Lexington Narcotics Hospital: A Special Sort of Alma Mater

Early next year, control of the federal narcotics hospital near Lexington, Kentucky, is scheduled to pass from the National Institute of Mental Health (NIMH) to the Bureau of Prisons. Cynics say they are just putting the bars back up after taking them down in the middle 1960's, but the transfer really seems to have been made inevitable by changes in narcotics laws, in methods of treating addicts, and in public attitudes.

The hospital has been known officially as the Clinical Research Center (CRC) in recent years, and informally as Lexington or K-Y to generations of American narcotics addicts. The massive institution, a 1930's hybrid of prison and hospital, seems oddly misplaced in the rolling horse-farm country outside Lexington. But more to the point, current opinion holds that it is unrealistic to keep narcotics addicts in rural isolation and then expect them to deal successfully with the pressures of "the street" to which most of them return. And now the spread of community narcotics treatment and rehabilitation programs provides an alternative to Lexington.

It is the existence of an alternative that was the key to the decision to make the transfer. The shift is expected to take place between 15 January and 1 February unless—as seems highly unlikely—Congress objects to the plan. Lexington is to be used by the Bureau of Prisons mainly as a treatment center for federal prisoners with histories of drug abuse. The pattern of treatment developed at the CRC is expected to be continued in substantially its current form.

The advent of control by the Bureau of Prisons will complicate the organizational picture at Lexington, since, in addition to the CRC, Lexington is also the location of the NIMH Addiction Research Center. For nearly 40 years, the unit now called the ARC has been the principal center for basic and applied research on narcotics and narcotics addiction in the United States and, for that matter, in the world. Actually the ARC has made the noteworthy record in research while the Clinical Research Center, despite its name, has primarily performed a service function. ARC has been in the unique position of being able to use federal prisoners as volunteer subjects for narcotics research and has, over the years, produced the main body of important research in the field. Under the transfer plan, ARC is to remain under the aegis of NIMH, and the new arrangements are not expected to affect ARC operations significantly. (An article on the ARC will appear later.)

For the hospital, the change in management and mission will mean a partial return to an earlier phase. For 30 years after it opened in 1935, the hospital dealt with two kinds of patients, narcotics addicts convicted of violating federal laws and also voluntary patients—narcotics addicts who were admitted on a space-available basis. That phase reached an end in 1966 with the enactment of the Narcotics Addict and Rehabilitation Act (NARA). This legislation (*Science*, 24 June 1966) embodied a new national policy stressing medical treatment and rehabilitation for addicts and providing the device of civil commitment of addicts charged with or convicted of a federal offense as an alternative to prison. Lexington, at that point, stopped taking both prisoners who were already serving time in federal prisons and voluntary patients. The program designed for the NARA patients is based on a 6-month period of treatment at Lexington followed by a 3-year period of supervised "aftercare" in community facilities. In the future, these NARA patients are to be handled in programs operated by state and local authorities.

Somewhat ironically, the transfer of the hospital was expedited by an alumnus of its staff. Jerome H. Jaffe, who served as a young Public Health Service (PHS) physician at Lexington in 1959 and 1960, gave a crucial push last year to the transfer while he served as director of the White House Special Office for Drug Abuse Prevention. Jaffe, who is now a Columbia University professor, compares Lexington today to "a big old TB hospital out in the country" which has been made obsolete because comparable treatment is available practically everywhere. Lexington was created, says Jaffe, "when people were afraid of addicts and wanted to ship them a thousand miles away." Now the hospital is a "rather expensive anachronism."

