REHABILITATING THE NARCOTIC ADDICT

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THE MENTAL HEALTH PROGRAM OF THE COMMONWEALTH OF PUERTO RICO

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It has been said that there is no cure for drug addiction and until recently statistics seemed to confirm this. The usual relapse rate among addicts treated at such centers as the Federal Hospital in Lexington, Kentucky and Fort Worth, Texas has been about 92 per cent. Even the most advanced experimental centers in the United States average a relapse rate of 70 to 75 per cent. However, at the Addiction Research Center in Rio Piedras, Puerto Rico the relapse rate is 5.6 per cent, which is remarkably low. During the past three and a half years 124 heroin addicts completed treatment at the Center, with only seven becoming readdicted. Because of the effectiveness of the Puerto Rican program, New York City is about to launch a similar one, which because of its range may set the pattern for fighting drug addiction in all the large cities of the world that face this problem.

The extraordinary results in Puerto Rico can be explained by the unique approach of the program. A truly comprehensive approach to drug addiction must revolve around the fact that the overwhelming majority of grug addicts (96 per cent of Puerto Rico's 1,800 patient series) are not psychotic, and that they are legally and psychiatrically responsible for their behavior. Yet, they have adopted a system of values and an outlook on life that make their behavior contrary to what most citizens consider normal. For this reason, we classify most addicts as "sociopathic," that is, as people whose distorted personalities have oriented them away from the attitudes and activities pursued by the normal productive citizen. There are at least 10,000 addicts in Puerto Rico, and probably 100,000 in Greater New York.

The objective of any rehabilitation program is to help these persons reorient their motivations, their energies and their values to become better attuned to the prevailing social trends. This does not merely mean to adjust or to go along with the crowd. It means a personality reorientation that makes the individual capable of functioning as a productive, nonparasitic member of society. This process occurs normally in most people, but in drug addicts and other psychopathic personalities this capacity has not developed to a sufficient degree. To achieve rehabilitation this process has to be recreated in a reasonably short time within an easily controlled environment. This basic requirement for the successful treatment and rehabilitation of addicts has been recognized by the Addiction Research Center (ARC) since the program began in 1961 and is the basis of its internal structure.

At the Center, treatment and rehabilitation are divided into three phases, which correspond to natural phases of the reorientation process. These three phases are: induction, intensive treatment and re-entry. Induction is actually a training process by which the street addict is taught to become a patient. Intensive treatment is a personality reconstruction process. Re-entry is a resocialization training process. (Diagram 1)

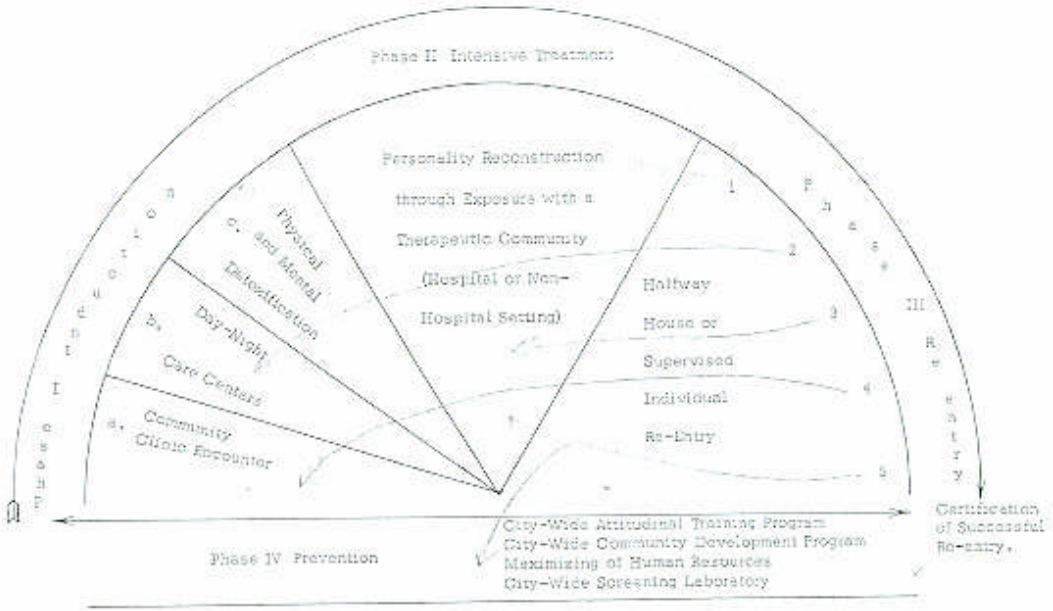

Diagram 1. The Three Phases of Treatment and Rehabilitation at the Addiction Research Center in Puerto Rico, and the Fourth Phase, Prevention.

