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THE COUNTER-JUNK CULTURE: A COMMUNITY STUDY

by

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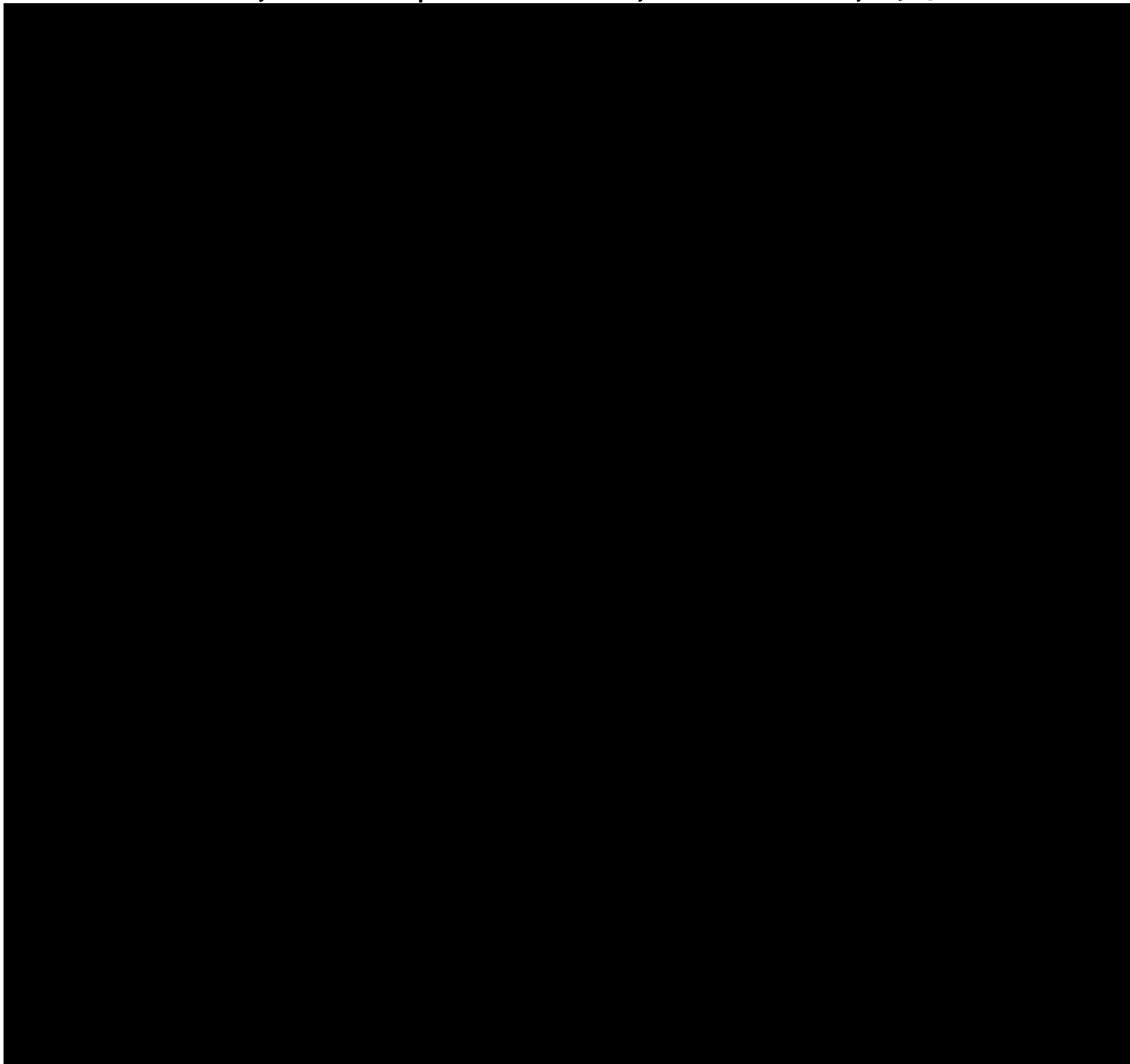

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"The President is a junky but he can't take it direct because of his position. So he gets fixed through me..."

(William Burroughs, _Naked Lunch_)

This is a study of those who provide treatment and care for heroin addicts. The investigator, a doctoral student in nursing, spent 11 months at a well-known drug treatment service - the Haight Ashbury Medical Clinic - in the role of a participant observer. This study was completed in August of 1971 - it must be considered a piece of history. Since that time, federal funding has altered the heroin detoxification service dramatically. Therefore, this study does not attempt to present a picture of the heroin section of the HAMC as it exists today. Rather, it presents an examination of culture among a working group.

TABLE OF CONTENTS

Introduction	1
Chapter One: Background	5
Chapter Two: The Setting	62
Chapter Three: The Observer	86
Chapter Four: The Observed	112
Chapter Five: The Culture	127
Chapter Six: Conclusions	168
Figures and Charts	201
Abstract	204

INTRODUCTION

1970 will go down in epidemiological history as the year in which the heroin epidemic "hit" San Francisco. Of course, the problem of opiate addiction existed in the Bay area prior to this time, but it was contained. In San Francisco, and elsewhere in the United States, the heroin problem remained endemic to the ghetto - striking mainly at the children of the lower classes. Thus, while in February of 1967 the New York Times reported that New York City had an addict population of 100,000, and a related theft rate which cost 8 to 10 million dollars daily - addiction still affected "them". "They" committed the estimated 70% of property crimes relating to addiction[1]; "they" subsequently filled the courtrooms and prisons; and "they" went through withdrawal sickness when deprived of heroin. It was in 1970, when addiction moved beyond boundaries of race and class, that it was declared to have assumed epidemic proportions. By a conservative estimate (one based on arrest figures which may not account for wealthy or lucky addicts), there are now 250,000 addicts in the United States.[2] They are getting younger: the average age of the addict has dropped from 35, in 1950, to 23, in 1971.[3] They are also getting whiter: even the Bureau of Narcotics and Dangerous Drugs, who base their figures on law enforcement data and therefore tend to underreport on the privileged, report a 7% increase in white addiction since 1959.[4] The upsurge in addiction is costly. Congressmen Murphy and Steele estimate that addicts, in 1971, spent $2,737,500,000 on heroin - and in order to obtain that sum stole goods worth four to five times that amount last year.[5] It is costly in human as well as economic terms. In New York City, for example, heroin has become the leading cause of death for teenagers.[6] The population of heroin addicts in America is younger, whiter - and growing. Race and class no longer confer immunity

from "Public Enemy Number One."

In keeping with its epidemic status, the phenomenon of heroin addiction is pervading public consciousness. According to the Gallup Poll, since the first quarter of 1971 heroin addiction has moved from seventh to third place as the nation's "most important problem".[7] Government has taken notice: the President, the Congress, and local officials concern themselves with and report upon addiction. The business sector shows its interest: Forbes magazine reports that heroin is "an industry that runs to nearly three billion dollars in the United States alone . . . It's a real growth industry, expanding in the United States at 10% or more yearly."[8] The media - films, music, popular literature - reflect the extent to which heroin has become a fascinating and pervasive force in middle-class American culture. Take motion picures, for example. In the past twelve month period an assortment of films have made the addict the hero (or anti-hero): "Panic in Needle Park" and "Dusty and Sweets Magee" are two. Other films involve drugs in subplots - "Joe",for instance, or "Klute". An extremely successful "dope movie", "The French Connection", has a sophisticated plot which presupposes knowledge about heroin and heroin traffic on the part of the general viewer - knowledge which was probably non-existent ten years ago. The image of the addict is softening. Legislators tend lately to speak more in terms of rehabilitation than eradication; films picture him less as a monster and more as a victim. In San Francisco, and elsewhere in the United States, a new kind of addict is emerging and claiming his place in the thoughts and concerns of the middle-class from which he comes.

