A Visit to Narco

By GERTRUDE SAMUELS

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'I've Searched and Searched, and I Can't Find Anything in My Background That Made Me Go on Drugs'

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By GERTRUDE SAMUELS

LEXINGTON, Ky.

IN a small room, the shade drawn against the sunshine, a young man lies curled up fetuslike on his hospital bed. He has pulled the Army blanket close to him. Then, as the door opens, he slowly sits up. Bone thin, with prematurely graying hair and puzzled blue eyes, the patient seems eager for help and eager to please the crisp young psychiatrist who enters the room.

"Do you think you'll stay this time?"

"Yes."

"Why do you think so?"

"Well, my wife's in with me now."

"Anything else?"

The man passes his hand wearily over his face.

"Because . . . I'm losing."

"What?"

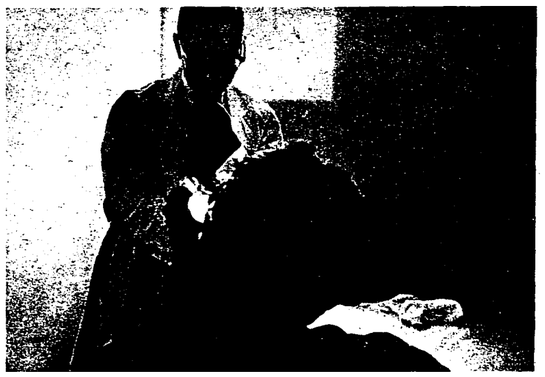
"Everything, doctor. I'm losing my respect. I'm losing my friends. I'm . . . begging from friends. I'm losing jobs. Everything."

He slumps back on the bed and pulls the blanket up close to him again.

JERRY MOORE (not his true name) was one of 873 patients—707 men and 166 women—at the United States Public Health Service hospital here. Narco, as it is known, is the national center for the treatment and rehabilitation of narcotic addicts and research on addiction. There are approximately 100,000 junkies in the nation—half of them in New York City. And since thousands of addicts have been to Narco at one time or other during their illness, this is the place where a reporter wants to come to understand addiction and what can and should be done about it.

Every day for most of the last 12 years Moore had been injecting himself with at least four "decks" of heroin and swallowing six pills of Seconal and Tuinal. Now, the doctor has started the addict's withdrawal from his physical dependence on the drugs with a sedative and small doses of methadone, a narcotic often used to flatten the peaks of pain and make withdrawal more bearable. The medication used during the abstinence syndrome—characterized by runny nose, sweating, gooseflesh, hot and cold flashes, severe cramps in the back and legs—is taken orally in liquid form since patients could palm the pills and sell them. Each day the medication will be reduced until, within seven days, the patient will be "brought off"—physically detoxified.

GERTRUDE SAMUELS is a staff writer on The Times Sunday Magazine. She took the accompanying photographs.



EXAMINATION—Just after their arrival all patients are given a physical exam. "Since the war we've gotten a much younger addict, from more deprived, congested, poverty-stricken areas."

WITHDRAWAL—An addict in the throes of "drying out." This is but the first step: "The basic problem," one doctor says, "is in changing a person and his whole personality."

Moore is a "vol"; he came here voluntarily and without court pressures. He is 32, had gone to college for a year and was an unemployed salesman from New York City. He had been to Lexington four times previously: three times he left after a week; the last time he stayed for 40 days. Now he had come with a new wife, also an addict but a "first admission."

Narco is part Federal prison, part Federal hospital. The doctors who run the institution wryly describe it as "more like a prison than a hospital and more like a hospital than a prison." The confusion over its dual character has persisted ever since the $5-million facility was opened in 1935. It was created by an act of Congress in order that prisoner-addicts could be treated in a health-type facility. Reflecting the uncertainty over whether the place should be a penitentiary or a hospital, Lexington originally was called a "Narcotic Farm." But when people began to ask where the narcotics were grown, the name was changed to Public Health Service Hospital. (Nevertheless, the old designation still appears over one gate, to the irritation of the doctors.)

The red brick and granite buildings of the institution, six miles from downtown Lexington, stand isolated on gently rolling hills, with seven miles of fence around a 1,000-acre tract. In the compound behind the main building, khaki-clad Federal guards watch the inmates' comings and goings through old-fashioned iron gates and grilles. Most gates are open since this is a minimum-security prison. The outer gates which lead beyond the compound are always locked.

