## Appendix A

## Some Basic Problems in Drug Addiction and Suggestions for Research*

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## IX. METHODS OF TREATMENT OF DRUG ADDICTION

1. The Doctor and the Drug Addict In Western Europe, and in England, the treatment of drug addiction and drug addicts is primarily a matter for the physician. (See Appendix B, appended hereto.) Physicians may prescribe drugs to addicts either in the attempt to cure them of their addiction or to keep them in a state of comfort so that they can function without fear of the dreaded withdrawal symptoms. In this country, on the other hand, the physician has largely been deprived of an appropriate role in the treatment of drug addicts. There are many who believe that the physician must be substituted for the jailer in dealing with drug addicts, before fundamental progress can be made in controlling addiction.

This requires a review of the development of the laws in this country which has to a considerable degree resulted in the exclusion of doctors from the field of drug addiction.

Prior to 1915 physicians were permitted to treat addicts as they saw fit, and opiates were available to the general public. But Congress, pressured by the public's concern over the growing number of addicts in the country, enacted the Harrison Narcotic Law67 which was designed to control the domestic manufacture, sale and distribution of narcotic drugs. The Act requires importers and manufacturers to purchase and affix stamps to all opiates and cocaine packages. In addition, importers, manufacturers, wholesalers, retailers, and doctors must register and pay a graduated tax for the use of narcotics. Narcotics can only be legally transferred under the Act by registered persons through the use of special order forms. The Act does not seek to interfere with the legitimate practices of medicine, nor with the medical treatment of addicts, for it provides that: "Nothing contained in this chapter shall apply to the dispensing or distribution of any of the drugs ... to a patient by a physician, dentist, or veterinary surgeon registered ... in the course of his professional practice only." If an addict is a patient of

a doctor, narcotic drugs can be dispensed to him, if it is done in the course of the "professional practice" of the doctor. The Harrison Act did not seek to regulate the practice of medicine nor impinge upon a doctor's relationship to his patient. Nevertheless, despite the exception in favor of physicians many doctors were subjected to criminal prosecution because of the charge that their treatment of and prescription for drug addicts was not legitimate "professional practice" within the meaning of the Act. Targets of the initial prosecution were doctors who had many addict patients for whom they prescribed large amounts of drugs. Such doctors were charged with the illegal sale of narcotics in violation of the Act.

In the first Supreme Court case under the Act (United States v. Doremus),68 the defendant, a doctor, had dispensed 500 one-sixth grain tablets of heroin to addicts, and was convicted of a violation of the Act. He contended that the Act was unconstitutional because it sought the control of the distribution of narcotic drugs through the device of taxing- such drugs. It was contended that Congress could not constitutionally control the distribution of narcotic drugs. However, the Supreme Court, in a 5-4 decision, upheld the constitutionality of the Act, stating in the course of its opinion: "... the Act may not be declared unconstitutional because its effects may be to accomplish another purpose as well as the raising of revenue. If the legislation is within the taxing authority of Congress, that is sufficient to sustain it."69 This case did not directly pass upon the question of what a doctor may or may not do in the treatment of a drug addict. In the case of Webb v. United States70 however, which came before the Court on the same day, the Narcotics Bureau was able to persuade the Supreme Court to adopt its views concerning the treatment of drug addicts by physicians. Dr. Webb had been indicted and convicted for selling at 50 cents apiece, over 1,000 prescriptions for narcotic drugs, indiscriminately to anyone, and occasionally using fictitious names on the prescriptions. It was obvious that the defendant was a mere prescription peddler, who was neither treating patients nor practising medicine. His conviction, therefore, should have been affirmed since his activity in relation to drugs was not covered by the exception in the Act in favor of physicians. The Narcotics Bureau, however, apparently wanted more from the Supreme Court than the affirmance of a conviction. It wanted an authoritative expression of opinion from the Court as to what was and what was not, the legitimate practice of medicine in dealing with narcotic addicts. It therefore had a question certified to the Court for its answer, which went far beyond the facts of this case and which seems to impinge upon the domain of medical practice. The certified question reads as follows: "If a practicing and registered physician issues an order for morphine to an habitual user thereof, the order not being issued by him in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing the user with morphine sufficient to Keep him comfortable by maintaining his customary use, is such order a physician's prescription under exception (b) of section 2 (of the Harrison Act)?"71 A majority of the Supreme Court (5-4) answered this question as follows: "to call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion is required."72 Under this decision, it became possible for the Narcotics Bureau to warn doctors against prescribing drugs to addicts for the purpose of avoiding withdrawal distress or keeping the addicts comfortable. The position of the Narcotic Bureau was strengthened by another flagrant case the following year,'" in which the physician had prescribed 8 to 16 drams of morphine at a time, indiscriminately to anyone, for $1 a dram. In

