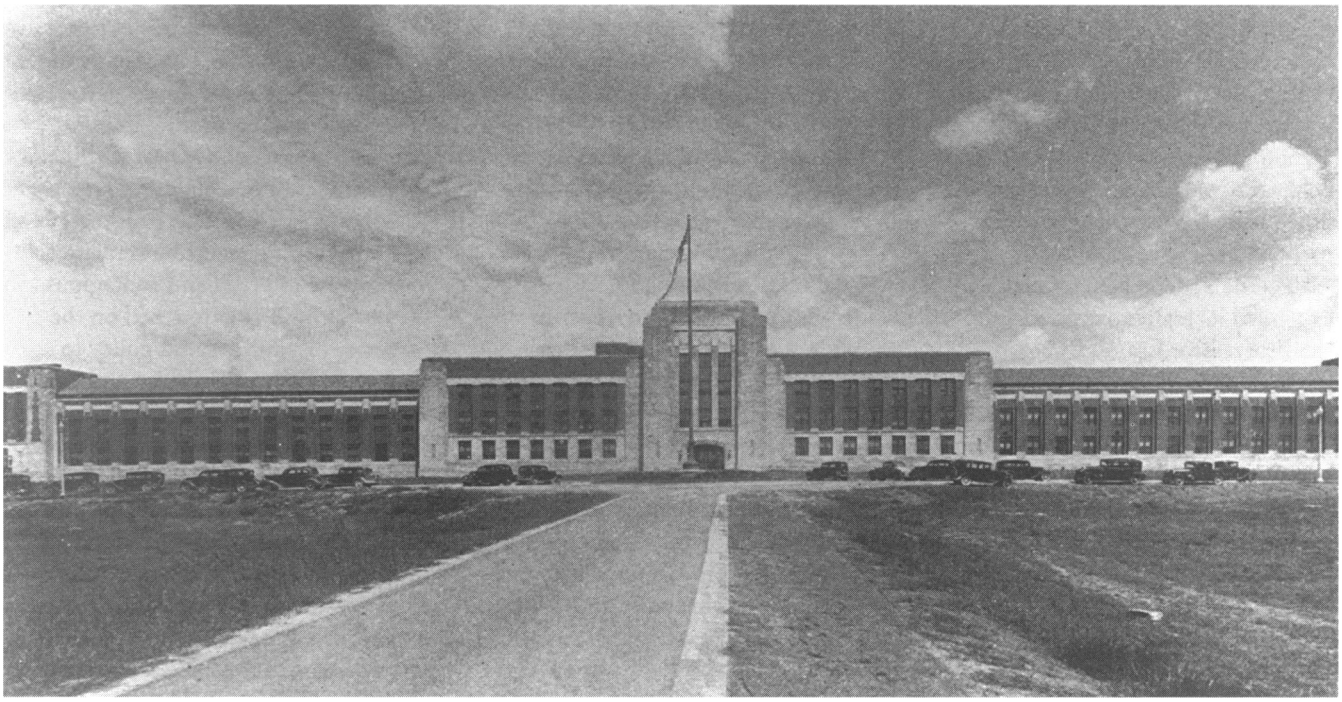

The Early Years of the PHS Narcotic Hospital at Lexington, Kentucky

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When the Public Health Service Narcotic Hospital at Lexington, Kentucky, opened on May 25, 1935, it embodied the hope that opiate addicts could be healed and returned to productive roles in American society. Within 20 years, however, the hospital had come to symbolize an entrenched pessimism about the possibility of curing addicts, a pessimism that affects policy to the present day.

In the keynote speech at the hospital's dedication ceremony, Surgeon General Hugh S. Cumming declared that the hospital exemplified the enormous expansion in the scope of Public Health Service (PHS) activities that had occurred since he had been commissioned 41 years earlier. He described the hospital as representing a "modern" approach to addiction, which he compared to "an endemic disease" warranting a "medico-social" response. Addicts were the targets of an illicit market in opiates that was in effect a source of contagion, endangering their fellow citizens. Segregating addicts from society "with the object of medical treatment" would protect the public as well as helping the addict. Cumming compared the treatment of addicts to the treatment of the insane: he said that in previous, less enlightened, periods, simple confinement of the insane had prevailed but that now medical progress had led to the provision of humane, therapeutic regimens for those suffering from mental illness. Similarly, new understandings of addiction offered hope of providing cures for a condition long viewed as intractable.

Cumming's remarks reflected both the triumphant progress of public health in controlling infectious disease in the wake of the bacteriological discoveries of the late 19th century and the reform currents within psychiatry that were casting mental illness as a public health issue.