Not surprisingly, the addict is mainly a custodial problem to the guards. William F. Owsley, security chief, says firmly: "No matter what you call it, this is still a prison, because there are prisoners here who are being detained against their will. Very few people are self-motivated to come for treatment, so the emphasis is on security."

At least one psychiatrist bitterly feels that the hospital "suffers from operating on several levels." Despite attempts at reorienting the guards, called "nursing assistants," he said, "it's hard to change the training of many who were only guards in the old days."

TO doctors here, the addict is primarily a psychiatric problem. Dr. Robert W. Rasor, Medical Officer-in-Charge, a psychiatrist who cares deeply about his addict-patients, says:

"An addict is an individual who loses control over the use of a drug to such an extent that he or society or both suffer. In this respect he is like other patients with mental illnesses. Drugs themselves do not make an addict any more than alcohol makes an alcoholic. It is only when a compulsive urge has developed to such an extent that all his personal resources are directed toward obtaining the drug that the state of addiction may be said to exist."

Physical withdrawal from narcotics is only the first phase of treatment procedures here. The basic problem, as one doctor put it, "is not in changing a neurosis but in changing a person and his whole personality."

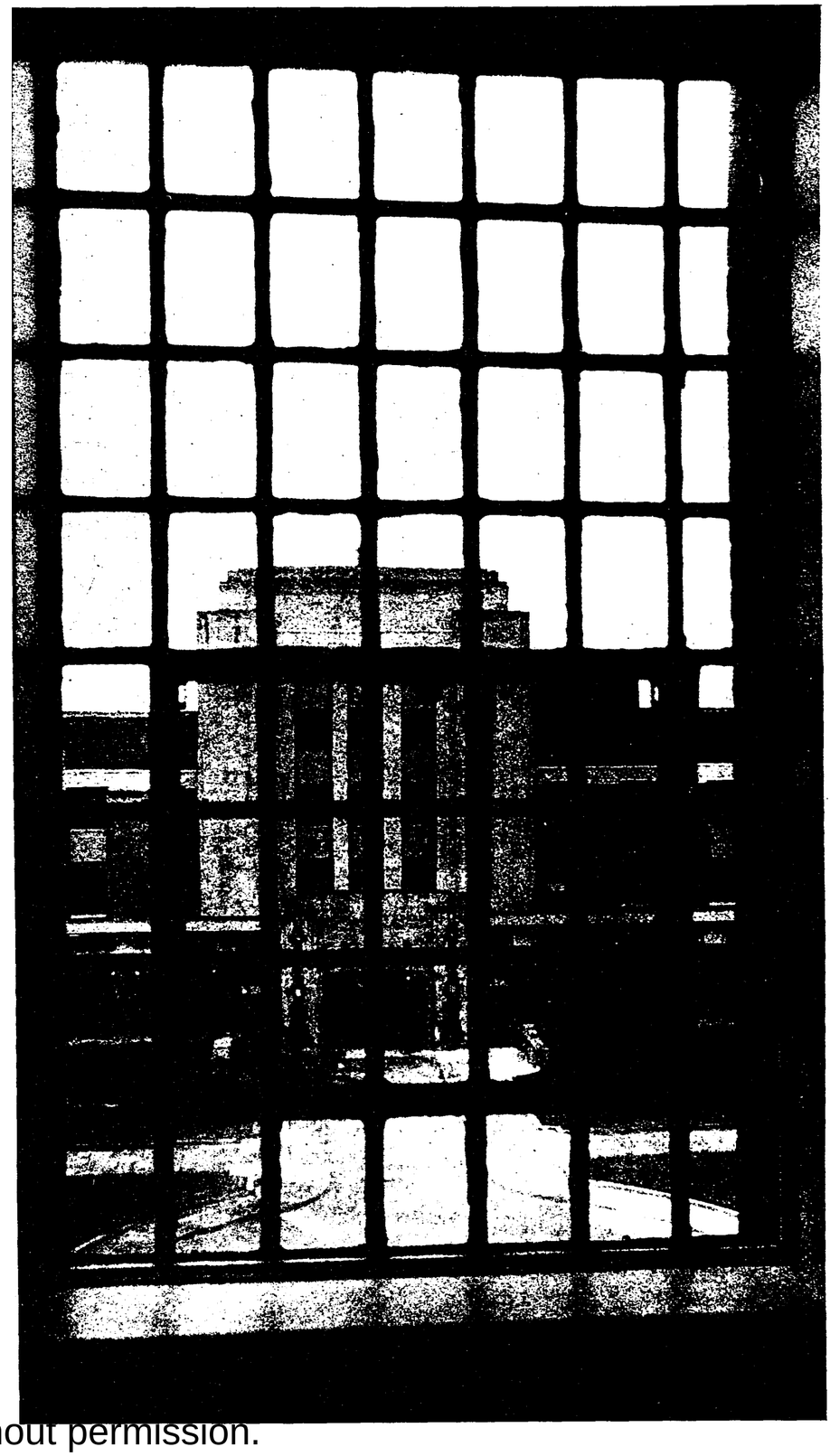
The trouble is that the overwhelming majority of patients return to the same environment they came from and soon get hooked again. "And there is no time when an addict has more friends," says Dr. L. Thomas Carroll, deputy chief of the Psychology Service, "than when he returns to the streets—clean. His former friends are ready, willing and anxious to 'turn him on.' This explains why so many who leave here relapse into addiction."