dismissing the appeal from the conviction the Supreme Court observed: "Manifestly the phrase 'to a patient' and 'in the course of his professional practice only' are intended to confine the immunity of a registered physician, in dispensing the narcotic drugs mentioned in the Act, strictly within the appropriate bounds of a physician's professional practice, and not to extend it to include a sale to a dealer or a distribution intended to cater to the appetite or satisfy the craving of one addicted to the use of the drug. A 'prescription' issued for either of the latter purposes protects neither the physician who issues it nor the dealer who knowingly accepts and fills it."74 In the Behrman case75 two years later, the Supreme Court began to realize that the earlier cases may have trespassed upon the domain of medical practice in attempting to dictate what a doctor could or could not do in relation to a drug addict. The Court dismissed the demurrer to the indictment of Dr. Behrman, who had prescribed 150 grains of heroin, 360 grains of morphine and 910 grains of cocaine to an addict, at one time. But it observed in the course of its opinion that: "It may be admitted that to prescribe a single dose or even a number of doses, may not bring a physician within the penalties of the Act."76 It should be noted that the indictment in the aforementioned case did not allege bad faith on the part of the physician-defendant. Nevertheless the Court held that such wholesale prescribing of drugs to an addict regardless of good or bad faith of the doctor was a violation of the Act.

The aforementioned precedents enabled the Narcotics Bureau to prosecute many physicians, and unquestionably resulted in most doctors leaving the narcotic addict severely alone. However, a few physicians continued to treat and prescribe drugs for addicts. One such man was Dr. C. O.

Linder,77 who was charged with the unlawful sale to an addict "stoolie" of one tablet of morphine and three tablets of cocaine for self-administration in divided doses over a period of time. The Linder indictment, like the Behrman indictment, did not question the physician's good faith. But the Court sustained the demurrer to this indictment and observed: "Obviously, direct control of medical practice in the states is beyond the power of the federal government. Incidental regulation of such practice by Congress through a taxing act cannot extend to matters plainly inappropriate and unnecessary to reasonable enforcement of a revenue measure. The enactment under consideration levies a tax, upheld by the court ... and may regulate medical practice in the states only so far as reasonably appropriate for or merely incidental to its enforcement. It says nothing of 'addicts' and does not undertake to prescribe methods for their medical treatment. They are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purposes solely because he has dispensed to one of them in the ordinary course and in good faith four small tablets of morphine or cocaine for relief of conditions incident to addiction. What constitutes bona fide medical practice must be determined upon consideration of evidence and attending circumstances. Mere pretense of such practice, of course, cannot legalize forbidden sales, or otherwise nullify valid provisions of the statute, or defeat such regulations as may be fairly appropriate to its enforcement within the proper limitations of a revenue measure."77 The Court refused to adopt the interpretation placed upon the Webb Case (supra) that no