The PHS Narcotic Hospital at Lexington at about the time it opened in 1935. (Courtesy of the Program Support Center, Department of Health and Human Services)

PHS's own involvement in the development of public health psychiatry strongly conditioned the approach it took toward the problem of narcotic addiction. The career of PHS psychiatrist Lawrence Kolb, first medical director of the Lexington Narcotic Hospital, parallels PHS's move into the treatment of narcotic addicts. Kolb joined PHS in 1909 and was soon stationed at Ellis Island, where PHS personnel screened prospective immigrants for diseases that were grounds for exclusion from the United States. There, Kolb studied with psychiatrist Thomas Salmon, who had developed the screening systems used at Ellis Island for detecting mental illness and then left PHS to join the National Committee for Mental Hygiene, an organization committed to asylum

reform and preventive psychiatry. Salmon had developed a model of psychiatry as a public health activity based on the view that surveillance of the population and early detection of problem behaviors could have a preventive effect in reducing the incidence of serious mental illness.

As the Federal government expanded its regulatory powers during the Progressive Era, PHS became involved with the problem of opiate addiction. The Harrison Act, passed in 1914, for the first time instituted criminal sanctions for the sale or use of certain drugs (chiefly opiates and cocaine) except as authorized or administered by a physician. PHS launched a series of studies on the prevalence of opiate addiction in the United States and, in 1923, assigned Lawrence Kolb to the PHS Hygienic Laboratory in Washington DC to study the nature and causes of addiction.

Kolb embarked on a two-year study of about 200 addicts to learn more about addiction and those who were susceptible to it. In 1925, he published his conclusions in a set of landmark articles. He argued that the cause of opiate addiction lay in psychoneurotic deficits that preexisted any drug use by the addicted individual. Before possession of opiates was outlawed in 1914, many people had become addicted to morphine through careless prescribing, he said, but the passage of the Harrison Law meant that now only certain types of unstable or "psychoneurotic" individuals were likely to become addicts. For these individuals, according to Kolb, opiates provided a sense of well-being that masked feelings of inferiority and allowed them to feel equal to what he described as their unrealistic ambitions.

In position papers prepared for PHS, Kolb stated his beliefs that the incidence of addiction was not rising significantly and that vigilance and public education would keep the problem under control. He argued that almost any treatment method would be successful given two weeks in which it could be insured that the patient would not have access to any opiates while he or she went through drug withdrawal and achieved a state of abstinence. Therefore, when an Act came before Congress to authorize the construction of special prison-hospitals for addicts, Kolb saw no reason for such institutions.

In 1928, PHS sent Kolb to Europe, where he spent three years evaluating PHS methods of testing the mental fitness of prospective immigrants in several countries. Meanwhile, his view that prison-hospitals for addicts were unnecessary did not carry the day. By the late 1920s, Harrison Act violators were the most numerous class of Federal prisoners, and wardens did not agree with Kolb's view that their institutions had appropriate facilities for managing addicts.

In the 1920s, prison reformers such as Thomas Mott Osborne and Frank Tannenbaum offered a model of a prison that was designed not just to punish but to rehabilitate. The prison should be structured as a community within which the prisoners would learn to be good citizens. Advocates described this as a form of quarantine for the diseases of society. Thus, when Stephen Porter, Republican member of the House of Representatives from Pennsylvania, brought a bill before Congress in 1928 to create a new kind of institution, to be called a "narcotic farm," its supporters included a range of constituencies. Porter's bill became law in 1929. Lawrence Kolb, ironically, was named Medical Director of the first hospital, built in Lexington.

PHS psychiatrist Lawrence Kolb studied opiate addicts in the 1920s and became the first director of the Lexington Narcotic Hospital. (Courtesy of the National Library of Medicine)

As a "narcotic farm," Lexington blended aspects of the past and the present and of hospitals and prisons. Cumming's description of addicts in his keynote address as both market consumers of drugs and contagious agents of addiction touched on the capacity of public health policy to embrace both enforcement and medical concerns. Cumming also described addicts as people who failed to meet the challenges of an increasingly complex American society. Yet this institution, designed to prepare individuals for productive life in a modern industrial and urban society, was initially envisioned as a farm. This approach juxtaposes an awareness of modern social problems with an axiomatic view that the traditional values of America's agricultural past were a model of personal and civic health.

The mixed character of the institution was also reflected in the categories of patients it would admit: Federal prisoners who were addicted to opiates, probationers whose terms of probation included completing treatment at a PHS narcotic hospital, and patients who sought admission voluntarily.

Kolb's treatment regimen was divided into three phases. First came the withdrawal phase, typically completed within 10 days. During this phase, the patient was interviewed and the social service staff contacted relatives, agencies, and others who knew the patient to assemble a profile. At the end of 30 days, the hospital classification board considered each patient's case and determined his classification (in its first 10 years, Lexington admitted only men) according to a typology Kolb had developed.

