Contradictions in Addiction

THE Narcotics Conference at the University of California at Los Angeles, April 27–28, 1963, was much more than a road show version of the White House Conference on Narcotic and Drug Abuse held in September 1962. The spirited discussion in the university setting evoked a high level of agreement on the many baffling and contradictory aspects of addiction.

The program, organized by staff of the UCLA School of Public Health, also offered fresh international comparisons by Leslie T. Wilkins, deputy director, Research and Statistics, Whitehall, London, and by Dr. E. Leong Way, professor of pharmacology and toxicology, University of California Medical Center, who had a report on Hong Kong. Data obtained since the Washington meeting enabled Dr. Nathan B. Eddy to speak with optimism about the prospect for an effective nonaddictive substitute for opiates (see p. 673).

The program committee for the UCLA Narcotics Conference consisted of Dr. Daniel M. Wilner, chairman, Dr. Gene G. Kassebaum, Rosabelle Price Walkley, and Dr. David A. Ward. Dr. Lenor S. Goerke, dean of the UCLA School of Public Health, was chairman of the conference steering committee. The conference was funded in part by a grant from the National Institute of Mental Health, Public Health Service.

To put to maximum use the statements of international experts, the speeches and discussions were taped for reproduction by closed circuit television to selected audiences. The conference proceedings are to be published soon by the Blakiston Division, McGraw-Hill Book Co., Inc. The text below presents highlights of the personal views and opinions expressed by the speakers.

The area of agreement plainly contradicted the familiar notion that there is a bureaucratic conflict between law enforcement agencies and public health agencies for authority to manage addicts. Despite their differing outlooks, it was evident that in California the department of corrections and the department of mental hygiene had performed like Alphonse and Gaston, each eager to concede to the other the duty of managing addicts under involuntary civil commitment. The State legislature eventually assigned the responsibility to the department of corrections because it had the facilities and experience to treat the patients under custody.

Commenting on the differences between custodial and therapeutic approaches to addiction, Richard A. McGee, administrator of California's Youth and Adult Corrections Agency, observed that the duty to receive addicts under civil commitment was assigned by a legislature responding to public demands that something be done about the increasing rate of addiction among youth. The policy toward addicts, he said, is shaped by law, custom, and public opinion, rather than by physicians or penologists. Dr. Harris Isbell, director of the Addiction Research Center at Lexington, Ky., and Dr. James F. Maddux, medical officer in charge of the PHS hospital, Fort Worth, Tex., supported the point that custodial treatment of addiction, whether in a hospital or in an institute of correction, tends to impose its own rules of iron necessity to keep drugs out of the hands of addicts and to limit the number of unauthorized departures. In effect, it was agreed that even if addiction is not regarded as a crime, it is difficult for an addict to avoid punishing experiences.

At the same time, punishment was conceded

to be no absolute deterrent to addiction. Many addicts consciously risk their lives every time they take heroin. They suffer more from their habit than from the most severe penalties of the law.

Much of the information about the addict population and its health and habits is necessarily speculative.

In Hong Kong, where a day's supply of high-grade heroin may cost as little as 35 cents, it has been estimated that one out of every eight adult males is an addict. Their numbers have increased substantially in recent years, it is believed, because repressive measures drove the drug traffickers out of Shanghai.

In New York, addicts are likely to be Puerto Rican or Negro; in Chicago, Negro. In California, a high proportion are Mexican, and most are addicted before they are 21. In Hong Kong, it is rare to see an addict younger than 21. Family responsibility, in the opinion of Way, accounts for the rarity of young addicts in Hong Kong.

In New York the traffic is highly organized and heroin prevails. In California the illegal traffic is divided among small entrepreneurs, and barbiturates, which sell freely at the Mexican border, are rising in favor.

A large number of addicts, despite the high price of illegal drugs, are at the lowest economic and educational level. On the other hand, addicts in the health professions, although they account for only 30 to 50 of the 3,000 to 4,000 patients admitted to Lexington each year, still represent a contradiction to the usual social background of the addict.

Some addicts are said to survive to a full term of life on a stable ration of opiates. But the addict population drops off sharply beyond the age range of 35 to 45. Among the few figures available on mortality of addicts, those analyzed by Tu for Formosa, from 1901 to 1935, showed mortality of addicts to be almost three times as high as in the general population.

