Rehabilitation of the Street Addict

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The street addict is a special and troublesome kind of drug-dependent individual—a person identified with the slums of a large city, alienated from normal society, a thief and a chronic jailbird. He (or she) supports an expensive habit without legal income and so, inevitably, is involved in crime. The life of a heroin user is not a pleasant one, however, even though heroin does provide some periods of euphoria. Increasing doses and more frequent injections of the drug are needed for relief of abstinence symptoms, while the euphoric state becomes more difficult to attain. Heroin fails to satisfy the user on a long term basis. Heroin addicts—like alcoholics and heavy smokers—try from time to time to escape the slavery of their habit. In their dissatisfaction with the habit lies motivation and the hope of any program of rehabilitation.

The social trap in which the street addict is caught sharply distinguishes him from the middle class user (who may ruin his family, but maintains respectability) or the addicted physician or nurse (who diverts narcotic supplies to personal use) or the patient with chronic disease given narcotic medicine by medical prescription. All of these individuals have in common a physical dependence on narcotic drugs, but the problems of rehabilitation are widely different.

Any program that ignores the social deficits of the street addict will fall short of making him a productive citizen in free society. Acquisition of the drug habit is only the first step in the social deterioration of the street addict and, likewise, stopping the use of heroin is only the beginning of rehabilitation. When an adolescent becomes addicted to heroin, his maturation ceases. The normal experiences of school, family life, vocational training, and assumption of responsibility are blocked, and his energies become diverted to the means of getting money for heroin. If he was not delinquent before becoming addicted, he becomes so; his alienation from society widens with exposure to the addict world and jail. This is the path that must be retraced in therapy.

Suppose, for the purpose of discussion, it could be possible to cure heroin addiction instantly and completely by giving a medicine. Let us imagine that this utopian treatment would end all craving for narcotics and establish a state of perfect physical health. This, obviously, would be a valuable adjunct to treatment, but it would not repair the deficit caused by several years of addiction during the critical period of a young person's life. The patient, although cured pharmacologically, would still lack a job and lack the self-assurance and work record that would make him employable. To the world, perhaps even to his family, he would still be a junkie. Rehabilitation is a slow process; this, indeed, is true of learning in general, but the cured addict has the extra burden of having been a failure and having lost faith in himself. A pharmacological cure is no more than a beginning. To be...
come a productive and responsible member of society, the ex-addict needs help from someone who understands the nature of his struggle.

Methadone is not quite the magic medicine outlined above. It does provide a blockade against heroin effects, and it relieves the insidious drug hunger of detoxified addicts, but it does not suddenly banish all interest in heroin. Many patients must pass through a period of experimentation in which they return to the old neighborhood and try heroin again. For some, one test is enough; the lack of euphoria in a properly blockaded patient eliminates the appeal of this drug. For some others, the experiments will continue for a time, even though the blockading action of methadone prevents euphoria. It would seem that the habit pattern of heroin taking is deeply established in some addicts and can be extinguished only by a number of negative experiences. With the methadone blockade, however, the patient is protected against readiction to heroin; not only does methadone block euphoria from heroin, it also eliminates the secondary abstinence symptoms that otherwise follow after heroin taking and lead the addict back to regular use.

With time, with discussion of his problems, and with monitoring of the urine by objective tests, the patient can be carried through the transitional period of intermittent drug taking. Meanwhile, many important changes are taking place in his relationship to society and in his attitude toward himself. If, as is true of many street addicts, he came from a deprived background, where drugs were widely used, and had become addicted through curiosity, he may have no residual psychopathological symptoms once the pressure of heroin addiction has been removed. Such a patient will pass through a series of stages during the first year of rehabilitation (with methadone blockade) will have a good chance of becoming a productive member of the community. This is not merely an expression of hope; the expectation is based on the experience of the Methadone Maintenance Research Project over a period of 2½ years involving, at the current census, a total of 124 patients who had been intractable street addicts. No patient in the program has become readdicted to heroin while blockaded with methadone; two thirds of the patients under treatment for three months or longer are steadily employed or at school.

First, consider the sequence of events in an uncomplicated process of rehabilitation (if addiction ever can be described as uncomplicated) and then the additional problems caused by an underlying psychopathology independent of addiction—problems that remain when the use of heroin has been discontinued (eg, psychopathic personality, anxiety neurosis, schizophrenia).

In the treatment of primary, or uncomplicated, addiction with methadone, four stages can be distinguished, each with characteristic problems and therapeutic responses. The first stage, called phase I in previous reports, is a period of induction and uncertainty. The addict comes to treatment with mixed feelings and many doubts. He can be helped substantially by reassurance from older patients who have experienced similar anxieties on entry into the program and who have succeeded in starting a new life. An early and favorable sign in the response of the new patient is the development of pride in personal hygiene. His clothing is washed and pressed; he shaves each morning and helps maintain the ward. Perhaps he has no usable clothing and no money. For such patients the purchase of inexpensive but decent clothes and a raincoat is an essential step in rehabilitation, since he must present an acceptable appearance for employment interviews, and for his self-respect. Some time during the second or third week, if the methadone is given in proper doses (enough to prevent abstinence symptoms, but not so much as to produce narcotic effects), the patient comments on the disappearance of drug hunger and begins to talk with other patients about non-drug topics of current interest.

During phase I the patient is receptive to many educational approaches; groups go with counselors or older patients to museums and to sporting events; patients read a surprising variety of books; they participate in YMCA events; some go to night school or start vocational training. They are, nonetheless, still insecure. They need the reassurance of frequent contacts with
professional and nonprofessional members of the staff; the street is only a few days or weeks behind them.