Unlike the general public, who must relate to heroin through magazines, television, and the like, the health worker has special access to the sensational world of addicts and addiction. With the emergence of what has been

referred to as the "middle-class junkie", a flow of money, resources, and prestige has moved toward drug treatment situations. Thus, cadres of health workers are able to treat the heroin user, to build helping careers around the core issue of addiction. Nowhere is this seen more clearly than in the Haight Ashbury district of San Francisco. This area, notorious as a kind of barometer for national patterns of drug abuse,[9] also housed the first free clinic in the country. In November, 1969, the Haight Ashbury Medical Clinic formed a special Detoxification Section, for the treatment of heroin addicts. By August of 1970 this section served fifty clients a day.[10] In accomodating a growing number of addicts, the treatment service provided career opportunities for a growing staff as well. Health workers could come here to treat the addict - to medicate, psychotherapize, investigate, and rehabilitate him. The Heroin Detoxification Section of the Haigh Ashbury Medical Clinic provided an institutional juncture where both addict careers (sick heroin careers), and health worker careers (therapeutic heroin careers) could be pursued.

The Heroin Detoxification Section is an institution with many of the properties of a "community" in the anthropological sense of the term: the staff constitute a small, distinct group characterized by homogeneity and self-sufficiency.[11] I entered the "community" in October, 1970, and remained until August, 1971, in the role of a participant-observer. As a participant, I functioned as a psychiatric nurse, counseling and medicating addicts, attending staff meetings and so forth. As an observer, I kept records of the daily activities of the staff group - notes which described their behavior with their patients and with each other. My purpose was to conduct a community study: to describe and analyze the behaviors and beliefs of a worker group who came into existence because of the phenomenon of heroin addiction. Findings from this study reveal that the staff community is distinguished by

its culture, its system of shared understandings. Thus culture is expressed through shared sets of addict-like behaviors common to community members. Underlying these behaviors is a shared attitude toward life - an ethic. Before presenting the description of the staff community, it is necessary to examine the social events leading up to the heroin epidemic, those forces which which paved the way for new sick and therapeutic heroin careers. Chapter 1 - "Background" - will serve to place the Heroin Detoxification Section into context, in the historical as well as the social sense. Next, the "Setting" will be presented - a description of the treatment served itself. The "Observer" follows - a discussion of the method used in this investigation. Chapter 4 considers the "Observed", the types of participants who make up the staff group. "The Culture" consists of a description of the shared behaviors which typify the community. Last - "Conclusions" - some theoretical propositions about the world of health workers who steep themselves in the heroin culture.

CHAPTER 1: BACKGROUND

To understand the work-world of the participants at the detoxification service, it is necessary to offer some framework, some set of concepts, which make the setting meaningful. Within the conceptual framework of this study, the heroin service will be seen as an institutional juncture where addicts and health workers pursue their careers. These careers are significant because of their relationship to historical events and social conditions. Hence, in "Background", the concept of heroin "careers" will be discussed as well as the social-historical factors which gave rise to them.

Careers

The concept of "career" is useful in discussing both the addict and his therapist. The term refers to the "sequence of movements made from one position to another in an occupational system made by any individual who works in that system."[12] Two ideas are included in this concept: the notion of sequential movement, and the idea of "career contingencies". Sequential movement means that the careerist moves from one position to another - he is not static but rather proceeds through time. Career contingencies are "those factors on which mobility from one position to another depends,"[13] and may be objective(changes in the occupational structure) or subjective (changes in the thoughts and feelings of the individual). The concept has several advantages for the purposes of this study. First of all, as Becker points out in Outsiders, the term career may be used with both occupational and deviant groups. Since the addict and his therapist belong, respectively, to deviant and occupational groups, this term provides a common conceptual tool for discussion of both. Further, the addict and his therapist will be seen as individuals moving through time - hence, a concept in which the notion of sequential movement is implicit will be helpful. Most important, both the

addict seeking treatment and his therapist move from one position to another within the same occupational system. Both are subject to the influences of heroin economics, heroin laws, heroin myths. At the treatment service they share an institution; they occupy common temporal and spatial ground. Certain classes of events affect them both: a cut-off of clinic funding will influence the career of client and worker alike. In short, the addict and his therapist share common career contingencies. The term "heroin careers" will be used to refer to all participants whose occupational systems include the Heroin Detoxification Section of the Haight Ashbury Medical Clinic: addicts and health workers pursue heroin careers. When speaking specifically of clinic clients, the term "sick heroin career" will be used. "Therapeutic heroin career" will refer to staff members.

How did two such disparate groups as addicts and health workers come to share occupational territory? Recent social conditions have operated to simultaneously create opportunities for sick heroin carrers and therapeutic ones. Of course to some extent dividing those factors which encourage sick careers from those encouraging therapeutic ones is artificial. What affects one must influence the other as well. For instance, factors creating a client population also open up employment possibilities for health workers. Nevertheless, forces leading to sick or therapeutic careers may be separated by classifying them according to the type of career on which they exert maximum, or <u>primary</u> impact. For example: Operation Intercept, which reduced marijuana traffic during the summer of 1969, probably encourage heroin experimentation.[14] This had primary effect on the individual who used - and perhaps became addicted to - heroin. It eventually affected health workers treating addicts, but that effect was secondary to the heroin user's addiction. Similarly, the community mental health movement affected many workers

in a primary way by training them in store-front psychiatry. It had a secondary effect on the addict, by providing a type of therapy for him. Events and forces exerting primary impact on sick heroin careers will be discussed first. These are: (1) American drug dependence in general, including the "legal" addictions of the middle-class; (2) the phenomenon of the "Counter-Culture" with its effects on drug practices; (3) military addiction as a result of the war in Southeast Asia. Next, those factors which primarily encourage therapeutic heroin careers will be considered. They are: (1) the rise of the store-front approach to health care delivery, and the free clinic movement; (2) flow of money and resources presently being directed toward heroin treatment; (3) the increased visibility of the individual pursuing a therapeutic heroin career.

Preludes to Sick Heroin Careers

American Drug Dependence

Drug dependence and drug abuse are pictured in the rhetoric of "drug control" as foreign, alien elements which threaten to contaminate a basically drug-free society. Infection analogies abound, implying that drug abuse first corrupts a carrier, who spreads the disease:

> When the addict is institutionalized he not only loses his value to the peddler but he is also prevented from contaminating others.[15]

Carriers must be identified, for their own good and for the public welfare:

> Alarmed parents in such places as Smithtown, Long Island; Clifton, New Jersey; and Grosse Point, Michigan, are insisting that school officials give their children saliva, blood, or urine tests to detect what drugs they are using.[16]

While use of certain <u>illegal</u> drugs such as heroin is colored by subcultural elements which indeed appear foreign to middle-Americans, there is nothing alien, nothing un-American about the use of mind-altering medications.

For a vast number of middle-class adults in the United States, the use of mind-altering substances is the norm - not the exception. Our society is willing to pay the price for drug abuse: Americans tolerate a high degree of social loss from drug-related causes. Drug use is woven into the fibre of our economy - indeed the same system of attitudes and sanctions that makes opiate and psychedelic use illicit in turn protect the "licit" status of our socially acceptable addictions. Through marketing, legislation, and custom, pharmaceutically prepared pills, alcohol, and nicotine become our most accessible drugs of abuse.