LEXINGTON receives male addicts from east of the Mississippi River and female addicts from the entire country. (Another, smaller, Federal hospital at Fort Worth, Tex., takes male addicts from west of the Mississippi.) Fully 40 per cent of the patients are from New York; Illinois ranks second, with about 15 per cent.

About half the addicts are prisoners sent to Narco by the Federal Bureau of Prisons to serve sentences of from two to 10 years. The remainder are "vols" or those in trouble with the law to whom judges have given the choice of "jail or Lexington."

The voluntary addict must apply for admission in writing. He receives application forms which ask about his personal history, employment, the drugs he uses and the amounts. Later, he is notified when a bed is available, for there is a waiting list of several weeks and addicts who have never been to Narco before get priority. They pay $11 a day, if they can afford it. Very few can and, like Moore and his wife, pay nothing.

Unlike the prisoners, vols can sign themselves out at will. More than one-third take the opportunity within a week or *(Continued on Page 35)*



NARCO—The Federal addiction treatment center at Lexington, Ky. "More like a prison than a hospital—and more like a hospital than a prison."

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two, immediately after they "dry out; more than half are gone within a month; three out of four leave within three months. They are discharged "A.M.A."—against medical advice. Some patients use Lexington merely as a convenient place to dry out because they can no longer afford to buy the increasingly large doses necessary to get a "jolt." Such addicts arrive with the intention of renewing their "habit" with smaller doses to recover the old "charge."

Over the years, Dr. Rasor reports, the type of addict at Narco has changed considerably. "Prior to World War II," he says, "we saw an older addict, more often from rural areas. He was more apt to be white, more apt to have been taking morphine or paregoric or codeine. He rarely committed a crime to get the drugs.

"Since World War II we have been getting a much younger addict from the more deprived, congested, poverty-stricken areas of our larger cities, more likely to be a member of a minority group, colored or Puerto Rican, more likely to have started using marijuana and, after a period, gone on heroin"—today's first choice among addicts.

The personality of addicts varies a great deal "from those who might be fairly close to normal to those who are psychotic," says Dr. Rasor. "The patients we see are trying to solve personal problems of living through the use of some drug that changes their psychological state or outlook on life. In general, they fail.

"You have to accept the fact that addiction is a chronic, recurring type of illness," he adds. "But just because an addict relapses once, twice or three times, it doesn't follow that he's doomed to be on drugs for the rest of his life. There is a significant number who get off and stay off. The fact that they, too, exist is important."

TYPICALLY, the addict arrives by bus or cab at Gatehouse No. 1, a small building at the entrance occupied by a 24-hour guard. The guard makes a cursory search for drugs or weapons. Most vols know better than to arrive with either since if they are caught they are guilty of taking in contraband, a Federal offense. (One woman came as a vol and ended up a prisoner with a two year sentence; she had smuggled in barbiturates to tide her over the pains of withdrawal.)