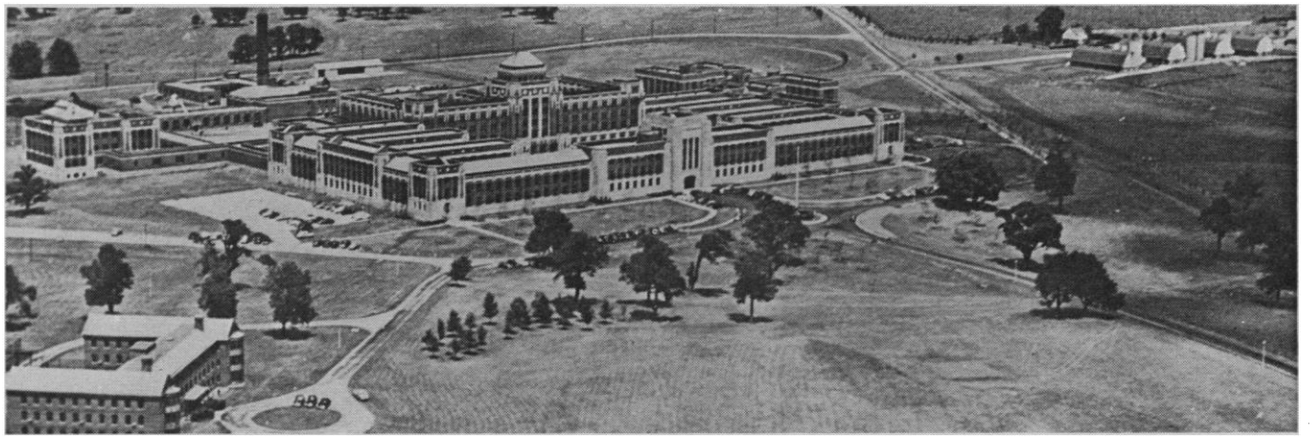
When he was in the White House job, Jaffe says, he felt that if there was going to be a crunch in research funding, the hospital "ought to do real research or get the hell out of the business." Lexington has a huge physical plant, and the scale and design of the facility actually made research difficult. "Sad as it was," in view of the "grand tradition of training people there," Lexington was obsolete, he says, comparing it to one of the old Cunard Line Queens of the Atlantic run.

"We were also concerned about human factors," says Jaffe, referring to the staff of about 400 people employed in all capacities at Lexington. The federal prison system was expanding, and this was an opportune time to make the transfer. Soon there would have been no place for the staff to go, says Jaffe. Because most of the staff will continue to work at Lexington, the transfer caused "minimized human trauma and redeployment of people."

There does seem to be a firm consensus that the hospital, in contrast to the ARC, has not been a prime source of theory and practice in the narcotics field. In the 1950's and early 1960's, the hospital was crowded, with patient population rising to nearly 1500. During the NARA period, a patient count of around 500 was normal. Few knowledgeable people, however, deprecate the hospital's importance over the years as the place that made a beginning in treating addiction as an illness rather than a crime and, however successful it was in rehabilitating addicts, always stuck to its guns.

The hospital was established in a flush of New Deal–era idealism as the result of the collaboration between Walter Treadway, the head of the PHS division of mental hygiene, which mutated into NIMH, and a young Bureau of Prisons official, James V. Bennett, who went on to a stint of more than a quarter of a century as director of the bureau.

Lexington was conceived as a prison



NIMH Clinical Research Center at Lexington, Kentucky.

without walls or towers. Access to various sections of the facility was provided through tunnels. An emphasis on rehabilitation was prominent in the design of the complex, with classrooms, a library, a chapel, and even shops included. Perhaps most important, Lexington from the start was operated as a PHS hospital. Lexington was not without locked gates and other security measures, but these were meant as much to keep contraband narcotics out as to keep patients in. By the standards of the federal prison system, violence at Lexington has not been a serious problem; it is said that no member of the staff to date has been killed.

Another narcotics hospital, at Fort Worth, Texas, was authorized in the legislation creating Lexington. Fort Worth opened 2 years after Lexington and accommodated patients from west of the Mississippi, while Lexington drew from east of the Mississippi. Fort Worth was transferred to the Bureau of Prisons in 1971.

The hospital's earliest name, the Lexington Narcotics Farm, conveys something of the period flavor. At first it was felt that fresh air and sunshine were the best prescription for addicts, and the regimen called for withdrawing addicts from drugs, building them up physically, and giving them some marketable skill. Lexington was literally a farm in those days, with much of the 1000-acre federal holding devoted to a self-sustaining farming enterprise operated by the patients. There were three other "capital industries"—sewing, woodworking, and printing—whose products were utilized by government agencies. But the industries were eventually cut back. Farming, although popular with patients, is a demanding business. If a hay crop had to be brought in, for example, it took precedence over patients' therapy sessions. So the farm was phased out. Only the printing operation will be carried on under the new regime.

As with any institution, Lexington's character has been shaped by the people who have run it. Because Lexington has been a PHS hospital, the dominant personalities in both the CRC and ARC throughout have been members of the PHS Commissioned Corps, the career service of health professionals organized on quasimilitary lines. In recent years, the Commissioned Corps has been passing through a twilight zone on a scheduled trip to oblivion, but during the Depression years and after World War II, its members played a central role in the expansion of the federal health and biomedical research establishment.