The Extent of American Drug Dependence

Joel Fort, in The Pleasure Seekers, points out the extent of drug dependence among middle-class adults:

> . . . the same parents and other respectable adults who ask why young people are using drugs are themselves using three to five mind-altering drugs daily and providing a regular model of drug use for their children to identify with and imitate. The average middle-class bathroom cabinet contains somewhere around forty drugs, a goodly number of which are mind-altering substances. A typical using day for housewife, businessman, or factory worker begins with the stimulant caffeine, goes on to include the stimulant nicotine, then some alcohol, not uncommonly a tranquilizer, perhaps a sleeping pill at night, and sometimes a prescription stimulant for the next morning . . .[17]

Fort offers some impressive information about the amounts of mind-altering drugs wer produce and consume as a nation. In 1965, 971,000 pounds of barbiturates were produced - and 1,179,000 of the equally abuse-prone substance meprobamate.[18] A similar figure for barbiturates (300 tons consumed per year) is given by Smith and Wesson.[19] According to Fort, 20% of all MD prescriptions are for some type of mind-altering drug: sedatives, tranquilizers. And they are the type of prescription which are most commonly refilled.[20] In 1965, over 153,000 pounds of amphetamine compounds were obtained through legal, medical channels.[21] Other customary drugs of abuse need no prescrip-

tion. Our national caffeine consumption is high enough to allow for 20 pounds of caffeine per man, woman, and child each year.[22] Between 75 and 80 million Americans are cigarette smokers: total nicotine consumption in the U.S. would allow for each American to smoke eight cigarettes a day.[23] Alcohol, our most destructive legal drug of abuse, is used by 80 million Americans who consume millions of gallons of hard liquor, beer, wine, and homemade alcoholic beverages. Since the drugs of abuse are in every medicine cabinet, the abusers are "under our noses" as well. Such middle-class organizations as the Commerce and Industry Association, and the United Auto Workers are taking steps to deal with drug problems of the executive and the laborer.[25] Popular magazines, like McCall's, warn about the growing problem of housewives' habits: ". . . nearly two out of three women are taking some kind of mood-altering drug as prescribed by their physicians. The heaviest users of pills are women ages 25 to 39 in middle-class urban and suburban communities, who are high school graduates or better."[26] Children too use large amounts of legally prescribed mind-altering drugs, often for school problems. Charles Witter, in an article entitled "Drugging and Schooling", reports that 200,000 children in the United States are now being given amphetamine and stimulant therapy, with probably another 100,000 receiving tranquilizers and antidepressants."[27] Drug dependence does not lurk at the fringes of our society - it is found within the territory of the middle-class: the office, the factory, the home, the school.

Social Loss From Drug Dependence

When the amount of social loss - financial loss, death, disease, and injury - attributable to drugs is considered, it becomes clear that Americans are willing to pay a high price to protect the customary patterns of drug use. Numerous social problems - divorce, child neglect, and so forth - have been linked to drug use. However, to claim that such family problems

are drug-induced would lead to a chicken-egg type of controversy: did the drinking disturb the marriage, or did the marriage drive them to drink? No doubt, drug abuse (especially alcoholism) has some effect on prevalent forms of social breakdown. However, simpler and more direct examples of social loss due to "legal" drug abuse are easy to come by. Consider the relationship of alcohol to crime.[28] Between one third and one half of all arrests in America are for chronic drunkenness. More alarming is the extent to which drinking is associated with serious crime: more than one half of the prison population serving time for crimes such as murder, rape, theft, burglary, and embezzlement were using alcohol during the commission of the crime. Americans foot the bill for drug-related crime. They pay in terms of supporting the overburdened judicial and penal systems - as well as in terms of property loss and damage associated with drug-related crime. Fort reports that the man hours lost to alcoholism cost American business two billion dollars per year.[29] Social loss is seen quite clearly in the area of public health. Here the public tolerates not only a financial burden , but also incalcuable human loss, due to disease, injury and death. For example -"the overall cigarette mortality figure is 300,000 according to the U.S. Public Health Service."[30] Fort reports on the disease toll taken by alcohol: cirrhosis is the sixth most frequent cause of death in the United States; 20% of state mental inmates suffer chronic psychoses due to alcoholism; "between 50 and 70% of the almost 55,000 deaths and 2.5 million severe injuries each year from automobile accidents involve or are caused by alcohol."[31] More than 10,000 deaths result each year from the misuse of sedatives - some are accidents, some suicides.[32] Americans are willing to tolerate enormous loss - loss of money, loss of well-being, and loss of life - which grow out of our national patterns of drug abuse.

Drug Abuse and the Economy

Lindesmith has reported extensively on how the control policy of a nation - by creating an illicit traffic and by giving drugs symbolic significance to certain groups - will dictate the shape of its heroin problem.[33] Through its control policy, the country also protects its legal drug traffic, and maintains it "legal" drug problems. If some drugs are taboo, then others become the only available options for the conforming consumer. True, the United States spports a heroin industry which runs, according to reliable sources (Forbes[34]; Business Week[35]) to between 3 and 3.5 billion dollars per year. But the heroin industry, created by heroin laws, is minor compared to the legal drug industry - the one the narcotic laws protect. Gross profits from the alcoholic beverage industry alone amount to 12 billion dollars per year.[36] Cigarettes support an industry with an annual income of 8 billion dollars.[37] Add to these figures the probable profits from prescribed mood-altering drugs: 220 million prescriptions were written for such substances in 1970.[38] Consider sales of over-the-counter mood medications as well: Sominex, No-Doz, Compoz, and so forth. The heroin figures begin to pale in contrast. George and Ann Gay credit the young American's belief in a "pill for every ill" to "television's pharmacologic overkill."[39] 25% of every dollar spent on drugs does in fact go to advertising.[40] The media pay lip-service to an ethic of drug abstinence and self-reliance in a few public service messages. For example, "If you drink, don't drive." But the overriding message of T.V., magazines, and billboards is that drug use is a normal and attractive part of adult life:

> On one page a liquor advertisement asks 'What do you drink when you grow up?' (Arrow cordials), while another carries a warning to our children on the dangers of drug abuse.[41]

A decade ago, the middle-class young person had limited access to drugs. Thus he used liquor, prescribed drugs, and so forth. Other drugs

tended to be available only within closed subcultural groups. Heroin, prior to World War II, was used by people "in the life - show people, entertainers, and musicians; racketeers and gangsters; thieves and pickpockets; prostitutes and pimps;" and those ethnic groups associated with the entertainment world.[42] After the war, addiction increased among people from ethnic minorities. When middle-class people had access to opiates - as in the case of medical workers - they too sometimes became addicts. The Bureau of Narcotics and Dangerous Drugs discovered addicts among the ranks of doctors, nurses, and druggists long before the heroin epidemic "infected" the children of the middle-class.[43] These addicts, however, were exceptions. Middle Americans generally were channeled into normative patterns of drug use - and that was that. Since the late 60's, middle-class young people have been offered more options with regard to drug-taking than their predecessors had to choose from. Social events from 1967 to the present have brought about a situation of access to opiates for many of them. And such access is a necessary factor in the development of a sick heroin career.

The Counter-Culture

The "counter-culture" is a major social orientation with political and philosphical elements which oppose the prevalent culture. These elements provide a rationale for certain types of drug use - espeically psychedelics. Events connected with the counter-cuoture and psychedelism - the so-called "hippie migrations" - were to influence the development of sick heroin careers. This is not to suggest that the use of psychedelic drugs "leads" to narcotic addiction. On the contrary, the "Domino Theory of Drug Abuse" (marijuana leads to LSD, leads to pills, leads to heroin, etc.) has generally been debunked as a myth. The Presidential Commission studying marijuana found no evidence that the "killer weed"causes the user to seek out more

powerful drugs. Heroin addicts and psychedelic users seek different types of experiences. Cheek, et al., in an article entitled "The Down-Head Behind the Up-Head", report that while "the actual experiences of the addicts under LSD appear to be quite similar to those reported by other groups . . . we found the majority of the addicts neutral or negative in their evaluation of the experience . . ."[44] Of course, to say that psychedelic use does not <u>have to</u> lead to heroin does not mean that it never can. Steve Pittel, who has studied many types of drug abusers, points out that in the rush to dispel drug myths, the facts about <u>multiple</u> drug abuse have been obscured and distorted:

> . . . it is tempting to accept the notion that more differences than similarities exist between users of different drugs. Yet . . . some unknown percentage of casual experimenters go on to the use and abuse of other, more dangerous drugs regardless of their expressed motives for particular subjective effects.[45]

The counter-culture experience - that is, the psychedelic movement of the late 60's which culminated in events such as the 1967 Haight Ashbury Summer of Love - brought together a drug-taking population and a cafeteria of illegal drugs. Through a flourishing street trade, it introduced drug experimenters to impure and adulterated substances. In the aftermath of the summer of 1967, the most widely distributed drugs were those which <u>do</u> link pharmacologically with heroin - barbiturates and amphetamines. Thus, while the use of psychedelic drugs per se in no way causes heroin addiction, the phenomenon of the counter-culture is an important factor in considering how sick heroin careers came into being.