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The induction phase is further divided into three parts. The first is a "community encounter situation"' the second is a day-night care period and the third is physical and mental detoxification in a special hospital ward.

In the community encounter the addict meets an ex-addict from the same neighborhood, who has gone through the entire process of rehabilitation and has returned, as part of the re-entry what treatment can do for willing patients. This meeting may occur on the street, in the church club, in a store front clinica or in an apartment in a housing project.

The encounter is a challenging and stimulating experience for the street addict, who is usually not too optimistic about his chances of kicking the habit. Realizing that treatment has benefited his ex-addict friend, the addict begins to wonder, "If he did it, why can't I?"

At this level the addict learns the basic philosophy of the ARC program. He is told that an addict is considered as a person capable of responsibility, if he really wants to assume it. The program will not do anything for him; the program will not do anything against him; the program will only do things with him.

Most addicts wish to kick the habit permanently and become productive citizens. The addicts is first asked to cut down voluntarily on his intake of heroin as proof of his interest. This is actually easier to achieve than it sounds. In our experience, covering almost five years, we have found that if the addict is challenged enough, the compulsion to take heroin becomes less marked.

When the addict is thus challenged and responds to the challenge, he begins to get involved in the idea of personal rehabilitation. At this point he is taken by the ex-addict neighborhood friend to a day-night care center run by a medical doctor with a mixed staff of professionals and ex-addicts. This is step two of the induction phase.

The addict who comes to the Day-Night Care Center of the atree finds himself in a "part-time hospital". When he arrives in the morning he is placed in a regular hospital ward, where he stays until 3:30 in the afternoon. During that time he is "a part-time patient". An important aspect of the process is to get involved in the treatment and get accustomed to the routine of hospital life.

As the addict spends most of his time at the day care center, his delinquent activities are curtailed and he has a much better chance of reducing his drug intake. Our experience has shown that at this stage most patients kick the habit without actually being hospitalized. During the three month period from January to April, 1966, of 32 addicts admitted to the detoxification

ward from the Day-Night Care Center, 30 were clean. This is a good measure of the depth of involvement and motivation that patients have developed toward treatment at the end of the Day-Night Care experience.

They may, however, drop out during the early part of this stage and return at the community level (the previous induction stage). We do not lose these patients, for they keep trying to come back into the program. As long as they do, we are convinced that the social and economic impact of their addiction has been reduced.

Most patients who go throught the Day-Night Care Center are candidates for the detoxification ward, the third stage of the induction phase. This ward is at the Addiction Research Center hospital. Here, the addict can stop using drugs in only a few days, suffering in the process only slight diuscomfort. Even this can be relieved with intravenous fluids and tranquilizers, such as thorazine and Librium, and without resorting to opiates. It seems to us that the use of methadone and other narcotic substitutes in some programs reveals the lack of involvement by the patient in the treatment process.

Following detoxification the patient rapidly becomes a physically fit individual. His appetite returns and he may gain 15 or 20 pounds in two or three weeks. He may find sleep difficult but that is easily overcome with non-narcotic hypnotics, such as nodular.

After the patient is physically detoxified, he remains in the ward for a period of eight to ten weeks for "mental detoxification" (clearing the mind of thoughts of drugs), a preparatory step to formal psychiatric treatment.

The detoxification ward is run by a medical doctor, a psychiatric social worker and a psychiatric nurse. The staff includes psychologists, auxiliary nurses, occupational therapists and ex-addicts who work in the ward as part of their own process of re-entry.

Frequent discussion sessions are held to help the addict realize that this use of drugs was just an excuse for not facing his own problems, his personality limitations and his difficulties in coping with everyday reality.