The rate of relapse is high: once habituated it is highly probable that the usual addict returns to the habit. But the record of rehabilitation among addicted physicians in California is 92 percent.

The drug habit is held to be contagious. One addict entices another. But it is also self-limiting: high barriers restrict both demand and supply of narcotics, and the obvious effects of the habit limit its growth.

Peddlers are frequently users who sell narcotics in order to maintain their own habit, but Dr. Isidor Chein, New York University, observed that a peddler may refuse to sell to members of his own circle, especially those who have been addicted and are released after treatment. In Denver, the peddler is rarely a user. It is believed peddlers rarely entice a novice simply to develop a buyer for personal gain.

Most persons who receive therapeutic doses of morphine report that they associate no pleasure with their use of the drug, although they are physically dependent on it. On the other hand, addicts have imagined they were enjoying a fix when in fact they were given a placebo. In one situation, pushers adulterated the drug to the point that, without realizing it, they broke their clients of the habit; solemn reports were issued about the appearance of a new form of heroin, free of withdrawal symptoms, until the facts emerged.

Definitions of addiction differ among pharmacologists, sociologists, psychiatrists, and lawyers, noted Dr. Louis Lasagna, Johns Hopkins University School of Medicine. The term is not applied to alcohol, which may create a physical dependency, but it is applied to some nonaddictive drugs. Certain drugs are called dangerous while others, even more hazardous, are not.

Although narcotic analgesics in proper medical use pose no serious risk of addiction, their use is restricted by exaggerated fears on the part of nurses and physicians, he added. "It is poor medical practice to permit pointless suffering," he said, "when more flexible dosage regimens are both compassionate and safe."

The law, Lasagna added, introduces other contradictions, such as according d-propoxyphene nonaddictive status, although a similar drug, codeine, is treated as a narcotic. He also cited the contradictions between the attitudes toward alcohol and narcotics, toward coffee and amphetamines, and toward dihydromorphinone and heroin. (The Bureau of Narcotics, on advice of the National Research Council, ruled that addiction to d-propoxyphene is too rare to warrant control.—ED.)

Dr. Alfred R. Lindesmith, Indiana University, pointed out that addictive behavior is not the same as physical dependency. The theory that addiction is caused by a defect in personality, he said, would stand up only if it applied also to addicted dogs and monkeys.

Many users are not addicted; many addicts manifest a craving which is not a result of the drug; and there is no sound basis for assuming that every addict demands progressively larger doses, he said. Effects of a dose, he said, vary according to time, place, person, circumstances, and mode of intake. The only generality in which he placed confidence was that opiates do relieve physical symptoms of withdrawal of the drug.

The question he posed for those seeking a general social-psychological theory for addiction was, "What is the experience in which a craving for drugs is produced?"

All speakers deplored the lack of satisfactory records on addiction. The best records, police files, contain duplications, including repeaters and false names, and they list many users as addicts who may not be genuinely addicted.

Even so, more than 3,300 narcotics addicts are in Federal custody. The present cost of their maintenance in Federal institutions is more than $8 million annually. New York with an estimated 50 percent and California with an estimated 14 percent of the nation's known addicts have both introduced systems of civil commitment.

While there was little support for the view that addiction is an excuse for crime, there were strong arguments that the public and legal attitude toward addicts drives the addict into crime. In effect, if craving or physical dependence for drugs cannot be accommodated legally, the addict feels compelled to smuggle, peddle, or rob in order to satisfy his needs, unless he can break the habit.

It was also pointed out by Chein that, for many presumptive addicts, the habit provides a justification for criminal exploits, and it was argued that with access to medical treatment this excuse for crime would be removed.

In England, Wilkins pointed out, little if any crime is associated with addiction, which in that country is legally treated by physicians rather than through the police and prisons. The amount of traffic in illegal narcotics is negligible, he believes, because 90 percent of the British public regard addiction as an illness, a factor which he felt may be more significant than governmental policy.

Reporting of addicts is voluntary and treatment is available from physicians under regulations adopted in 1926.

In the United Kingdom as in the United States, it is forbidden to administer drugs to an "otherwise healthy person," but Wilkins suggested that perceptions of the "otherwise healthy person" differ from place to place. He also noted that resistance to the custom of a society is strongest among those who are denied full membership in society, a condition which is not commonplace among the relatively homogeneous population of the British Isles.