<u>Addiction and Access</u>

The variety of theories about the hippie psyche, and the addictive personality shed little light on the <u>social</u> reasons why the so-called "hippie" migrations helped launch the heroin epidemic. Theories damning the hippie personality tend to confuse the characteristic traits of a social

movement with the psychopathology of those individuals involved in the movement who require psychiatric treatment. Luce and Smith, for instance, explain the "Hippie Modality" by offering observations made by Dr. Ernest Dernberg, in a psychiatric practice near the Haight Ashbury district. Thus, they characterized the group as "impoverished" in the areas of symbol formation, interpersonal relationships, and in the handling of sexual and aggressive drives.[46] Other writers - for example, Theodore Roszak (The Making of a Counter Culture) or L. Simmons (It's Happening) tend to bend in the opposite direction, seeing the proponents of youth culture as visionaries:

> I am at a loss to know where, besides among these dissenting young people and their heirs of the next few generations, the radical discontent and innovation can be found that might transform this disoriented civilization into something a human being can identify as home.[47]

Neither the gloomy nor the sublime view of the counter-culture helps to clarify why involvement in events such as the Haight Summer served as a benchmark in the careers of some middle-class addicts. A good amount of study has focused on the drug dependent type - the typical addictive personality. Recent psychological investigations seem to confirm the findings of earlier studies of old-style addicts. The classic picture of the addict as established by Chein (The Road to H) reappears in studies of new San Francisco addicts:

> It is interesting that Chein's original personality breakdown defined almost 40% of his addict population as being either overtly schizophrenic or having a borderline schizophrenic process. Programs dealing with the middle-class addict, such as the Haight Ashbury Medical Clinic, are finding the same percentage of overt and borderline schizophrenics. Further, it appears that both heroin addict populations have similar pathological family background and suffer from a serious deteriorating self-esteem.[48]

So - a number of new addicts share personality facts with old addicts. But a weakness with this sort of information is that it is gathered from an addicted population. Thus it becomes difficult to distinguish whether old

ghetto and new middle-class heroin users always suffered from "deteriorating self-esteem", or whether the addict career causes the self-esteem to deteriorate. And establishing that all addicts have problems such as pathological family backgrounds does not mean that these problems are exclusive to addicts. Some writers explain the addict-type by emphasizing his position in the social structure. Cloward and Ohlin, for instance, use Merton's model of anomie and deviant behavior and conclude that the addict is a "double-failure" - that he fails to succeed within either legitimate or illegitimate success structures.[49] But discussing the addict as a position in the social structure has no more precise value than psychologizing after the fact of addiction - for as Lindesmith has stated, the social conditions surrounding addiction cannot cause heroin use unless heroin is available.[50]

No doubt, among the large numbers of young people involved in the social events of the late 60's there were some visionaries, some pathological characters, and many psychiatrically normal types. To analyze the way in which their participation in the counter-culture facilitated development of sick careers. What must be considered are the number of possible drug "abusers" who gained access to heroin. In 1967 San Francisco was attracting much of the national attention, but similar "hippie" communities were flourishing in New York City, Los Angeles, Denver, Seattle, and elsewhere.[51] In the Haight Ashbury district alone, it is estimated that 100,000 young persons took up summer residence.[52] And this figure does not include those who took part as spectators. In a population in excess of 100,000 it must be assumed that least some individuals were "drug dependent types." It should be recalled that this large population was brought up on an ethic of drug-taking. As middle-class Americans, they were no more likely to enjoy social events without drug use than their alcohol-and-nicotine-abusing parent. Further, this was the counter-culture - the alternative way. The milieu

established here encouraged experimentation with the new, the unconventional, the taboo. Hence, the group not only used drugs - but used alternative drugs. The nicely packaged PDR and FDA approved substances which the rest of the nation prefers were rejected here in favor of new, illegal, and more exciting compounds. These were distributed, not through the pharmacy and the liquor store, but through street trade. Hence, the purchase of drugs occurred in the same arena (the illegal marketplace) where heroin has traditionally been handled. Finally, the events created by the counter-culture - youthful migrations, musical happenings, etc. - were sensational. They attracted a large number of "camp followers" who fed off their glamour and notoriety. The media "got theirs" - that is, they made newspaper and magazine copy, films, and so forth through coverage of the "counter-culture". The social scientists most assuredly "got theirs" - the "hippies" were the raw material for academic production in a number of fields - psychology, sociology, criminology, to name a few. And the manufacturers and distributors of illicit drugs certainly "got theirs". Citing Smith and Luce with regard to the Haight Ashbury Summer:

> . . . almost every toxic substance known to science was now available in the Haight. Several clandestine laboratories were supplying the district with speed and acid by June of 1967; blacks and whites were bringing even more amphetamines, barbiturates, and opiates into the area; and the adolescents themselves often arrived with contraband drugs.[53]

Multiple Drug Abuse

The element of hazard plays some part in most careers - heroin careers are no exception. Early studies found that psychedelic users were "repulsed by narcotics".[54] Surely most residents of alternative communities like the Haight never envisioned their followers as statistics in a heroin "epidemic". But that unknown percentage with a predeliction toward drug dependence introduced an element of chance into their careers through ingestion of misidenti-

fied and adulterated substances.

During the period from summer, 1967 through 1968, the manufacturers of "quality" hallucinogens could not supply the large and expanding drug market.[55] Adulterated and impure substances became widely available. For instance, Smith and Luce report that in San Francisco, in 1968, substances sold as hallucinogens were generously laced with amphetamine.[56] It is likely that a number of "bummers" and "bad trips" treated in the late 60's and attributed to LSD were in fact reactions to any number of impure and misidentified substances:

> Many were so confused they neither knew what they were taking nor had any way of determining the percentage compositions of the chemicals they took . . . furthermore, these compounds were identified not generically but by misleading brand names . . . over two hundred preparations purported to be LSD were sold . . .[57]

Of course, no reports indicate adulteration of street drugs with heroin. But taking of adulterated drugs had several results which tie in, indirectly, with heroin use. First, it served to introduce amphetamines (more to be said about this shortly), which link, pharmacologically with the use of barbiturates and heroin. Secondly, they induced toxic reactions - these were treated with <u>more</u> drugs. The records of the Haight Clinic indicate that many of their addicted clients who began their careers in 1967 are "self-treaters"[58]; they use one street medication to soothe the effects of another. Thus, the use of toxic compounds creates a need, in the street market, for sedative medication. The treatment of drug reactions with use of further, possibily adulterated substances, finally leads to decreased discrimination about drug use in general. As Yorick puts it:

> . . . increments of toxicity stored in bodies created conditions of perpetual intoxication and lowered resistance to what formerly would have been recognized as dangerous.[59]