A Government car then drives the patient to the Admissions Unit in the inner compound, where he strips and everything he wears is thoroughly searched. Even shoes are dismantled on a shoemaker's last, since drugs have been, at times, secreted inside the heels. The addict is also photographed, a confidential but vital part of the procedure because some try to come back with "first admission" priority under assumed names. He undergoes physical and laboratory tests. A fairly large number of new arrivals have infections, usually from contaminated needles. These routine checks take about an hour.

In his maroon corduroy hospital robe, the addict now goes immediately to the Withdrawal Unit. If he has been taking an opiate he requires four to 12 days, depending on the depth of addiction. If he is hooked on a barbiturate-sedative, withdrawal takes about two weeks. This process is far more painful than withdrawal from heroin, often accompanied by hallucinations resembling the alcoholic's D.T.'s.

The second phase of treatment lasts three or four weeks. A team of psychiatrists, social workers, vocational and correctional experts try to analyze the patient's psychic disorder and his willingness to accept treatment. The course of therapy is charted as well as the job or vocational training he will attempt at Narco. Every able-bodied patient must work. The hospital runs several farms and such shops as printing, bookbinding, microfilming and needlework.

Finally, after a brief stay in a "continued treatment" ward the patient is moved into "pop" (meaning general population) for what doctors hope will be a minimum period of five or six months.

It is a shock for some patients to move from the conventional hospital setting into prison-like pop. One men's cell block, called a "ward," consists of small single rooms with iron bunks, barred windows and doors. The walls are bare except for pin-ups and holy pictures. There is also the "hole"—isolation—the traditional cell block for disciplinary cases.

The Women's Unit, segregated from the men's, is rather more decorative, with handmade curtains and flowered bedspreads, paintings, ceramic work and stuffed dolls. On a record changer in one room Sammy Davis was singing "What Kind of Fool Am I?" A purple Bible-marker on a wall recommended: "When In Sorrow, Read John 14; When Men Fail You, Read Psalm 27." Facilities included a large day room for relaxation and games, and a visitor's room where married couples and close relatives meet once a week for an hour.

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Patients rise at 6 A.M., shower and clean their rooms. Kitchen and dairy workers have early chow; the others breakfast at 7:15 in various mess halls. Work begins at 7:55 and everyone is expected to put in 30 hours a week. If a male patient refuses to work, he can be sent to the hole; women ordered into isolation go to a "bing," a locked room. Quitting time is 5:15 P.M.; recreation and sports go on until 9. Lights out is at 10.

Patients have commissary books and may spend up to $15 a week for cigarettes, candy, shaving and cosmetic items. Every day a guard searches each room, examining even mattresses and pillows. Patients expect the "shakedown" and resent it: "Aw, here come the hacks. . . . Don't put your hands on me!" Guards recently retrieved a kitchen knife filed down to a deadly point, and several clubs made from mop handles. Addicts also try to steal certain condiments, finding they can get a mild "high" by drinking them in warm water.

IN her definitive book, "The Drug Addict as a Patient," Dr. Marie Nyswander, a one-time Lexington doctor now at the Rockefeller University (formerly Institute) in New York, wrote: "In the long run, as with alcoholism, the patient's inner decision to stay off drugs determines the cure."

Every human contact and every job at Narco is said to be part of therapy. Basic treatment, however, consists of a battery of formal techniques.

Until about 10 years ago, doctors emphasized individual psychotherapy, given one hour a week. But even an hour a week was too big a load for the staff and the emphasis has shifted to group therapy with eight or 10 patients. A growing number of studies showed that a fellow-addict, rather than the "square" therapist (often a hostile figure in the mind of an addict), could make quicker headway in helping a patient understand his personality disorder. Group therapy also encouraged introverted, silent addicts to speak up and thus be drawn into treatment, even though they might not want to participate at first.

Additionally, the clinical staff began to focus on a so-called mental health approach with larger groups of patients —25 or 30. This technique uses films and literature discussed by a staff member who employs an active, didactic approach, in contrast to the traditionally passive role of the psychotherapist.

Unfortunately, only one-fourth of the patients get any formal therapy, "partly because the staff is too small," reports the United States Department of Health, Education and Welfare, "and partly because many patients resist [therapy] or are judged incapable of being benefitted by it." In one recent month, only 284 patients out of nearly 900 were in therapy.