prescription to an addict which sought to keep him comfortable or ward off withdrawal distress could be justified under the Act: "The question (in the Webb Case) specified no definite quantity of drugs, nor the time intended for their use. The narrated facts show, plainly enough, that physician and druggist conspired to sell large quantities of morphine to addicts under the guise of issuing and filling orders. The so-called prescriptions were issued without consideration of individual cases and for the quantities of the drugs which applicants desired for the continuation of customary use. The answer thus given must not be construed as forbidding every prescription for drugs, irrespective of quantity, when designed temporarily to alleviate an addict's pains, although it may have been issued in good faith and without design to defeat the revenues."78 In commenting on the Behrman Case (supra), the Court stated: "This opinion related to definitely alleged facts and must be so understood. The enormous quantity of drugs ordered, considered in connection with the recipient's character, without explanation, seemed enough to show prohibited sales and to exclude the idea of bona fide professional action in the ordinary course. The opinion cannot be accepted as authority for holding that a physician who acts bona fide and according to fair medical standards, may never give an addict moderate amounts of drugs for self-administration in order to relieve conditions incident to addiction. Enforcement of the tax demands no such drastic rule, and if the Act had such scope it would certainly encounter grave constitutional difficulties."80* *In a subsequent case, Nigro v. United States, 276 U. S. 332 (1928), the case involved a layman who was accused of selling one ounce of morphine not in pursuance of a written order form, and he argued that the act only applied to professionals. The Court said: "In interpreting the act, we must assume that it is a taxing measure, for otherwise, it would be no law at all. If it is a mere act for the purpose of regulating and restraining the purchase of the opiate and other drugs, it is beyond the power of Congress, and must be regarded as invalid ...

Everything in the construction of section 2 must be regarded as directed toward the collection of the taxes imposed in section 1 and the prevention of evasion by persons subject to the tax. If the words cannot be read as reasonably, serving such purposes, section 2 cannot be supported."81 Thus, the Linder Case lays down the rule that a doctor acting in good faith and guided by proper standards of medical practice may give an addict moderate amounts of drugs "in order to relieve conditions incident to addiction." The Harrison Act does not regulate how much a physician may or may not prescribe to an addict nor delimit either the quantity or frequency with which a physician may prescribe for an addict in his practice. This is illustrated by the case of Boyd v. United States,82 where a physician had been convicted of unlawful sale of 30 to 98 grams of morphine, by means of prescriptions, issued to two known, confirmed addicts.

The trial court had charged the jury that: "... it was not admissible to issue prescriptions to a known addict for an amount of morphine for a greater number of doses than was sufficient for the necessity of any particular administration of it." The Supreme Court pointed out that this statement was: ... ambiguous and might be regarded as meaning that it never is admissible for a physician, in treating an addict, to give him a prescription for a greater quantity than is

reasonably appropriate for a single dose or administration. So understood, the statement would be plainly in conflict with what this court said in the Linder case."83 The rule of the Linder Case was also applied by the Circuit Court of Appeals of the 10th Circuit in the case of Strader v. United States.84 There the trial judge had charged the jury that a prescription for morphine to an addict is a violation of the law, and that it may not be given merely for the purpose of relieving pain incident to addiction. The court in reversing the conviction stated: "We think the court incorrectly stated the law and unduly circumscribed the testimony. The statute does not prescribe the diseases for which morphine may be supplied. Regulation 85 (of the Narcotics Bureau) issued under its provisions forbids the giving of a prescription to an addict or habitual user of narcotics, not in the course of professional treatment, but for the purpose of providing him with a sufficient quantity to keep him comfortable by maintaining his customary use. Neither the statute nor the regulation precludes a physician from giving an addict a moderate amount of drugs in order to relieve a condition incident to addiction, if the physician acts in good faith and in accord with fair medical standards."85 Under these decisions, the exception in the Harrison Act in favor of physicians still has vitality. The Act does not purport to regulate medical practice, nor determine what drugs a physician may prescribe to an addict; nor indicate the quantity or frequency of the prescriptions.