Amphetamines and Opiates

In tracing a progression of drug use, in some some individuals, from psychedelics to barbiturates and heroin,the use of intravenous amphetamine provides something of a missing link. In the records of drug treatment facilities a movement can be seen from the treatment of psychedelic reactions, to the treatment of amphetamine reactions, and finally to the treatment of barbiturate and opiate dependence. For example, the Haight Ashbury Clinic, in reviewing records of addicted clients, reports that those who began heroin use between 1964 and 1967 were heavily involved with amphetamine (54.4%) and barbiturates (26.2%) before becoming addicted.[60] To some extent, the movement from one drug to another can be traced to supply. Ernest Hamberger states that both "hippie" and addict groups will use amphetamine and barbiturates when nothing else is available.[61] In 1968, amphetamines were in ready supply in areas such as the Haight Ashbury.[62] (HAMC clients addicted since 1967 - when amphetamine was less plentiful and heroin more available - show less involvement with stimulants - only 40.5%). It may be that the use of amphetamine was at first dictated by its cheapness and general availability. But in addition, as George R. Gay explains, there are "sound pharmacologic and physiologic reasons" for progression to speed use: to calm acute anxiety reactions from other drugs, and to induce a feeling of self-esteem in a violent atmosphere."[63] Smith[64] and Gay[65] both indicate that once amphetamine use becomes prevalent, it becomes dominant. The aggresive, active amphetamine user tends to puch out the more peaceful, passive user of psychedelic drugs. By 1968 the use of intravenous amphetamine had become problematic in many parts of the country - it was creating a crisis in San Francisco. Looking at the characteristic of amphetamine abuse, it is possible to establish the reason why heroin was seen as the

next drug of choice of many middle-class young people.

In "Characteristics of Dependence in High Dose Methamphetamine Abuse", David Smith points out some of the effects of the "speed run".[66] He divides drug effects into two categories - action and reaction. The action phase is pleasurable and consists of sensations such as a "rush", and euphoria. The reaction phase, however, is unpleasant , and many include the following: fatigue, confusion, paranoia, panic, and finally depression. Continued use brings about extremely distressing symptoms, including four types of psychiatric problems: acute anxiety reactions, psychotic reactions, exhaustion reactions, withdrawal reactions. The very negative states which follow prolonged use of intravenous amphetamine serve as the reason why this type of drug abuse is "self-limited".[67] The user must find some way to alleviate his subjective discomfort. Since he is a"self-treater", he will seek out a new drug to cure the effects of the old one. He needs a sedative - and he shops within an illicit drug marketplace. Thus, he moves from amphetamine abuse to the use of addicting depressive medications. As Smith states:

> The paranoid characteristics may become so frightening to the speed freak that he may inject barbiturates or heroin as a form of self-medication. Unfortunately, secondary forms of barbiturate and heroin dependence have resulted from this practice.[68]

Even without much knowledge of the effects of amphetamine and heroin, the progression from one to the other is not hard to understand. The upper-downer sequence (coffee: martini; diet pill: tranquilizer; cigarettes: sleeping pills) is the normal pattern for drug abuse in the United States. After the use of an extremely powerful stimulant, such as intravenous amphetamine, the movement to a potent sedative and tranquilizer - heroin - makes sense.

Because of the misconceptions and distortions that abound about so-called "hippies and junkies", several points must be re-emphasized, before

proceeding to the third force creating sick heroin careers. When it is said that the counter-culture opened up opportunities for heroin use - this is not to say that the original participants in what has been termed the "hippie movement" were necessarily the same individuals who became addicted. On the contrary, many psychedelic users left areas such as the Haight Ashbury when they became centers of amphetamine and heroin use. The counter-culture, as the term is used here, was involved in creating addiction only insofar as it opened up an illegal market for those middle-class drug abusers who previously had to rely on sanctioned addictive or harbituating drugs. The situation of access to many drugs - some toxic, some linking phrmacologically with heroin - places multiple drug abusers in jeopardy of addiction. Once a mobile population of addicts emerges, they will expand the heroin marketplace, taking heroin with them in their travels. And hence the "epidemic" - new groups of middle-class drug users are given a situation of access to heroin and consequently some of them are able to begin sick heroin careers.

The War In Southeast Asia

In some respects the war in Southeast Asia and the counter-culture have similar effects in opening up opportunities for addiction: in both cases a population at risk and a supply of heroin were brought together. In addition it must be conceded that the war in Vietnam serves as a source of "situational stress" - provides the military addict with some reason for heroin use. In June, 1971, John G. Kester, deputy assistant secretary of the Army, addressed the National Heroin Symposium, meeting in San Francisco. Kester denied that the war itself caused heroin use - he attempted instead to discuss the characteristics of the GI addict. The hooting audience was delighted, however, when he listed as one of the "personality traits" of

such addicts: "do not take much satisfaction in the kind of work they have to do".[69] Kester and the Army's opinion aside, there is clear evidence that the soldiers in Southeast Asia are made all the more "addiction-prone" by their involvement in a war which is probably as unpopular among the troops in South Vietnam as it is here. Studies on returning military addicts conducted in San Francisco (Bentel and Smith[70], Stewart[71]) as well as journalistic accounts about drugs and the military (Wille[72]) would support this view. When in 1968, assisting Thai troops brought their local variety of heroin to American troops in South Vietnam, they probably brought a product to willing consumers. Bentel and Smith report that by June or July of 1970, economic opportunits had sized up the situation. They were supplying a growing consumer group with high quality, inexpensive white heroin. A consumer group - a reason to use drugs - a market - the yield: a heroin problem. To understand the phenomenon of military addiction, three aspects of this problem must be considered: the dimensions of the drug problem in Southewast Asia; the nature of the product being consumed there; the manner in which the Army is dealing with its heroin problem and resulting consequences in terms of heroin use at home.

Extent of Military Addiction

Estimates on the exact number of military addicts vary. June 28, 1970, Time magazine cited a figure of 26 - 30,000 as an official estimate. At the same time New York Senator Seymour Halpren quoted a figure of about 60,000.[73] More recent Army figures are lower: they estimate about a 2% addiction rate among troops in Vietnam.[74] Congressmen Murphy and Steele, who have looked into the problem of military addiction extensively, report that 10-15% of the troops use heroin - with some units having as high as 25% rates of involvement.[75] Bentel and Smith review much of the information on military addiction and conclude that methodological problems (lack of precise infor-

mation about soldiers making up the sample, and lack of data on the type and quality of drugs used) make unqualified acceptance of these figures impossible. However, they point out that all figures indicate a serious drug porblem within the military, as well as a supply of heroin. They report upon a study done at Letterman General Hospital, defining a "population at risk", which they find methodologically sound:

> Out of an estimated 250,000 total troop strength 'in country' (in South Vietnam) of all military services, about two-thirds of this population, or roughtly 170,000 troops (figure doubled for two years of estimated highest risk, 1971-72) are the 'population at risk'.[76]

This at risk group will not all use heroin. And of the users, 40-45% sniff heroin, 50% smoke it - only 5-10% actually inject the drug. Nevertheless, many of this population run the risk of becoming addicted <u>within 30 days</u> after entry.[77] Considering the size of the group at risk, and considering how quickly some of them develop dependencies - it is easy to believe that ". . . in the last two years of the war our biggest casualty figures will come from heroin addiction, not from combat."[78] A sobering indication of the dimensions of military addiction can be found in the death figures attributed to heroin use. According to Murphy and Steele:

> Between August and December, 1970, there were 90 deaths which were suspected to have been drug-related. Autopsy confirmed that 59 of these had died from an overdose of heroin.
>
> In January, 1971, there were 17 deaths which were suspected to have been drug-related. In February, there were 19 such deaths . . . if this trend continues more than 200 young Americans will die of heroin addiction in 1971.[79]