Jaffe mentions the importance of Lexington as a training ground. It was not only a routine assignment for many PHS physicians, but an obligatory experience for Commissioned Corps psychiatrists. Because the narcotics laws were harshly punitive and strictly enforced, Lexington and Fort Worth were virtually the only places where treatment of addicts and research on narcotics was permitted during much of this period. It was true, at least until the early 1960's, that almost everybody who knew anything about addicts or addiction had learned it at Lexington or Fort Worth. Jaffe himself is an example, and another is Marie Nyswander, who, with Vincent Dole, pioneered methadone maintenance methods at Rockefeller University and Beth Israel Hospital in New York. Experience at Lexington also influenced such administrators as Robert H. Felix and Stanley F. Yolles, who, as directors of NIMH, helped give addiction research standing in the mental health field.

Felix, who is now dean of the University of St. Louis medical school, was at Lexington from 1936 to 1941 when knowledge about addiction and narcotics was rudimentary. It was a period, in fact, when the scientific techniques for withdrawing addicts from opiates were being worked out at Lexington. Felix recalls that the staff in those days felt like a "brotherhood of isolation. There was so much we didn't know and so much to know." The doctors there sometimes felt they had "holes in their heads to be working in an area in which nobody else was. If we got a 10 percent nonrelapse rate, we felt very good about it."

Psychiatrists met patients all day, says Felix. They did good work, "but the next step was always missing. There was no follow-up. It was like bailing out the ocean with a thimble."

Nyswander, who went to Lexington fresh from her internship at the end of World War II, also recalls that drug addict rehabilitation was at a primitive level. "We were the only ones trying it. There was nothing to compare with it." Nyswander recalls that she thought the place had the grim atmosphere of a prison, but after her later experience of dealing with addicts in city jails she realized that the prisoners were right in calling Lexington a country club. Like others interviewed for this article, Nyswander feels that the big custodial facility, like Lexington, has outlived its usefulness, but she feels that Lexington was historically important in establishing a scientific status for work on drugs and in contributing to a new view of addict patients.

Not all PHS officers who passed

through Lexington became experts on narcotics or addict rehabilitation, of course, but a fair proportion seem to have. Jaffe makes this comment, "Most people got there at a time when they were formulating their professional interests. It was not that the place was so stimulating, but people were there when they were developing professional identities." They had spent 2 years in an arcane area, says Jaffe, and there was a growing demand for this experience. This demand, of course, grew increasingly heavy in the 1950's and 1960's and, in retrospect, it seems that the hospital's most lasting contribution may have been in initiating a cadre of capable physicians knowledgeable about addiction.

What of the addicts? Is there a profile of the patient at Lexington which would be accepted as typical? Certainly the composition of the patient population has changed over the years. When Lexington opened, there were sizable numbers of Chinese and Orthodox Jews there, and the majority of patients were poor, white Southerners. Most of the Chinese were said to be there because of opium addiction; the Jews' addiction was ascribed, however accurately, to a religious prohibition against alcohol. Among the Southerners, many of the patients apparently had become medically addicted, and a large group are said to have come from New Orleans, where morphine addiction seems to have been rampant.

There was a sharp drop in admission of addicts during World War II, attributed to a scarcity of narcotics. In fact there was room at Lexington and Fort Worth for scores of psychiatric patients moved from other PHS hospitals to make room for expected battle casualties. A group of these men, their number now dwindled to under a hundred, are still at Lexington. Most of them former merchant marine sailors, they have grown old in the narcotics hospital. Still occupying their corner of Lexington, with any proclivity for violence or bizarre behavior controlled by medication, they enjoy the freedom of the place, and are likely to be the last patients to go. Plans call for their transferral under contract to the care of the Kentucky state mental health department, since, under the Bureau of Prisons, there won't be a place for Lexington's "old men."

After the war a new pattern emerged. Jimmie D. Hawthorne, a psychiatrist who has been at Lexington since 1959 and is acting director in CRC's last phase, says that, in the postwar years, addicts typically were criminally involved or had dealings with criminals, which had not been necessarily true of earlier patients.

What generalizations can be made about addicts from the experience at Lexington? Hawthorne notes that, since the beginning, the hospital has treated people on the lower end of the social ladder. The more affluent addicts got private care. Sports and show business celebrities did not show up at Lexington. Patients for the most part were "the underprivileged in terms of education, vocation, and social standing." The other thread, says Hawthorne, is that addicts have come from minority groups having trouble making it into the mainstream of society. In the early days there was a whole ward of Chinese patients; now there is not a single Chinese patient in the place. At the same time there were numbers of Irish and groups who came in the later waves of Hungarians and members of other ethnic immigration.