IN a typical group therapy session one afternoon, three male and five female patients, colored and white, from New York, Chicago and Detroit, sat informally with two social workers. The girls looked attractive in well-ironed blouses, trim skirts and costume jewelry; the men wore neat sports clothes. The social workers encouraged the group to do most of the speaking and probing. One or two patients were aggressive talkers, curiously lacing their argot with social work terms; others sat smoking and silent.

A large colored girl started off the session. "I find that when we get close to our own problems we back up," she blurted. "This is my reason for being in therapy, to find why. When my mother writes about her arthritis pain, this bugs me. I can't feel sorry. My own real-life flesh-and-blood, and I can't get the sadness in me that I get from a phony movie. I wonder what's wrong with me."

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66Lexington's population is made up about equally of prisoners, serving from 2 to 10 years, and 'vols'—voluntary patients . . . . Vols can sign themselves out at will. More than a third take the opportunity within a week or two, after they 'dry out,' and three out of four leave within three months 'A.M.A.'—against medical advice.99

GROUP THERAPY—Though an effective form of treatment at Narco, it reaches less than a fourth of the patients. When one complained, "It's like blind people helping the blind," a staff member replied, "No, you give to each other."

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This struck a chord in a quiet blonde: "I laughed when my mother died." The room became tense and silent. "Everyone stood around waiting for me to cry, and I couldn't feel a thing."

"What do you feel you can give her about her feelings toward her mother?" a social worker asked a pretty redhead who has sat silent in this group for weeks.

"I don't like . . . hurting people."

"Even if it hurts, don't hold back," the big colored girl said.

"No, I still haven't learned this."

"Does it mean," the social worker persisted, "that because someone says she hates her mother that she doesn't love her mother?"

"Don't hold back," the colored girl said. "You wouldn't hurt me."

At last the redhead leaned forward, her voice breaking. "I've been angry with my mother, but I've never hated her." Then she added: "I've searched and searched, and I can't find anything in my background that made me go on drugs."

For the next hour several members of the group struggled to uncover their feelings toward parents, each other, the Parole Board. "It's like blind people helping the blind," someone in the room mocked. "No," the social worker said firmly, "you give to each other."

ONE therapeutic tool, which some staff members consider naive, is "blue mail" or "cup cakes"—uncensored letters exchanged between males and females. The letters, intended as substitutes for personal relationships, are supposed to be friendship notes. In fact, many cup cakes are far from innocent.

Through the prison grapevine the men know all about the women who enter Lexington, particularly those who have been "in the life"—prostitutes. The "players," or pimps, continue an adaptation of the outside relationship inside the hospital, using the letters to "hit" the women for commissary goods and money.

And yet the blue mail helps answer a need. The addict's emotional demands are greater than ever once the drug is taken away. There is, doctors say, a terrible void, and a desperate desire to fill it with love or some other gratification. Women try to fill the void by catering to the men's requests in the letters. Men find satisfaction in getting their requests fulfilled.

THOUGH Narco's main efforts are aimed at treating addiction, the job of preventing addiction goes on here, too. "One aspect of prevention is education of the public through information," says Dr. William Martin, 44, director of the Addiction Research Center, an arm of the National Institute of Mental Health. "The other is to understand the nature, the pathology of the addiction process and what causes it—just as it is to learn that streptococcus causes scarlet fever. Whether we will stumble on anything like penicillin, which cured scarlet fever, is unlikely. But we have to keep trying, at least, to understand the nature of this illness."

Dr. Martin heads a staff of 58 sociologists, psychologists, chemists, pharmacologists and neurologists who occupy a network of laboratories in the basement of the prison-hospital. There, selected patients work side by side with white-coated technicians on test tube experiments to develop new synthetic pain-relieving drugs. Others care for animals used in drug tests.

In its stubborn search for the underlying mechanism responsible for an addict's enslavement to a drug, the Center now believes that it has obtained supporting evidence, in animals, of a major medical concept: In their tests on rats and dogs, the doctors noticed that the abstinence syndrome —eyes watering, nose running, cramps and nausea—persisted for from three to six months. The findings thus run contrary to the popular notion that all one needs to do is detoxify an addict for a few days, then begin treatment to rehabilitate him.