<u>The Nature of the Product</u>

How do so many young Americans embark upon sick heroin careers so quickly? In order to understand military addiction, it is necessary to consider the unique characteristics of the product being peddled to GI addicts. To begin with, U.S. servicemen are situated next-door, so to speak, to 80%

of the world's opium supply. While heroin sold in the United States gets here generally from France, much of Asia's supply (and consequently the serviceman's supply) is grown in what is referred to as the "Fertile Triangle" - Northwest Burma, Northern Thailand, and Laos. The Meo Tribesmen who occupy this area raise opium as their only cash crop, and hence rely on heroin production. (The importance of this area for the heroin industry - and the possibly complicity of some American officials in keeping production alive - have been reported on extensively [Earth[80], Ramparts[81], even The Christain Science Monitor[82]]. These sources contend that the government also plays a role in bringing heroin to the troops - that is, in supporting the flow of illegal opium traffic rhtough Laos and Thailand. Murphy and Steele, in their investigation, reject the idea of actual involvement of any U.S. official in heroin smuggling. However, they do point to use of Air America planes, and to high level corruption in the governments of Laos and South Vietnam, which facilitate the flow of heroin to the troops.[83] Whoever the actual smugglers are, the probably involvement of many high officials in the transport of heroin assures soldier continuing access to the drug.) The product, then, is readily available. Moreover, the product is of exceptional quality. Murphy and Steele claim that while Southeast Asians are sold the "number three" "purple-smoking"heroin, opium for American consumption goes through an additional refining process to become "number four white heroin."[84] According to Bentel and Smith:

> The 'drug of choice' for young Americans in Southeast Asia is now the popular and easily obtainable, high-potency, 95-97 percent pure No. 4 white heroin packed in clear white gelatin 100 mg. capsules.[85]

Compare the potency of that drug (95-97%) to that of the street drugs in the United States (2-15%). The heroin of higher potency is obviously more addicting. Further, this heroin is cheap - Bentel and Smith claim that a

habit costing from 100 to 200 dollars in the United States can be supported in Vietnam for a few packs of cigarettes, or perhaps $5.00 a day. Soldiers may snort or smoke heroin - they do not need to accept the subcultural trappings of addiction (needles, paraphenalia) which accompany heroin use at home. They may use it in conjunction with other drugs which are reportedly available in Vietnam - amphetamines and barbiturates[86] - which link pharmacologically with opiate dependence. Even "social" use of such high grade heroin can result in addiction.

Consequences of Military Addiction

What are the consequences of military addiction for the heroin problem at home? It has been suggested that the GI addict may give up his heroin use upon return to the United States. Ravis, for example, suggests that the returning soldier may be unwilling to take up the life of danger and crime required of the stateside addict.[87] Other sources disagree, however. Jon Stewart, who interviewed returning servicement at the Treasure Island Naval Base in San Francisco, reports the following:

> All of the men of 209.8 want to go home. The exclusive topics of conversation in the barracks are of scoring dope and of going home. Of course, the two ideas may be mutually exclusive. Most of the men are from small towns . . . They'll find it harder to score their brand of dope back there than it is on Treasure Island where there's a steady influx. . . They'll have to settle for one or the other - home town or dope - and the cards are stacked against them to say the least.[88]

In June, 1970, when the facts about military addiction were made public, military drug programs were announced which promised to treat the problems of the addicted GI before he returned home. However, several sources indicate that the military approach to drug problems has been punitive. Soldiers are denied treatment and are discharged with habits intact. June 28, 1971, Time magazine reported that 344 out of 1,003 marines dismissed for drug-related reasons were discharged dishonorably. The Washington Bulletin (July 28, 1971) reports on the punitive handling of drug cases: "Arrests

for use and possession of heroin by Vietnam servicemen were 250 in 1969, 1,146 in 1970, and 1,084 in the first quarter of 1971. In the past two years, 11,000 servicemen have been less than honorably discharged for drug-related offenses, making them ineligible for Veterans Administration benefits." The Army's practice of testing urine samples of soldiers entering or leaving Vietnam provides a means of getting some individuals into short-term treatment programs: "one week mandatory detoxification in Vietnam which may be followed by three weeks of therapy at VA hospital at home."[89] But in light of the low success rates in voluntary short-term detoxification programs, it is doubtful that this procedure will produce massive "cures". Further, the Health Rights News, in an article called "Abusing the Drug Abusers", reports that GIs identified through urine screening are being subjected to prison-like and brutal conditions of "treatment".[90] The Army's voluntary program - the "amnesty" program - has been estimated by one program director to have a cure rate of 10-20%.[91] While this rate is high, it still means an 80-90% "failure rate". And the amnesty-type programs (or as they have been successively called - "exemption", "immunity", and "treatment" programs), by several accounts, will not attract addicted GIs. Ravis reports that while the amnesty agreement protects the addict in some respects, it also puts him in danger.[92] He claims that the individual seeking amnesty is protected from prosecution only in the case of possession and use of a small amount of drugs. If, in the course of his treatment, he reveals involvement in other drug-related offenses, he can be brought to trial. Further, in entering the program he gives up VA and disability benefits for treatment of injury or disease which are drug-related. Participants may find their tour of duty extended. They may also have the fact of their participation in the program brought up during court-martial proceedings for other charges. According to David Raskin, in "Amnesty Unlimited":

> 'Amnesty' means that if you are using drugs you can go to your commanding officer and say 'I am using heroin', which constitutes an admission of guilt. And his commander will say, 'That's great, I grant you amnesty. I will not bust you for admitting to me that you use heroin. However, to-morrow if we find you with heroin we'll put you in jail.'[93]

I appears the Army's handling of its drug problems - both through mandatory and voluntary programs - may preclude, rather than encourage, rehabilitation.

> The President's counter-offensive is not having its intended effect. It is having another effect: many GIs returning to the United States are distrustful of all rehabilitative treatment. They are antagonized by the generally unsympathetic attitudes concerning the problems which led to their use of hard drugs, and by the systematic transgression of their civil liberties . . . the medical problem is not being solved by the counter-offensive, but a formidable legal problem is being created.[94]

Even the most conservative estimates indicate that thousands of soldiers now have habits which would cost hundreds of dollars daily to support in the United States. Many of these soldiers will be heroin dependent upon discharge. With their civilian counterparts, they help to establish and expand centers of addiction at home.

The general drug-dependence of the middle-class, the so-called counter-culture or hippie movement, and the war in Southeast Asia - these three social forces helped to pave the way for the beginning of sick heroin careers. The children of a drug-abusing society, through a series of unique events, have access to heroin. They are the "carriers" in the epidemic of opiate addiction which now confronts middle America. But the events of the past few years did not only give rise to a population of health care "clients". Parallel forces were at work, opening up carrer opportunities for health care workers as well. Thus, while the way was being paved for sick heroin careers, therapeutic heroin careers were also beginning.

Preludes To Therapeutic Heroin Careers

The Store-front Approach to Health Care Delivery

When looking over recent developments in medicine - the intensive care unit, artificial organs, heart transplants - it is tempting to oversimplify matters and conclude that medicine is moving along a linear path to increased technology, more complicated equipment, and sophisticated techniques. Yet, in fact, another trend has developed simultaneously. This is the trend toward delivery of ambiguous and hard to define types of "care" in unconventional surrounding, with virtually no heavy hardware at all. Concomitant with this is the huge increase in expenditures for social science research: although massive amounts are still allocated to the natural sciences - the support areas for technological medicine, funds for social science investigation, which support less precise therapeutic activities, have risen from $4 million in 1956, to $59 million in 1968.[95] It will be shown that during this time period the store-front approach to health care delivery has roots in the Federal War on Poverty, the Community Mental Health movement, and lately - the Free Clinic movement. Through these events, numbers of young, middle-class workers have been trained in counseling, referral, and crisis type treatment. They became accustomed to dealing with a poor population beset with "social problems" which formed part of their diagnostic set. They performed under less than sterile conditions, in physical situations which were anything but hospital-like. Addicts, it must be remembered, are generally poor, in need of crisis counseling and referral type services, and accustomed to primitive surroundings.The store-front practitioner, then, is a "natural" for a therapeutic heroin career.