The "mental detoxification" period tests the addict's under-standing of his limitations without submitting him to actual psychiatric treatment, which is neither necessary nor effective at this stage. He can achieve this new insight, and this new confrontation with himself and his problems with the help of the ex-addict clinical aides, who comprise the nonprofessional part of the staff.

When the patient is sufficiently involved in his own long-term treatment, he is transferred to the second phase of the program, i.e., an intensive psychiatric therapeutic environment.

At this point, I would like to interject a discussion of our treatment of addicts who have been jailed. It has always been a problem to determine just what should be done with these individuals. Of course, merely incarcerating them is not going to cure them. In our experience addicts who are unwilling to accept treatment voluntarily will become involved in treatment, even if they are in prison, if the proper induction treatment is carried out within the prison walls. In Puerto Rico, this has solved the problem of how to deal with the nonvoluntary patient. By reproducing within the prison the psychiatric and psychosocial aspects of induction, we are able to convince convicted addicts to become psychiatric patients.

After working on this program for three and a half years, we have transferred, with the approval of the Department of Justice, 50 addict inmates to the hospital for intensive psychiatric treatment after the process of induction was completed within the prison. Of these 50 from the Penitentiary, the Vega Baja Women's Prison and the Miramar Juvenile Jail, only three were sent back to prison because the challenge of being patients in a hospital was even tougher than

staying in jail. All the others made a smooth transition from prison to hospital, much to their benefit.

The intensive psychiatric treatment is carried out in a 40-bed ward headed, by a trained psychiatrist who is backed by a team of professionals and nonprofessionals, including a medical doctor, psychiatric nurses, nurse aides, psychiatric social workers, psychologists, occupational therapists, a vocational counselor and such volunteers as Red Cross workers, religious leaders, teachers and, most important, ex-addicts in training to become community orienters. The end result of the interaction of these workers and the patients is called Therapeutic Community. The patients benefit from their encounter with the collective efforts of professionals and nonprofessionals, and the encounters among the patients, themselves. This brings about a continuous revision, re-examination and identification of the patients and the staffs proficiencies. All this interaction creates a stimulating climate for progress.

The psychiatric treatment is conducted in groups. Individual interviews are given only for evaluation or when some special circumstance precludes the use of the group approach. Throughout the years we have found that in this type of therapeutic community the patient undergoes definite changes in his personality. He becomes more concerned about his family and about his own responsibility and he is bothered by true guilt and anxiety. This tortions that characterize the addict before he undergoes intensive treatment. At this stage the distorted outlook that turned the addict away from general society has become mostly reoriented toward the prevailing values of that system.

The treatment is now defined as complete, but this does not mean that the addict is ready for successful integration into society. The transition from the hospital subculture to the general society is a difficult step. Therefore, we have developed a re-entry, or third phase in our treatment and rehabilitation program.

The re-entry phase is a period, possibly a year or a year and a half, during which the ex-patient is supervised in his attempt to return to society as a productive, nonparasitic, nonpsychopathic individual. Re-entry is a flexible process, supervised in his attempt to return to society as a productive , nonparasitic, nonpsychopathic individual. Re-entry is a flexible process, supervised by an 11 member rehabilitation board, which is composed of second-echelon professionals (nurse, social workers, psychologists, chemists, etc.). The board's diverse make-up guarantees that the candidate's evaluation will not be based on the opinion of one person or one discipline, which could possibly be biased. The rehabilitation board also presents a challenge to the re-entry candidates. Allamount of red tape is built into th eprocess to condition the candidates to some of the realities that exist in the outside world. Of the 124 re-entry candidates, we have had 18 women, 27 juvenile males and 79 adult males. The group includes those who came in voluntarily and those from prisons through the institutional induction program.

Re-entry may be accomplished in one of two ways, either as an individual non-resident in a community for people capable of attempting re-entry on their own, or by institutionalized re-entry. The latter is carried out at the Center's Halfway House, which is 60-bed dormitory for men and women and provides a supervised residency stay.

At Halfway House the re-entry process is divided into five leves, which are levels of progress within the program. There are usually approximately ten individuals in a level at a time, except for the first level which may have as many as 20.