After six weeks' residence in the medical ward (an arbitrary time fixed for the pilot study), the patient has been stabilized on medication, his initial medical and psychological examinations have been completed, and he is ready for discharge to the outpatient clinic. He enters phase 2a. The most urgent problem at the time of discharge is housing, since many street addicts are homeless and destitute. For such individuals an interim period of support on public welfare is essential; the patient must be enabled to live in a rented room and begin to establish a new life. Some patients—the younger ones with unfinished schoolwork or others with defined vocational interests—may return to school; scholarships and money for vocational rehabilitation can be obtained from various agencies for qualified students. Other patients are encouraged to seek jobs. Since they are likely to be overwhelmed by nervousness and memories of previous failure, it is helpful if a member of the staff accompanies the applicant on his first visit to the employment office. This support may seem unnecessary—and perhaps it has been in some cases, since agencies have confused the patient with the staff member in the interview, but both the older patients and the counseling staff insist that this support is desirable. The physician can provide an essential reassurance for prospective employers by describing the program and giving guarantees of medical control.

Phase 2a, the stage following discharge from the hospital, may last six weeks to six months. It is followed by phase 2b, in which the patient has established a socially acceptable routine of life and may have a steady job. The episodes of experimental drug-taking characteristic of the earlier phase have ended or become infrequent. The main problems of the patient in phase 2b relate to his difficulties in finding employment; to schoolwork; to the burdens of newly assumed responsibilities; and, for some patients without family or close friends, to loneliness. Counselors, not necessarily trained in social work but good listeners, are invaluable.

It is important to recognize that some patients, driven by feelings of guilt for their past life and by a desire to please the staff, will attempt to overperform. Some patients have taken multiple jobs and have worked to exhaustion to purchase new furniture and clothes for their families; others have combined an ambitious program of schoolwork with a new job. These overperforming patients must be helped to find a reasonable pace, since the deficit of years cannot be remedied in a moment. Like many of us, they need help in finding a balance between work and recreation.

Phase 3 may not ever be reached; but, if it is, the patient will have established a new routine of life, socially acceptable and consistent with his abilities. He will have developed a long range outlook for the future; he will have a bank account and friends. At this stage he no longer needs support from older patients or counselors. He looks to the physician as a medical advisor, not as a guardian. The chief danger in this stage is his complacency, since a successfully treated patient ceases to consider himself as an addict. He is likely to feel that continued taking of medication is a needless inconvenience. Admittedly, the question as to whether or not the blockading medication should be continued into phase 3, or even indefinitely, is still unanswered. It is clear, however, that the decision as to continuation should be made by the physician and not by a patient who feels that maintenance of the blockade is inconvenient.

The problem patients—the disturbed individuals with psychopathology independent of addiction—respond less well. These patients may not be recognizable in the initial interview or in phase 1, since addiction and the resultant social pressures cause anxiety and distortions in attitude that cannot be well separated from more fundamental disturbances. In the course of treatment, however, some patients fail to progress as expected. Psychopathic individuals cause disturbances in the ward and in the outpatient clinic, sometimes episodes of violence. Schizoid individuals remain isolated and may or may not be able to hold a job. Patients with anxiety neurosis may not find a sufficiently protected environment. They may report symptoms of abstinence and be
convinced that the medication has been reduced when, in fact, the dose has remained constant and the recurrent symptoms are emotional. Other patients may continue to use alcohol to excess or to have continuing problems of barbiturate, tranquilizer, or amphetamine abuse.

The problem patients, fortunately, have been a minority in the group that we have treated. The relatively low incidence of disturbed patients in our series may result from a favorable selection. Our patients were chosen mainly from the deprived groups—Puerto Rican and colored persons coming from the slums. For many of these individuals, addiction was more a matter of exposure to drug use in adolescence than of psychopathology. Another group of patients, drawn from middle class areas in which addiction is a more extreme deviation, presumably would show a higher proportion of disturbed individuals.

Now consider a question that might be asked about any program for street addicts: What can be expected of the treatment? What are the measures of success or failure that will permit different therapies to be compared and appropriate treatment to be prescribed for different patients?

Most of us would agree that the greatest success is achieved when an addict becomes a productive member of society. For some patients—those with disabling psychopathology—this goal may be impossible, and, for them, life in a protected environment certainly is preferable to the anti-social existence of a street addict. But it does seem that for many patients a brief period of hospitalization may be sufficient to initiate the process of rehabilitation. Prolonged confinement of these patients in institutions would seem to be unnecessary and expensive and might defer the beginning of their rehabilitation.

Conclusion

Many street addicts can be rehabilitated by stopping heroin usage by methadone blockade and by giving common sense support. This approach, however, is not a cure for every addict; an undetermined proportion of addicts have additional psychopathological problems and need more specialized facilities for treatment.

This study was supported by grants for the Health Research Council, Department of Hospitals, and the Community Mental Health Board, New York.

Generic and Trade Names of Drug

Methadone—Dolophine.

References


DISEASE ERADICATION

Eradication of a communicable disease is defined as the complete elimination of the infectious agent from the world. The term should be restricted to this concept and thus national or regional programs can only be considered in relation to the global effort. The financial implication in eradication is that a short term campaign will be much cheaper than the eternal maintenance of a control program. A limited time element is implied.—Himman, E.H.: How Much Control of Communicable Diseases?, Amer J Trop Med 196:125, 1966.