Doctors in the Center also have a theory that abstinence may be "conditioned" in the Pavlovian sense of the word. That is, a person can begin to associate certain stimuli (it could be the old street, or seeing the old "connection") with symptoms of abstinence which create the craving for drugs; the stimuli *by themselves* evoke drug-seeking behavior and relapse. In short, drug addiction is like many diseases: it depends on individual susceptibility.

"This sort of condition may be extinguished," says Dr. Martin, "if we can prevent this 'conditioned stimulus and response' from being reinforced [by taking a fix]. It is possible we can do this by blocking the effects of heroin with so-called 'narcotic antagonists'—that is, non-narcotic drugs."

His staff is now experiment-

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Probably Lexington's greatest weakness is the lack of an after-care program

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ing with certain of these antagonists—Nalline and Cyclazocine—on animals and certain patients who have volunteered for the studies. The hope is that the new nonnarcotic drugs will block the effects of heroin and morphinelike drugs by eliminating the "kick" that draws addicts back for more.

A third drug, methadone, is being used in a pilot project in New York. Some patients previously addicted to heroin are taking daily, oral doses of methadone while they live and work normally. Drs. Vincent P. Dole and Marie Nyswander, who are conducting this clinical trial, report that the medication appears to have two useful effects: "(1) relief of narcotic hunger, and (2) induction of sufficient tolerance to block the euphoric effect of an average illegal dose [of heroin]."

Scientists at Lexington believe that the role of methadone in the treatment of addicts is still in the investigation stage, however. "The difference between the antagonist drugs we are using and methadone," says Dr. Martin, "is that methadone produces a morphine-like dependence while Cyclazocine does not." Dr. Warren Jurgensen, the dynamic deputy medical chief at Lexington underlines the distinction.

"At one time," he says, "morphine was used as a 'cure' for opium addiction. Then heroin became the 'cure' for morphine addiction [before it was realized that heroin was addictive]. Now methadone is being hailed as the cure for heroin.

"Methadone is definitely addictive. It may prove to have some treatment value, but we get many methadone addicts here and it takes longer to withdraw them because the action lasts longer than heroin."

PROBABLY the greatest weakness in the Lexington program—one that is freely admitted on all sides here—is the lack of an after-care program.

Despite the great body of knowledge amassed at Lexington in its work with addicts, the institution has never been able to offer its patients the supervision that is crucial to their permanent cure once they go out the door. Opinion is divided here over whether Lexington should have a field staff to supervise discharged addicts. But many would agree with the recent report of the New York State Division of Parole that "drug addiction is a phenomenon of community living; it must be fought there, not in an institutional setting, where the drug addict generally poses no problem."

The best information on what happens to Narco patients is a study of 1,912 New York City residents discharged between 1952 and 1955. More than 90 per cent were readdicted within a year. When 453 of these were evaluated for five years, the relapse rate was still 75 per cent.

Bill Turner, who went to Lexington twice as a voluntary patient, told me: "As soon as I signed out, I found that my way of thinking got me right back to using drugs again. The day I came out I jumped off the train at all the stops and bought enough 'cough syrup' [paregoric] to help me until I got back to New York. In Manhattan, I went to my old stamping ground at 28th Street and met someone who had some Dilaudid [a morphine derivative] until I could get the heroin."

The high rate of relapse has led many medical experts and social scientists to ponder the worth of Lexington's methods. Lexington's own staff ponders the question, too.

Dr. Jurgensen says frankly: "Many people feel that since there are so many addicts today, and certainly so many in New York, that somehow we have failed, and that there is no answer to the addiction problem. My answer is simply that there are many partial answers—and we are one of them."

Another partial answer, he said, is Synanon, and its self-help, drug-free houses on the West Coast. But while Synanon is "wonderful" for the addicts it helps—some 600 today—it is "irrelevant for the others who don't go into Synanon—and they are the great majority."

"If you ask, do we cure ev-

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OCCUPATIONAL THERAPY—Every able-bodied patient must put in a 6-hour day at a job. The hospital runs several farms, a printing and microfilming section (above), and bookbinding and needlework shops.

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eryone we see, then the answer is no," says Dr. John Curtis, 31-year-old psychiatrist and chief of the Men's Addiction Service. "We're not successful, and I don't know of any method that is. If you mean, are we effective, I think we are for the type of patient who is motivated and will work at what he's offered in terms of therapy."