At Halfway House the re-entry candidates have their own internal government, called the Democratic Progress Committee. This is a representative body that takes care of most of the inner discipline and operational matters of the group.

The candidates in Level I work six hours a day, seven days a week in around-the-clock, 4-hours shifts, as clinical aides in the detoxification ward. This is a healthy confrontation for detoxification patients because 24-hour a day contact with Level I candidates gives the patient a change to see the results of intensive treatment in another addict. To the Level I candidate, this experience is a test of his own treatment achievement.

Level I candidates after a satisfactory performance reach Level II after approximately ten weeks. Level II offers more privileges at Halfway House, and at the same time, more responsibility. The candidate must spend seven hours a day as a clinical assistant to the staff of the Day-Night care Center. He must confront himself, his treatment and his progress with patients under going the second stage of induction. This confrontation befits both.

When the candidate"s merits and efficiency warrant it, he is promoted to Level III, where he works as a therapeutic aide to the psychiatrist in the Intensive Psychiatric Therapeutic Community. The candidate becomes participant-observer in a thriceweekly intensive psychiatry group session. After the psychiatrist leaves, the candidate continues to work with the same group from 3 to 11 p.m. This not only extends the psychiatrist's work bbut also provides a therapeutic environment throughout most of the patient's waking hours.

Level III candidates are also very active in training community groups who come to the clinic and in presenting the Center's program through lectures, panels, etc. If proficiency and merit are high, he is promoted to Level IV.

Level IV is an apprenticeship during which the re-entry candidate is assigned to one of the Center's community clinics to work as assistant to the Community Orienter. He also is trained to work with groups and to interview. At this level, candidates have the opportunity to see again, deep within the addict subculture, the raw addict of the streets. This is again a mutually beneficial confrontation. After a period of about ten weeks in Level IV, the candidate is ready for promotion to the last level.

Level V, the highest, is the re-entry process, and is characterized by maximum privileges at Halfway House. Candidates have open passes after working hours. They can work as hospital assistants or as Community Orienters and in fact are the ones who carry most of the burden of community orientation activities outside the hospital.

At the moment of their promotion to Level V, a final evaluation of their re-entry process is undertaken by the ARC Rehabilitation Board. The five-pronged study by the Board includes psychiatric, psychological, social, vocational and moral and ethical evaluation. If the evaluation is satisfactory, the candidate has completed re-entry and is awarded a Certificate of Rehabilitation.

The Certificate of Rehabilitation is a unique feature of the Program, and resulted from a series of meetings between program officials and representatives of Puerto Rico's Office of Personnel. It was decided that since Puerto Rico had developed and paid for a rehabilitation program, it should also provide work for rehabilitated addicts. The certificates were adopted as a means of showing that the former addict's re-entry had been satisfactory, thus making him an acceptable candidate for job placement.

Of the 124 people who have finished their treatment and are in the process of re-entry, 11 have been awarded rehabilitation certificates. The way the program is now designed, it can graduate 50 or 60 addicts a year for re-entry from each basic treatment unit, one and a half to two years after the induction process was started.

A Basic Treatment Unit (BTU) has been developed in the last four and a half years. It has ten community clinics, the Day-Night Care Center, the Detoxification Ward, the Intensive

Psychiatric Therapeutic Community and Halfway House. It also sends visiting teams to provide induction within prisons.

These units can be readily multiplied, increasing the number of people who can be treated. At the present time in Puerto Rico, one BTU can engage a total of about 700 addicts in all the phases of the rehabilitation process at a single time for a total cost of about $6000, 000 a yaer (less than $1,000 per addict per year).

From a theoretical point of view we have enough evidence to postulate that the confrontation approach is the most effective method in dealing with the addict. If we consciously avoid the tendency to do things for the addict, i.e. help him in the conventional way, we can be much more effective in mobilizing his resources as an individual who can participate in his own rehabilitation.