Phase two of treatment comprised most of the remainder of the patient's stay at Lexington. Length of stay varied widely, since voluntary patients could leave when they wanted to but

prisoners had to stay for the duration of their sentences. Probationers were released when the Lexington physicians believed they were cured.

In an article in the *Southern Medical Journal* (1938 Aug;31:914–22), Kolb and W. F. Ossenfort characterized this phase as time for "building up the patient physically and mentally"; they recommended that voluntary patients spend at least six months at Lexington. The entire routine of life in the hospital was designed to provide a healing environment. Each patient had a work assignment; these ranged from woodworking, furniture making, or garment manufacture and repair to an array of food production activities, including raising and slaughtering pigs and processing the meat, managing a dairy herd or hennery, or raising and processing a variety of crops. Other aspects of life such as bedtimes, meals, and recreation were also routinized. It was expected that living in this well-regulated environment would help patients cultivate good habits and allow bad ones to wither.

The third phase of treatment involved preparing the patient to return to the world outside. This phase was crucial because relapse rates were known to be high and returning to the same environment where a patient had first became addicted was considered especially risky. The objective of this third phase was to attempt, through the social service staff at the hospital, to facilitate the patient's transition into an appropriate employment and residential setting. The ideal situation was to have a good job and welcoming family waiting for the patient.

In fact, such a scenario rarely occurred—except in the case of voluntary patients. In a 1939 *Supplement* to *Public Health Reports* entitled "The Kolb Classification of Drug Addicts," PHS psychiatrist Michael Pescor analyzed the case records for the 1036 patients admitted to Lexington between July 1, 1936, and June 30, 1937. He found that the voluntary patients, who represented just under 4% of the sample, were primarily farmers who had become addicted to opiates while being treated for a medical condition. These patients were typically married and had children, and they either owned farms or had jobs to return to. In essence, they represented the kind of citizen that the "narcotic farm" was originally intended to produce.

Far more numerous in the Lexington population were the type of addict that Kolb called a "thrill seeker." These patients typically came from economically marginal circumstances in deteriorated metropolitan environments. They worked in positions such as waiters or drivers, amused themselves in pool halls and gambling dens, and often had connections with the underworld, even if only as purchasers of illegal drugs. These patients had poor prognoses, based both on the impoverished situation they would return to after release and on their attitudes toward drugs. They had begun drug use either through curiosity or through association with other drug users. Such patients would often agree superficially with the staff recommendation that they live with stable relatives after release; however, they typically had no job waiting for them, and the risk of drifting back into association with drug users and relapsing was high. This group recalls Kolb's characterization of addicts as people of modest capabilities striving to improve their status and masking feelings of inferiority through drug taking.

Psychiatric explanations like Kolb's located the etiology of addiction in individual psychopathology; at Lexington, patients were grouped and treatment plans structured around a psychiatric categorizing of addicts. Yet a countervailing belief in the importance of environmental factors was evident in the institutional routine and in the great concern about the environment the patient would return to following release. This ideological tension was resolved in the idea that the psychopathology consisted of failure to adjust appropriately to social norms. In effect, the pattern of recidivism that developed as former patients relapsed, ran into trouble with the law, and returned to Lexington was blamed on the addicts themselves; the continuing need for a prison to house addicted prisoners and probationers undermined any tendency to question Lexington's therapeutic effectiveness.

A number of studies in the 1940s and 1950s attempted to determine the success rate of treatment regimens at Lexington and similar facilities. John O'Donnell, a social worker and sociologist who worked at Lexington, analyzed this research in 1965 ("The Relapse Rate in Narcotic Addiction: A Critique of Follow-Up Studies." In: Wilner D, Kassebaum G, editors. *Narcotics*. New York: McGraw-Hill; 1965). He pointed out that the studies had serious methodological problems—including a tendency to classify even brief episodes of drug use following treatment as "relapse" or treatment failure—but noted that their overall finding of an approximately 80% relapse rate sustained the idea that addiction was virtually incurable. Thus these studies bolstered the image of the addict as an antisocial personality type who belonged in prison.

Congress had appealed to a preindustrial vision of America in the legislative call for the creation of "narcotic farms." This vision both recalled a Jeffersonian past and invoked the rural asylums that dominated treatment of the seriously mentally ill in 19th-century America. Eventually, an entrenched pessimism based on treatment failures undermined Lexington's therapeutic mission; however, the same failure rate seemed to confirm Kolb's earlier description of addicts as individuals incapable of measuring up even to modest social expectations of productivity and adjustment. By the 1940s, when the studies cited by O'Donnell began to appear, Kolb's thrill seeking opiate user had become the paradigm for the addict as a social problem.

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