The Federal War on Poverty

Yorick suggests that the heroin epidemic provides "a means of job retraining for a whole body of social and poverty workers whose situation is threatened by massive cutbacks in the poverty programs."[96] The meteoric rise and fall of the Federal War on Poverty left some fledgling helping careers at dead ends. Daniel Moynihan, in Maximum Feasible Misunderstanding, gives some ideas about social problems, social research, and social reform in the 60's - how they shaped and were in turn influenced by the poverty program. Moynihan asserts that the War on Poverty met the needs of a newly professionalized middle-class.[97] He claims that since the second world war, a vastly increased number of middle-class persons have had the opportunity for higher education. Further, he points out that as part of the "general triumph of the graduate school"[98], a good proportion of the newly educated see themselves as professionals:

> The National Science Foundation estimates that the number of scientists and engineers alone nearly doubled between 1950 and 1965, a rate of growth 4.5 times that of the labor force as a whole. At mid-decade, the number of persons classified as professional and technical workers passed the nine million mark . . . And of this group, a considerable number are involved in various aspects of social welfare and reform.[99]

An upsurge in education, coupled with an emphasis on the career value of that education, turned "social problems" into a matter of professional concern. A new breed of middle-class careerists, steeped in and supported by social science theory, saw the planning and implementing of social change as their just occupational concern. Almost every type of "professional" could claim eloquence and expertise with regard to at least one facet of a major social ill. For example, consider statistics: Moynihan points out that we are now inundated with statistical information about our national problems - during the depression there was no reliable data with which to establish the rate of unemployment.[100] Groups such as nurses moved from

apprenticeship toward university preparation for practice. They then used their behavioral science backgrounds to claim their perogative for intervention into social problem areas - family breakdown, poverty, and health, etc. Thus, the country saw a process occur which Moynihan calls the "professionalization of reform."[101] As a result of this process, he explains that the impetus for social change began to emanate, not from the institutions to be changed, but from a class of professional planners and reformers. The Economic Opportunity Act was conceived and implemented, not by the economically deprived, but by middle-class careerists - those persons "confident in their own judgement in such matters."[102] The involvement of the professional reformers in applying their educational concepts about social ills and social change was so widespread that when satirist Paul Krassner cited an article called "The Ethnic Joke as a Barometer of Class Distinction" in The Journal of Poverty[103] many people did not know he was joking.

The Economic Opportunity Act was signed in August, 1964. It consisted of two parts:[104] Title I - relating to employment; Title II - relating to Community Action programs, including health action. In 7 years, over 900 grants were awarded for community action in over 1000 cities, and some rural areas.[105] Two key concepts - "maximum feasible participation" and "opportunity" - were used to indicate the kind of massive impact the poverty program was supposed to exert upon the poor. They serve well also, in explaining the program's impact on middle-class poverty workers. Moynihan explains that the phrase "maximum feasible participation of the poor" first meant that the poor themselves would operate community action programs established for their benefit:

> In the oldest and purest and strongest tradition of American democracy, the local people themselves, those actually caught up in the problem at hand, were to organize themselves to deal with it.[106]

In actuality, the poor were to achieve little control over their own community programs. The poverty program did nothing but

> ensure that persons excluded from the political process in the South and elsewhere would nonetheless participate in the benefits of the community action programs of the new legislation.[107]

Design and implementation of community action remained in the hands of the middle-class reformers, who developed something of a vested interest in social change. Wildavsky mentions the participation patterns in the OEO in his "recipe for violence": "Have middle-class civil servants hire upper-class student radicals to use lower-class negroes as a battering ram against the existing political systems . . ."[108] A "master concept" in the community action phase of the poverty program was that of opportunity.[109] In this respect, the program showed its roots in new social theory. The opportunity concept grew out of the work of Lloyd Ohlin - his merging of the anomie and cultural transmission traditions in the sociological explanation of deviance. Ohlin hypothesized that various types of deviant behavior - juvenile delinquency, for example - grow out of lack of access to legitimate opportunity structures. The individual, frustrated in his attempts to achieve conventionally, turns to illegitimate opportunity structures and moves within them, taking up deviant modes of being. The assumption was that the poor, given opportunity - access to sucess through legitimate means - could cease to be anti-social and become solvent, happy, and better integrated into the mainstream of American life. Moynihan points out that the opportunity concept was at best a theory - not even a generally accepted theory - and should never have been thought of as a "sure thing".[110] Further, with "maximum feasible participation" becoming a catchy phrase, rather than a real statement of community control, it was difficult to see what opportunity structures the poor would gain access to . Certainly not to ladders of

political power. By the late 60's, it appeared that the OEO had served to demonstrate to the poor that they were very much cut off from opportunity - thus ending the short-lived and idyllic period of good relations between white reformers and ethnic minorities. The opportunity model held true, however: rising expectations and blocking of "legitimate" success structures resulted in civil disorders - deviance. The model has application for middle-class poverty workers as well. By the late years of the War on Poverty many of the "soldiers" were frustrated with their attempts to achieve change through judicious application of social theory. Richard Cloward, Lloyd Ohlin's associate and fellow theorist, was organizing rent strikes and calling for an end to "Corporate Imperialism and the Poor."[111] Younger workers were sufficiently disillusioned with the government - through the Vietnam war - to want no part of opportunities available with the social welfare machine. Moreover, after 1967 the OEO saw cutbacks and changes which ended some programs[112] thus closing off opportunity for social action types who still desired to work "within the system". Some became involved in the treatment of unconventional, devalued social problems - like drug addiction. This is in keeping with Ohlin's Model, for as Moynihan points out:

> If middle-class reformers ceased to mind other people's business they would cease to be reformers. Their own opportunity structure would be artificially restricting; all manner of deviant behavior could be expected thereafter.[113]

The decline and fall of the Federal War on Poverty was all but complete as the 60's came to a close. Sargent Shriver was in Paris at a diplomatic post; most of the engineers of the program were completely out of government.[114] The causes for this occurrence were complex - although Moynihan may have summed up many of them with his assertion that "the government didn't know what it was doing."[115] And what of the professionalized and reforming

middle-class? Many were left, not only with their body of knowledge about social process and their instincts for social change, but also with skills. For many a young poverty worker, a great deal of skill-training had occurred in mental health settings, and within the ideological framework of the community mental health movement.

Community Mental Health Movement

Community mental health has roots predating OEO - in social psychiatry and in the mental health movement in general. But as J.R. Newbrough points out in "Community Mental Health: A Movement in Search of a Theory"[116], since the second world war mental illness has been viewed increasingly as a social problem - hence a proper site of endeavor for a variety of professionals. Further, publication, in the 60's, of works such as Hollingshead and Redlich's Social Class and Mental Illness changed the image of the mentally ill from that of the neurotic upper-class person to one of the crazy poor. As in the case of poverty, mental illness stimulated the desire to use social theory to effect sweeping changes in a large arena of life. Much of community action itself consisted of providing mental health type services. For example, in Strategies Against Poverty, Reissman points out that a core unit of "CAP" should be the "neighborhood service center", a quasi-psychiatric type facility. While Reissman believes it would spare the sensibilities of the poor to call the place something other than"mental health center" he admits that some of its functions would be psychiatric. Even the non-psychiatric functions -referral, helping people to secure services, etc. - have a decidedly "mental" type quality to them:

> In some cases on-the-spot advice and guidance are sufficient. In others, giving information as to where needed services can be obtained is all that is required; but more usually, the seeker of service must be helped to know how to deal with bottlemecks and red tape and will need the encouragement and support of the non-professional worker in order to maintain motivation, dignity, and self-esteem. In some cases the services required are not readily available (waiting lists) and

> the neighborhood service worker is called upon to engage in a 'holding action' - to use his knowledge and skill to keep a crisis situation from deteriorating further. [italics mine][117]

Similarly, the Chicago Board of Health, in planning their"Family Health Centers" for the poor, proposed that mental health services be available on the premises:

> In such a center it is likely that a fair proportion (10-20%) of individuals from families seeking treatment or consultation would have emotional difficulties severe enough to be referred to immediate therapy or counseling. While the remainder might not require immediate psychotherapy in a formal sense, large percentage might profit from brief education programs . . . or counseling activities designed to assist them in better understanding and coping with the complex emotional determinants of family living and child rearing. Such a service . . . might serve as a center where families from poverty areas could be encouraged to come almost routinely. . . [118]

The community mental health movement was spurred by passage, in 1963, of the Mental Health Facilities and Community Mental Health Centers Construction Act of 1963.[119] Mental health type occupations were opening at the same time the War on Poverty began. Additionally, it has been shown that "clinical" poverty work involved store-front type psychiatry. Thus, the careers of "professional reformers" from the middle-class were influenced by the force of community psychiatry.