Rehabilitation to us means the process by which an individual goes through an intensified but effective growth and maturation that will enable him to cope with the difficulties, limitations and adversities of reality. Our program does not intend to make the world easier for the addict. That is not our responsibility but the responsibility of society in general. Our program is designed to help the addict to be more effective in dealing with that reality, however contrary, conflicting, limiting or absurd it may be. This approach to the problem of drug addiction is somewhat similar to the existential approach to psychology. We believe that our program is an example of a new kind of application of this existential approach to the field of mental illness.

Our experience during the past four and a half years has led us to the conclusion that this approach is the most effective one in dealing with psychopathic personality disturbances in general, not only addiction problems, but some forms of alcoholism, homosexuality, professional gambling, prostitution, etc. This opens wide vistas for the future development of this approach. In Puerto Rico we have had the good fortune to have been able to develop, within a relatively short period and with few pbstacles, a qualitatively comprehensive program to deal with treatment and rehabilitation.

Prevention is a function of the ex-addict himself, most of it at least. The best preventioin possible in this kind of problem is the image, and the participation of the rehabilitated addict in the general structure of our society. Social re-entry of the core of ex-addicts unleashes a tremendously effective preventive force. These are people who can go into the community, to schools, to families, to institutions, into the professions, even into government with a personal experience of the nature of addiction and the nature of the rehabilitation process and work with general society to improve the understanding of society toward addiction. By so doing, they improve and increase the immunity of society toward the addictive diseases. Education cannot be expected to be completely effective unless the addict population itself is involved in this more effective process of social prevention.

A serious challenge to the system described is its application to a metropolis like New York, with an estimated addicted population of 100,000. The task is to develop a similar comprenhensive system in New York. In a city like New York the development of such system depends in great measure on the success with which existing groups, programs and institutions can be ideologically linked, primarily through a city-wide training program and also on the success with which existing gaps in the rehabilitation process can be filled by experimental programs and the incorporation of new talent and resources into the over-all picture.

The problem of which method is better in dealing with drug addiction has been frequently debated in public. Several methods are described: voluntary, clinic, methadone maintenance, the British system, religious conversion, sheltered communities, workshops, halfway houses and a

very impressive array of different techniques and approaches. One of the most relevant things we have found in Puerto Rico is that these methods are pieces of a total approach. They are not comprehensive, universally applicable methods by themselves, but are services which are relevant to different addicts at different stages of progress. We have to recognize that the addict population is a heterogeneous community. The addict subculture is composed of people who have every different qualities, attitudes and motivations. Some of them are moved toward the voluntary effort of achieving success through their own personal strength. Some of them are moved toward the mystic or religious kind of way out of the addict subculture. Some of them are chronic repeated failures and come to the conclusion that the only way they can get out of heroin addiction is by being maintained with a narcotic substitute. Some of them are only motivated by legal and penal pressures. These four different kinds of motivations, recognized by workers in the field, have led to the development of at least four kinds of programs to help the addict. The voluntary treatment programs are more geared to the kind of addict who will become apparently motivated by support and close counseling. The civil commitment programs, the compulsory rehabilitation processes, the parole systems or the surveillance systems are geared to those addicts who are moved more effectively by legal pressure. Systems like Synanon, Daytop Village and some of the religious orders are geared more toward the addict who tends to withdraw from the addict subculture into another subculture which is also withdrawn but is drug free. The repeated-failure addict embraces the opportunity to continue his life dependent upon a maintenance drug. This does not mean that there are four or five or six different kinds of effective treatment. It only means that the addict will move in four or five different kinds of ways at different stages of progress. Our responsibility is to recognize this phenomenon and then to provide approach which will encompass, in a rational order geared to the known stages of growth and maturity, all the possible options for productive involvement in treatment and rehabilitation. The system developed in Puerto Rico achieves this objective.

If this concept were understood, many conflicting statements and conflicting opinions, currently expressed by responsible professionals, could be avoived. Confusion in the minds of society and in the minds of the addicts themselves could be avoided. One of the most important obstacles to the rehabilitation of a drug addict is the confusing array of options and programs with which he is confronted. This variety, which unfortunately has been called healthy among professional groups, tempts the addict to use one of his foremost anomalies, his tendency to shop around and not to commit himself. Proponents of variety in the field of drug addiction should be asked whether increasing the alternatives for treatment for addicts in an uncoordinated way is healthy for the addicts or for them.