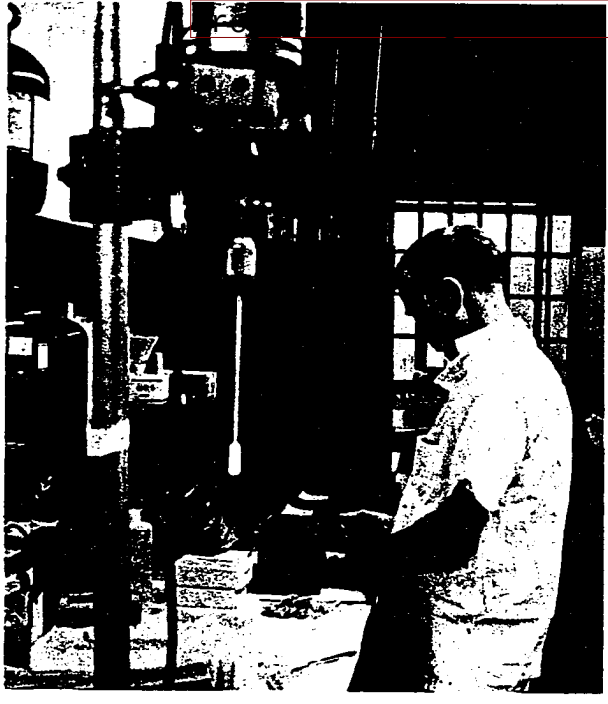
Often and emphatically, doctors here return to the point that every addict needs supervision after hospitalization. "It is essential that all patients be followed for a definite period of time," says Dr. Rasor.

PASSAGE by the New York State Legislature of controversial new legislation initiated by Governor Rockefeller also reflects the deep worry over the addict.

"This is war," the Governor said in a special message on crime and narcotics addiction to the Legislature, "and every addict should be enlisted in the battle with himself and the drug that imprisons him."

The Rockefeller approach covered four key points: (1) compulsory treatment and after-care for addicts, including the commitment of addicts (not to exceed three years) who are not involved in any crime; (2) stiffer sentences for pushers; (3) creation of a five-member Narcotic Addiction Control Commission; (4) creation of a broad network of rehabilitation centers to be located outside large cities to maintain a drug-free environment.

The legislation has been bitterly attacked as a regressive step, not a cure, by some state legislators, as well as Frank O'Connor, president of the New York City Council. They called the Governor's bill a "hoax," and a plan to "establish a leprosy colony [instead of recognizing] that addicts are afflicted with an incurable disease." The American Civil Liberties Union questioned the constitutionality of the bill, charging that its "commitment" provisos more resembled "imprisonment." "The Supreme Court has ruled that an addict cannot be called a criminal just for addiction," said the A.C.L.U.



RESEARCH—At Narco's Addiction Research Center much new information about drugs is being learned. "It's unlikely we'll stumble on any cures," says the center's director. "But we have to keep trying, at least, to understand the nature of this illness."

Dr. Rasor at Lexington said, "In general I would support this legislation. I would feel that addicts should have the opportunity for voluntary treatment, but if this fails and fails repeatedly, then they should be committed to a rehabilitation center where they should remain until the staff felt they were ready for discharge.

"This should not be a criminal procedure, but a civil type of commitment that would also enable us to assist addicts after they leave the hospital with after-care."

Dr. Jurgensen adds: "A good civil commitment program should not be a substitute for imprisonment. Our goal is to treat the patients and get them out of hospitals or treatment centers, rather than keep them in. After-care is crucial. After all," he argues, "the person with tuberculosis isn't forgotten after he leaves the hospital. He needs supervision to make sure his illness is under control. He has home visits; his medication is checked; he has periodic X-rays. Why should it be different for the addict?"

BEFORE I left Lexington, I checked the progress of Jerry Moore, the patient I saw in the early stages of withdrawal, and his wife. The doctor reported they had told him earnestly all week that they would never return to New York, but planned to go to Texas "to start a new life."

On the eighth day of treatment the wife had said frankly, "I feel like having a fix." Moore said he wanted to stay off drugs, but he did not want his wife to go out alone. He added, only half-joking, "But if I do take another shot again, I hope it's a good one."

They signed out A.M.A. They had lasted nine days.