of life's best qualities. His relationships with other people were usually severely impeded.

Upon leaving a drug program, the graduate has just finished spending a great deal of time learning that he is a valuable person, that it is healthy to be open and honest in dealings with others, and that narcotics use is less a crime than a disease.

As he leaves, he leaves behind him a great deal of supportive interaction that he has become accustomed to having. He also probably leaves behind him some of the first interpersonal relationships of any meaning he has had in years, possibly in his lifetime.

The environment he enters may be the same one that earlier contributed to the maladjustments which helped lead him to addiction. If the environment is a different one, it will still almost certainly present him with many contradictions of what he has recently learned about his self-concept and the desireability of giving others honest feedback.

Some areas of confusion about his new role seem very likely. The need for supportive interaction may become intense at this time. Certainly, nearly all drug programs have help available at this stage if the graduate asks for it. But feelings of having been misled, confusion, pride, or any combination of these may keep him from it. Going back to ask for help may be threatening to the fragile self-concept.

Having regular aftercare group sessions as an integral part of the program can go a long way toward helping with these problems. It can also provide valuable feedback for the program itself.
It is disturbing to the writer that such a large portion of a discussion of treatment programs' effectiveness must be based in speculation. It is disappointing that so little work has been done toward finding effective treatment for a problem that has been recognized for two centuries.

One could almost conclude that there is no interest in obtaining consistently high cure ratios. The conclusion could be drawn that the only real interest is in getting the addict off the street and into 'treatment' so that he is out of the way. If that is where official interest is, then it would be less hypocritical to repeal the laws for addiction treatment and go back to incarceration.

The potential for consistently effective treatment does exist. Even if the records of Odyssey House were to fall into question, another, larger group has proven that narcotic addiction can be cured.

Returning from Vietnam, as many as 15% of our GI's were addicted to heroin. This was one of the largest single groups of addicts ever known to the country, and many officials were quite concerned.\(^1\)

Fortunately, studies have shown that after one year back in the United States, 92% of those who had returned addicted no longer used heroin\(^2\) - the highest known cure rate of any statistically significant group of addicts in U.S. history.

Unfortunately it is impossible to set up new programs modelled after the one that worked for this group of veterans, because the overwhelming majority cured themselves. But the point is that narcotics addiction is curable.

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\(^1\) McCoy, op. cit., p. 1.

The obvious place to start is in studying our present programs and evaluating them to see which methods are most effective. This would give us indications as to directions for new research.

Before this can be done, two things must happen. Meaningful, consistent criteria for evaluation must be uniformly adopted, and accurate reporting methods must be found.

Progress toward good criteria does not appear to be in the immediate future. The National Commission on Marihuana and Drug Abuse has suggested the following\(^1\):

The federal government should sponsor a program to evaluate existing drug treatment and rehabilitation programs to see whether they (1) are cost effective; (2) are designed to deal effectively with their client population; and (3) have established suitable criteria and objectives.

These 'criteria' are best dealt with in sequence: (1) That this one is labeled "(1)" is not surprising; (2) it certainly would be inappropriate to design a program to deal ineffectively with its client population; and (3) if the program's criteria are as vague and subjective as those proposed for program evaluation, they will probably be met.

The writer would suggest that these criteria be specific and measurable in order to be of value in choosing among treatment alternatives. The obvious primary criterion for treating drug dependence is abstinence from the drug after treatment is complete. Others, such as employment levels and rearrest rates may also be of value.

The primary concern is that some type of criteria is selected and applied, and that it be sufficiently precise and measurable that it can be used in making comparisons.

Reporting methods go hand in hand with evaluation criteria. Assuming the use of abstinence as one criterion,

some type of aftercare follow-up will be necessary. The two immediate problems would be persuading program graduates to participate and persuading programs to participate.

When incorporated as a regular part of the program, as done at Odyssey, participation in such a program by the client may not be too difficult to persuade. Continuance through this part of the program could be incorporated into probation or parole requirements for court-committed addicts just as easily as the original treatment is required.

Persuading programs to participate in aftercare and other reporting admittedly could not be universal, especially in the cases of private institutions. However, Publicly funded programs could easily be required to report on all clients. Facilities with special licensing requirements, such as methadone clinics, would also present no problem. Private institutions could at least be required to report on all court-committed clients.

The essential point is that the serious problem of narcotic dependence is not unsolvable, but we have not yet reached the solution. We can begin to do so only after we establish some reasonable means by which to compare current programs in order to begin designing more effective ones in the future.
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