The Internal Immigrants

Black addicts began reaching Lexington in sizable numbers in the middle 1950's. This did not match the previous pattern until it was noted that this particular minority group had emigrated from the rural South to the urban North, says Hawthorne. In recent years, patients of Puerto Rican and Mexican background have also been overrepresented at Lexington.

When the staff looked for signs of common psychiatric disorders in the addict patients, says Hawthorne, they usually found the patients were not typically depressive or schizophrenic. How do you remedy the situation for patients who appear to be reacting to the problems of living in society? Hawthorne aligns himself with those who favor a preventive approach. He thinks it is most important to get minorities into the mainstream of society. But for a physician, concerned with the individual patient caught up in the problem, it is necessary to use the means available.

Treatment at Lexington appears to have gone through three main, although not sharply separated, phases. First there was the emphasis on the simple life down on the farm combined with an effort to give the addict some perspective on his problem. Then came a longer period when the accent was on individual psychotherapy. Finally, in the 1960's, the concept of the therapeutic community, with the emphasis on small groups which are in some degree self-governing, came to dominate.

A fair question is whether NARA, with its civil commitment proviso, has affected the context of treatment and relations between addicts and staff at Lexington. The answer appears to be, not dramatically. In the NARA period, Lexington has taken patients under two sections of the law—Title I, which authorizes federal courts to commit certain addicts charged with federal offenses rather than prosecute them, and Title III, which provides for commitment of persons known to be addicts but not charged with offenses. Title II of the act provides for commitment of addicts for treatment after conviction for federal offenses, but these addicts have been treated in other facilities. After the shift to Bureau of Prisons control, many Title II patients are expected to come to Lexington.

As one staff physician at Lexington, Robert L. Kuykendal, points out, even addicts who have chosen voluntary commitment under NARA are under significant pressure. This may be legal pressure arising from charges on violations of local or state laws or pressure from relatives or employers. Kuykendal is completing a 2-year assignment at Lexington and will go on to a residency in psychiatry. He is representative of the substantial number of young physicians who have chosen a term with PHS as an alternative to military service. At Lexington these physicians have maximum contact with patients and the nonprofessional staff.

There is a special set of hurdles in the situation at Lexington because patients under legal pressure tend "to play games with the staff," says Kuykendal. "They have to say, 'It's not the 5 years I'd get otherwise, I really want help. If I say I really want to be on the street, I'll get thrown into prison.' "

With the typical addict, says Kuykendal, "A small part of him does want to beat it [addiction]. If he's at all insightful he sees what he's lost. What I try to do is to convince him not to please me to beat going to jail, but to see that there are things he can do to change."

In describing the addict's view of the world, Kuykendal puts heavy stress on what the addict sees as "the attractions of the drug culture, of ripping and running, of life on the street.

"It's a funny thing. The addict sees

the alternative as Dull Street, an 8 to 5 job, watching TV, and going to bed. And that job probably offers a dull, humdrum existence. I'm convinced that, more than the drugs, it's the life-style that attracts them to the drug culture. Your acquaintances are doing the same thing. You con them, they con you. It's sort of cops and robbers at an adult level. By our standard, the addict may be capable of being a janitor. But he feels he's being very good in the life-style, and it's not hard to understand why he doesn't want to trade. He really can't envision a life without a good bit of larceny involved."

Asked what generalizations he would make about addicts' case histories, Kuykendal noted that "Most of the guys have bad relationships with their fathers. Most are from lower socioeconomic groups. Sex really doesn't seem to be an important thing. The addict looks down on the alcoholic and the homosexual, but sex is virtually meaningless in the real scheme. However, the myth of sexual prowess may be very important to people who are locked up."

The addict typically "has had quite a lot of trouble obtaining and maintaining close personal relationships. And he generally has a low opinion of himself. But he can define himself as a success as long as he is in the life.

"The people we see here are the losers. There may be a group of successful, happy addicts somewhere. We see only the unsuccessful ones."

As the hospital passes into a new phase, a balance sheet remains difficult to draw up. Judged on its performance in fulfilling its founders' hopes that it would find a "cure" for drug addiction, Lexington has failed. The relapse rate of those addicted to hard narcotics remains discouragingly high despite years of experience and, in recent years, ampler resources and the use of a variety of treatment techniques. This, of course, is generally true of narcotics rehabilitation programs. Effective follow-up care has been the weakest link in the rehabilitation equation, and, although community programs have improved markedly under NARA, the quality of these programs varies greatly.