The responsibility for prescribing rests upon the physician in charge of any given case, and the courts have been clear in holding that if he acts in good faith and prescribes a narcotic drug in the course of his professional practice, he is entitled to the benefit of the exception under the Act." As the court put it in the case of Bush v. United States:86 "A physician may give an addict moderate amounts of drugs for self administration, if he does so in good faith and according to fair medical standards." In the Strader Case (supra) the court ruled: "In Mitchell v. United States, 3 Fed 516 (6th Cir.,1925) the physician was indicted for dispensing drugs unlawfully. The defense argued that no offense was alleged because the indictment did not allege that the disposition of narcotics was not made to a patient in the course of the physician's professional practice. The court held that the indictment was defective because it did not negative the exceptions specified in the act.

* The Bush case involved a physician who was indicted for violating the act by issuing prescriptions for morphine, varying from 10o to 16 grains, to known addicts who pretended to be suffering with painful diseases. The indictment further charged that the quantities prescribed were enough to last more than one day. The defense relied upon the rule laid down in the Linder case that a physician is within his rights when he prescribes morphine to an habitual user as he sees fit.

"A physician issuing morphine prescriptions in good faith to a federal narcotics agent, whom he believes to be a bona fide patient, for the purpose of curing a disease or relieving suffering would not be guilty of violating the Harrison Act." But while the present law permits a physician

to treat an addict in good faith and in the course of his professional practice, doctors are still reluctant to treat or prescribe for addict patients. A physician who treats and/or prescribes drugs for an addict patient in good faith according to medical standards will be protected from a conviction. But his good faith and adherence to medical standards can only be determined after a trial. The issue of whether the doctor acted in good faith and adhered to proper medical standards must be decided by a judge or a jury. If the judge or jury decide against the physician, the latter may be sent to prison or deprived of his license to practice medicine.

The physician has no way of knowing before he attempts to treat, and/or prescribe drugs to an addict, whether his activities will be condemned or condoned. He does not have any criteria or standards to guide him in dealing with drug addicts, since what constitutes bona fide medical practice and good faith depends upon the facts and circumstances of each case. (See Bush Case supra.) The physician's dilemma in treating drug addicts is illustrated by the case of Teter v. United States,"87 where the physician dispensed nine one-quarter grain tablets of morphine over a two week period to an addict who was used as an informer by the Narcotics Bureau. The defense argued that the indictment was insufficient because of the small amount of drugs dispensed. In sustaining the indictment, the court said: "While the quantity was not large, nevertheless there was evidence tending to indicate that the sales were not in good faith from a physician's standpoint, and were for no other purpose than to enable this addict to further indulge her unfortunate propensities ... Notwithstanding two other physicians testified that in the treatment of addicts, it was not improper to give them doses such as appear to have been given to the complaining witness, we are satisfied that under all the circumstances, it was for the jury to say whether or not these sales of drugs to the complaining witness were in good faith, or were solely for the purpose of pandering to the habit of a drug addict, and selling the drug."88* * In Hawkins v. United States, 90 F. 2nd 551 (5th Cir., 1987), the physician was convicted for prescribing 15 grains of morphine to three known addicts, who he claimed were suffering from serious pulmonary conditions. The government had one witness who testified that he examined the addicts and found that none of them were suffering from such a condition. After the trial, one of these addicts died from a pulmonary condition. The defense argued that the amount prescribed was small and therefore it comes within the Linder Case because it was not large enough to put it within the power of the addict to sell part of the drug and thereby violate the act. The court, in sustaining the conviction, held: ". . .15 grains of morphine was enough to present a question of fact as to the good faith of the doctor to be decided by the jury." In United States v. Brandenburg, 155 F. 2nd 110 (3rd Cir., 1946) the physician was convicted for prescribing drugs to a narcotics officer who was introduced to him by an addict "stoolie," as a "tubercular brother-in-law." The physician also prescribed drugs for the addict who claimed that he had serious gall bladder trouble and that his doctor who was out of town prescribed morphine. The defendant was treating this doctor's patients while he was away so that when the addict walked into the defendant's office, there was no reason to suspect him. Subsequently, the addict and the agent received additional prescriptions. In sustaining the conviction, the court said: "The frequency of the issuing of the prescriptions and the quantities prescribed were factors which made the question of good faith one for the jury." In the recent case of McBride v. United States, 2229 F. 2nd 249 (5th Cir., 1955) an " osteopath was convicted for falsifying his records and illegally dispensing codeine. The facts show that the Chief of Police of Houston, Texas, who