Dr. Edwin M. Schur, Tufts University, had noted at the White House Conference that key determinations on management of addiction rest with medical practitioners in the United Kingdom. He doubted that addiction can be curbed so long as a market for illegal supplies persists.

Four fallacies govern American policy regarding control of opiate addiction, asserted Chein. The assumptions he attacked were: (*a*) that the number of addicts is large enough to threaten public welfare, (*b*) that addiction is highly contagious, (*c*) that the main task is to treat addicts to stop the habit, and (*d*) that differences among addicts are not significant.

The psychic effects of drugs, he said, were unattractive to most people. Where there were many users, he found, addiction was related to a prevalence of misery. The nature of the personal and social sources of misery, he said, is a condition of which addiction is but one symptom.

The worst consequences of addiction, he added, result not from the drug but from public policy toward users.

Civil commitment, he asserted, is "simply a euphemism for locking up the addict, whether or not he can benefit from treatment. If there are suffering individuals who have a need and if there is nothing better we can do, they, too, are as morally entitled to narcotics as the terminal cancer case."

"I would hope these would be recourses of last resort," he added, "but the decision of pro-

viding a patient with drugs should be a matter of medical judgment based on diagnosis and experience with the individual in the course of rehabilitation."

The range of habits and personalities among addicts is such that he is convinced that the task of defining and treating addicts should be removed from the courts and assigned to physicians, "without hindrances, qualifications, and restrictions other than those contained in existing codes of professional ethics." Chein was joined by Dr. Alfred M. Freedman, New York Medical College, who said expediency and moral outrage have led to pursuit of unrealistic goals in treating narcotic addicts.

Most treatment programs, Freedman said, have lacked a rational philosophy of positive social value, and have been discarded often without evaluation, comparison with other programs, or establishment of baselines. The punitive attitude toward the narcotic addict, in striking contrast to the feeling about cigarettes and alcohol, he said, is probably responsible for aiming treatment at total abstinence from opiates.

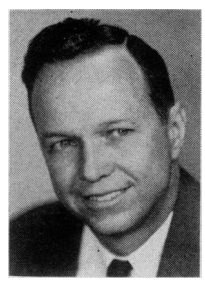
With the aim of developing their ability to play a constructive part in society as the primary goal, Freedman has undertaken to treat addicts at Metropolitan Hospital in East Harlem, a general hospital. Addicts are treated as are other patients, on a voluntary basis. After various experimental procedures, the present program entails a preadmission period, providing both psychotherapy and pharmacotherapy; a week or two in a detoxification ward, and 2 weeks in a rehabilitation ward, followed by posthospital care and referrals.

A report prepared for the White House Conference by eight scientists headed by Dr. David R. Goddard, University of Pennsylvania, stated, "Physicians trained today are largely unaware of the hazards of drug abuse and of the opportunities which do exist for treating the addict.

"Since the Harrison Act provides for the use of these drugs in legitimate medical practice, it is incumbent upon the physicians themselves to delineate what is acceptable medical practice in the handling of narcotics, particularly when dealing with a person known to the physician as an addict."

Facts about the nature of addiction, its prevalence, its victims, and its treatment are reviewed in a monograph entitled "Narcotic Drug Addiction" (PHS Publication No. 1021), prepared by the National Institute of Mental Health, Public Health Service (see Federal Publications, p. 735).—M.R.

PHS Grants Administrators



Dr. Allen

Dr. Martin M. Cummings, chief of the Office of International Research, was appointed associate director for research grants at the National Institutes of Health in May 1963. He will be responsible for development and coordination of NIH grant policies while continuing to direct the Office of International Research.

Dr. Cummings succeeds Dr. Ernest M. Allen, who was appointed to the new position of grants policy officer in the Office of the Surgeon General in January 1963. Dr. Allen is responsible for the entire Public Health Service policy on grants; administration of grants programs remains with the bureaus. The Service administers grants for training, research, health services, construction, and fellowships through the Bureau of Medical Services, the Bureau of State Services, and the National Institutes of Health. For fiscal year 1963, appropriations for these grants totaled $1,163,888,000.