The logic of the shift to Bureau of Prisons control seems generally accepted. But some informed people are skeptical of the effect. As one physician put it, "I wish the change were coming because of a sincere belief that the community programs were good. I'm concerned because the government would like to think that the problem is solved, when in fact it's worse than ever. Their reaction is to stick their heads in the sand."

As for the prognosis on the transfer of the hospital, Jaffe thinks there may be an unanticipated premium. Lexington is a modern, humane correctional institution, says Jaffe, and an important thing is that in the future "it may tell us more about what happens in a different kind of prison."

Instead of a place with people in cages, Lexington has single rooms instead of cells, day rooms, paneled walls, nice grounds, an air of pleasantness. "Most significant, they won't be starting with retreaded guards," says Jaffe. "The people at Lexington are trained and are used to working with addicts, not criminals. I think they may be in a new era of research and don't know it."

—JOHN WALSH

RECENT DEATHS

Nathaniel T. Coleman, 53; associate dean, College of Biological and Agricultural Sciences, University of California, Riverside; 1 August.

Lillian C. Compton, 88; former president, Frostburg State College; 1 August.

John P. Gillin, 66; former dean of social science and professor of anthropology, University of Pittsburgh; 4 August.

Walter R. Hess, 92; former head, Physiological Institute, University of Zurich; 12 August.

Dale H. Hutchison, 58; chief of research, California Air Resources Board, Sacramento; 29 August.

Lyman E. Jackson, 75; former president, South Dakota State University; 23 July.

Walter Jaunzemis, 47; professor of engineering mechanics, Pennsylvania State University; 6 August.

Margaret Kaeiser, 60; professor of botany and forestry, Southern Illinois University; 24 April.

Arthur M. Master, 77; professor emeritus of medicine, Mount Sinai School of Medicine; 4 September.

James V. McGlynn, 54; former vice president and dean of faculties, University of Detroit; 3 August.

William L. Messmer, 70; former chairman, mathematics department, Old Dominion University; 26 July.

Karl Ziegler, 74; head, carbon research division, Max Planck Institute; 12 August.

APPOINTMENTS

James H. Billington, professor of history, Princeton University, to director, Woodrow Wilson International Center for Scholars, Smithsonian Institution. . . . **Emil Frei III**, professor of medicine, Harvard Medical School, to director, Children's Cancer Research Foundation, Inc. . . . **Thomas C. Chalmers**, director, Clinical Center, National Institutes of Health, to president, Mount Sinai Medical Center, and dean, Mount Sinai School of Medicine. . . . **J. Aaron Bertrand, Jr.**, professor of chemistry, Georgia Institute of Technology, to director, School of Chemistry at the institute. . . . **George Bugliarello**, dean of engineering, University of Illinois, Chicago Circle, to president, Polytechnic Institute of New York. . . . **Daniel Bratton**, vice chancellor for student affairs, University of Maryland, College Park, to president, Kansas Wesleyan College. . . . **Michael H. Smith**, associate professor of zoology, Savannah River Ecology Laboratory, University of Georgia Institute of Ecology, to director of the laboratory. . . . **Walter J. Moore**, professor of chemistry, Indiana University, to chairman, physical chemistry department, University of Sydney. . . . **Kenneth D. Weide**, animal pathologist, University of Arizona, to dean, School of Veterinary Medicine, University of Missouri–Columbia. . . . **Samuel P. Asper**, vice president for medical affairs, Johns Hopkins Hospital, to dean, Medical School, American University of Beirut. . . . **Reuben Torch**, professor of biological science, Oakland University, to dean, College of Arts and Sciences at the university. . . . **Robert W. Hively**, acting dean, College of Arts and Sciences, University of Miami, to dean of the college. . . . **Arnold J. Moore**, chairman of curriculum and instruction, Kansas State University, to dean, School of Education, Youngstown State University. . . . **Philip W. Jackson**, professor of education, University of Chicago, to dean, Graduate School of Education at the university. . . . **Michael A. Falcone**, director of continuing education, Onondaga Community College, to dean of continuing education, State University of New York College, Utica-Rome.

Erratum. Through an oversight, the credit line for the photograph of Margaret Burbidge (30 November, page 901) was omitted. Credit should go to Terence Spencer, © 1973, *Smithsonian Magazine*.