was a personal friend of the defendant, had suffered a back injury and he was in constant pain. The defendant had given him a shot of codeine on one occasion in order to relieve a severe pain and when the Chief discovered that his pain could be relieved and that he was able to work, he asked the defendant to give him more; the defendant was reluctant to administer more of the drug because he feared the narcotics regulations. The Chief assured him that he would be within his rights if he dispensed the drug while treating him, and he brought in the regulations so that the defendant would be assured. Each time he prescribed the drug, he gave him an osteopathic treatment. The Chief had asked him not to use his name on the records which he kept because he feared losing his job if he was discovered; thus, he convinced him to use the name of an incurable cancer patient, again showing him the regulations, which he interpreted as being complied with so long as the dispensing of the drug was recorded. In sustaining. the conviction, the court observed that none of the expert witnesses (4 were called by the government, one being an osteopath and two were called by the defense) would say that the dispensing of codeine in quantities given by the defendant was standard medical practice, and it further said: "Evidence of the failure to follow standard medical practice shows a lack of good faith. So also as bearing on good faith is evidence of appellant's unorthodox attitude toward narcotics and addiction." The case of United States v. Anthonys89 crystalizes the problem which the physician faces in dealing with drug addicts. There, the defendant was approached by the City of Los Angeles to take over the treatment of addicts who were former patients at the City's narcotics clinic, before it was closed. These patients were confirmed addicts who were thoroughly examined by the defendant before he prescribed drugs for them, At the trial, three doctors testified that such prescription was good professional practice. Two other doctors testified that the ambulatory treatment of drug addicts was not proper medical practice under any circumstances. In acquitting the defendant, the court said:

"Good faith must be determined on the basis of evidence and expert testimony. The courts cannot arbitrarily say that, irrespective of the beliefs of the physician that he is effecting a cure or properly prescribing narcotics, the amount is excessive and ipso facto a violation of the law."

"There is no dogmatic rule which the courts have laid down for the purpose of determining what is good or bad professional practice."

"Ultimately, the question to determine is not whether the judgment used was good or bad, but whether the defendant believed... that the treatment he administered was proper by ordinary medical standards."90

This state of the law offers a challenge to the medical profession. It may question the somewhat misleading Regulation No. 5, Art. 167, of the Narcotics Bureau founded on the too sweeping

language of the Webb and Behrman Cases to the effect that:

"...An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of the act; and the person filling such an order, as well as the person issuing it, may be charged with violation of the law."

Despite this regulation, physicians may legally treat addicts. They may prescribe narcotic drugs to addicts. But they must act in good faith and according to proper medical standards. However, the medical profession should not leave the task of determining good faith and proper medical standards to an ex post facto judgment made by twelve laymen on a jury. It should not be left to the conflicting opinions of so-called experts, who may have differing views on how to treat narcotic addiction. The profession itself, through its authoritative body, the American Medical Association, should lay down the criteria by which a physician's treatment of an addict can be judged.

The A. M. A. itself should determine the standards of good faith and the limits of proper medical practice in the treatment of addicts. If the A. M. A. were to lay down standards, then the physician will know what is proper medical practice in dealing with addicts before he acts. A physician will also know that he need not fear criminal prosecution if he adheres to standards laid down by his profession. He will not be at the mercy of the stool pigeon and the informer. He will not tend to divorce himself entirely from the treatment of one group of unfortunate individual s, whose troubles lie legitimately within the domain of medicine. In laying down standards for the treatment of addicts, the American Medical Association may have to reconsider its resolution of 1924 condemning all "so called ambulatory methods of treating narcotic addiction." Thus, the present law provides the framework within which the medical profession, acting through the American Medical Association, can authoritatively determine what the role of the doctor should be in the treatment of addicts and in the treatment of problems of addiction.

2. Outpatient Clinics Medical counseling outpatient clinics for drug addicts have been set up particularly for adolescents in such cities as Chicago, Detroit and Los Angeles.91 These clinics offer some social case work and psychotherapy as well as some medical help for the addict. None of these clinics supply drugs to their patients. These clinics were established as a result of the concern with narcotic addiction immediately after the war. They were established in various communities under pressure to do something about the narcotics problem. A clinic is cheaper and easier to operate than a hospital dedicated to the rehabilitation of drug addicts. Unfortunately, the founders of outpatient clinics were not fully aware of the difficulties involved in

attempting to treat drug addicts. This awareness and understanding came as the clinic obtained actual experience. As the report of the Medical Counseling Clinic of Chicago pointed out: "The treatment of addicts is an extremely difficult problem, in large part due to the inadequate motivation of the person and to his instability and unpredictability, which results in sudden breaks of contact with treatment and a lack of noticeable progress over a long period of time. When the individual is able to continue in treatment over a sufficiently long period, we do observe movement and progress in adjustment, both in personal and social levels. It would then seem that successful treatment of the person with a history of narcotic addiction is a very slow gradual process taking place over a long period of treatment contacts, and fraught with difficulties created by outside social and legal pressures, as well as by the extremely inadequate and weak personality that we have to deal with."92 One hopeful development in connection with the outpatient clinics has been the establishment of agencies where the person who has been a patient at the federal narcotics hospital at Lexington or New York City's Riverside Hospital may come for advice, counsel, guidance and help.

For years, officials at the Lexington Hospital deplored the necessity of sending the released addict back to his community, where he had no one to turn to in case he needed help with his personal problems. Similarly, the officials at Riverside Hospital felt that contact must be maintained with the young addict after his discharge from this institution. A beginning has been made in New York City in providing after-care facilities for drug addicts discharged from Riverside Hospital. Similar facilities have been provided for Lexington graduates, in connection with a follow-up study of persons released from the latter institution. The clinics serve only a small part of the drug user or drug addict population in their cities. Confirmed addicts do not willingly attend outpatient clinics if they cannot obtain drugs there. Where they do attend such clinics, it is usually under pressure of official agencies such as courts, parole or probation officers or under pressure from parents or relatives. Contacts under these circumstances are restricted and are broken off at the earliest possible opportunity.

Many persons coming to the clinics may have been helped by their contacts with these agencies. Some may have been persuaded to stay off drugs. Many addicts may have been induced, by contact with these clinics, to take the more drastic institutional treatment at Lexington. One can, however, be skeptical as to whether outpatient clinics have any kind of decisive impact on the confirmed addicts living in the communities they serve.

3. Institutional Treatment of Drug Addicts Jail or prison is the usual method of treating drug addicts in this country. Drug addicts are incarcerated by the thousands all over the country for violations of the drug laws, or for thefts and other offenses committed in order to obtain money for drugs. Drug addicts also surrender themselves voluntarily for self incarceration under the laws providing for self commitment of drug addicts. The only value of jail or prison for the treatment of drug addiction is that the addict may be temporarily withdrawn from drugs during

the period of incarceration. Even this objective may not be achieved if the jail or prison is one into which drugs may be smuggled. There are practically no facilities for treatment of drug addicts in jails or penal institutions, beyond the forcible withdrawal of drugs. As a result, the drug addict comes out of jail or prison with his basic problems unresolved. The tensions, anxieties, pressures and personality problems which caused him to take drugs in the first instance are still with him. He usually goes back to the same environmental setting which facilitated his use of drugs in the first instance. There he also finds the same friends and acquaintances who have the same basic interest in drugs as himself. Under these circumstances, relapse to drugs is almost inevitable. The only value of prison or jail incarceration is in diminishing the dose of heroin or morphine necessary to keep the addict comfortable. But once the addict takes his first shot or "fix," after leaving jail or prison, he starts on the inevitable treadmill of tolerance and dependence, requiring greater and greater doses to obtain the elusive euphoria. His capacity will be limited only by the amount of money that he can borrow or steal in order to obtain the drugs necessary for his physical needs. If the addict was released from prison on parole (as he may well have been) he is usually an extremely unsatisfactory parolee. No threat of reincarceration prevents an addict from continuing to use the drug. Parole officers cannot prevent continued use of the drug or association with other addicts from whom parolees can obtain drugs, when they need them. Beyond jails and prisons and occasional addicts who may be accommodated at mental hospitals or private institutions, the only other institutional facilities for large scale treatment of drug addicts are the two federal installations at Lexington and Fort Worth, and the Riverside Hospital in New York City. These institutions were set up because of the belief that it is only possible to treat drug addicts in an institutional setting; that treatment of a drug addict is impossible unless he is first hospitalized in a drug free environment. The advocates of the hospitalization of drug addicts feel that only in a hospital setting can the addict be withdrawn from drugs and given the supportive psychological, medical, vocational and educational therapy necessary to enable him to cope with life without the use of drugs.

The author does not wish to minimize the great contributions that institutions like Lexington, Fort Worth and Riverside Hospital have made to an understanding of problems of drug addiction. Nevertheless, the limitations on the scope of their operations and their impact on the control of drug addiction in this country must be clearly understood.

The capacity of Lexington is 1280, of Fort Worth 1,053 . Riverside, the only narcotics hospital in New York City, is open only to adolescents under 21. It has a capacity of approximately 180.

It is obvious that these institutions of limited capacity can accommodate only a small fraction of the drug addict population of this country. Lexington and Fort Worth take federal prisoners who are drug addicts and who are permitted to serve their sentences in these institutions.

No technique has yet been worked out whereby drug addicts who have offended against state laws can be committed directly to Lexington or Fort Worth. Within the limit of the capacity of these institutions such offenders may be admitted as voluntary patients at Lexington or Fort Worth for the q-6 months believed necessary for rehabilitation. Most voluntary patients at Lexington and Fort Worth leave long before it is thought advisable that they should do so.

But even if all patients at Fort Worth or Lexington stayed for the 4-6 months believed desirable, it is unlikely that a permanent rehabilitation would result from such a stay. The programs of the institutions like Lexington, Fort Worth and Riverside are directed towards: (1) successfully withdrawing the patients from drugs; (2) building them up physically; (3) strengthening their vocational skills so that they can become productive members of the community; (4) eliminating gaps in their educational background; (5) attempting to give them understanding as to why they have had to resort to drugs in order to cope with life's problems, and (6) enabling them to resist the compulsion to use drugs as a means of resolving their difficulties.

There can be no doubt that institutions like Lexington, Fort Worth and Riverside have been a great deal more successful in the first four aspects of their program than in giving addicts a thorough understanding of why they use drugs and a resolve to resist the compulsion of drugs in the future. Addicts undoubtedly benefit considerably from their stays in Lexington, Forth Worth and Riverside.

Their systems are cleared of drugs, they become physically healthier and stronger. They are taught habits of regular work and may learn some academic subjects. But the exposure of a few months to a minimum amount of psychiatry, social case work, educational and vocational-activity, cannot eradicate the deep seated necessity and compulsion for drugs which most addicts seem to have.

There are no magic cures at narcotics hospitals. We simply do not know enough about the processes of drug- addiction to produce such cures.

The statistics on relapse to addiction after attempted cures at narcotics hospitals like Lexington, Fort Worth or Riverside tell the stark story of the basic failure of the hospital centered approach in dealing with problems of drug addiction.