In assessing the impact of the community mental health movement on those who were to begin therapeutic heroin careers, it is important to note the types of skills which were developed there. First of all, mental health centers for the poor place a heavy emphasis on the importance of crisis care. This is partly because some centers are required by law to treat psychiatric emergencies on a 24 hour basis (for instance, in California, under the terms of the of the Lanterman, Perlis-Short Act[120]). Still another reason is found in the belief that the poor are incapable of making appointments or committing themselves to long-term treatment. Catherine Kohler Reissman

states:

> A theory has evolved which states that 'members of the lower socio-economic groups are less likely to utilize existing health facilities or to take part in preventative health programs.' This view derives from a 'culture of poverty' concept which sees the poor as unable to plan, pessimistic, and difficult to reach in regard to health practices. This 'hard core', 'medically deprived' group is supposedly resistant to change in attitudes and behavior in regard to health, disease, and medical care.[121]

Through her own work with birth control for the poor, she finds this concept "inapplicable". Nevertheless, it has become something of an accepted fact in community psychiatry that "traditional ways of operating (waiting lists, weekly appointments, long-term service, and emphasis on 'talking through') are not consonant with the needs , experience, or life-style of low income people."[122] Thus, neighborhood health centers and community mental health centers are charged with the responsibility for provision of "psychosocial first-aid"[123], "emotional first-aid"[124], and so forth. For the health worker, this means that experience will be gained - not in long term psychotherapy - but rather in crisis intervention and one-shot counseling. The practitioner does not make rational plans for a progression of treatment strategies; he instead stands ready to assess and react to a series of emergencies. A second characteristic of community-center type psychiatry, is that it presupposes multiple needs on the part of the client. While the middle-class or upper-class psychiatric patient can be seen as merely a troubled psyche - otherwise in good nutritional, legal, and social shape - the poor patient is presumed to be laboring under various kinds of stresses which must be alleviated as part of his treatment:

> The problems that are brought to the neighborhood service center run the gamut of human misery, from helping a resident make application to a housing project to requests for assistance in more complex and stressful situations as aiding a parent accept the need for service to a retarded child, helping a family threatened with eviction, assisting a pregnant, unmarried girl and her family to secure appropriate services, and

> helping a resident to accept and obtain needed psychiatric services.[125]

Even when community mental health services are provided for the not-so-poverty-stricken, the assumption is that most patient will require concerted services from a mental health team who can do anything from medicating them to finding them food stamps and employment possibilities. All these kinds of services cannot be provided by the slow conventional process of treatment by one therapist with subsequent referrals for ancillary services. Thus, in planning for community mental health, new roles and new organizational patterns were to be implemented. The care given in these centers approaches a totality of services. The practitioner must be flexible and farsighted enough to absorb a number of functions into his professional role. This leads to a third characteristic of this kind of practice - its ambiguity. For both the skilled and the unskilled mental health worker, the job to be done sounds vague, hard to define. For the nonprofessional, much emphasis appears to be placed on his warmth, ability to relate, and so forth:

> This 'counseling consists basically of providing a listening ear and some emotional support. The skills involved are based on enlarging the friendliness and warmth believed to be characteristic of the neighborhood worker's style. The nonprofessional's basic pattern of relationship is not 'trained out'. The mental helath aide is made aware of the fact that in providing all types of concrete service, it is important for him to enable the client to talk fully and freely about his problems and to furnish him the personal emotional support that is so valuable. Hence, a psychological service is built in as a concomitant of most other services.[126]

Lest it be assumed that only the indigenous worker is supposed to "just act natural", it must be pointed out that the middle-class professional tolerates a great deal of ambiguity as well:

> Training in community mental health presents a variety of knotty problems for the university and the field training center. Community mental health is sometimes seen as a

> professional practice based upon a rigorous scientific discipline; it is often defined and discussed in quite impressionistic terms; it has no clear boundaries; it has no body of organized knowledge specifically applicable to its problems; it has no professional consensus of good practice . . . It includes an incredible variety of roles: consultant, group therapist, social diagnostician, counselor, advisor, scientist, researcher, collaborator, social change agent, public health officer, educator, trainer, and yes, reformer.[127]

Housewives, college students, and clergy were presumed to have innate capacities for therapeutic functioning[128] which could be encouraged, but not defined. The professional therapist was expected to be aware of the full gamut of human needs - individual and social - when assessing and treating a client. With such ambiguity and role diffusion set up as prerequisites for functioning in a community mental health setting, it was natural that qualities like flexibility became highly valued. "Rigidity" and needs for "structure" were frowned upon. Indeed, it took a fairly "loose" practitioner to function in the physical surroundings of some mental health facilities. As a fourth characteristic of care developed through the community mental health movement, the de-medicalization of the treatment area should be mentioned. The poor, especially, it was believed, were uncomfortable in an office-type, sterile setting:

> 'Psychiatrists leave a bad taste in my mouth . . . I had to take my daughter to one one time, and we were scared stiff to go up there. In fact, I was petrified. They have such fancy offices. I walked in and this fancy doctor scared the life out of me because he was so formal. I didn't like sitting around in that waiting room either . . . I don't know, but it was just hard to feel at home there.'[129]

Thus, the family health service, or other mental health facility, was envisoned as warmer, more casual - less forbiding. Reissman suggests the use of settings such as churches, trade unions, and settlement houses for mental health activities.[130] The worker in the community health setting, in the late 60's, developed some unique kinds of skills: expertise in crisis work; an ability to care for clients with a variety of individual and social needs;

skill in performing in ambiguous situations and under vague role-expectations; and the capacity to practice under demedicalized, casual conditions. The number of workers receiving this training was, no doubt, high. During the community mental health "boom" (for 1958-1969 in California, for instance, where community mental health appropriations jumped from $786,000 to $30,625,-000)[131] many professional reformers joined the psychiatric approach to a better world.

The Community Mental Health movement is alive and well in 1972, but like surviving poverty programs (pre-school education, for instance) it has stabilized and become secure. It has stabilized first of all in the sense that new centers are not being constructed and opened frequently - hence, while a number of store-front practitioners once looked toward mental health centers for employment, such centers cannot absorb many more workers. It has stabilized additionally by becoming a conventional part of the American health care picture. Since the demise of the War on Poverty the radicalization of many middle-class young people and professionals has weakened the links that the designers of the community mental health programs saw as existing between "preventive psychiatry" and "community action".[132] Indeed, the powers that be in mental health today sometimes favor a dissolving of those links, altogether:

> . . . in his 1969 Presidential Address to the American Psychiatric Association, Kolb stated that if the mental health establishment had any social responsibility at all, it was to prevent, rather to foment, community action. 'Administrators and deliverers of mental health services will have to sharpen their perception and recognition of their responsibilities in maintaining social homeostasis. They bear a social responsibility much in the same way as the courts and other law enforcement agencies do in the support of a healthy community environment for all.'[133] [Emphasis added]

The Health Policy Advisory Center, using New York City as an example, demonstrates how the community mental health center has become a part of corporate health enterprises (big medical school complexes, regional programs, etc.) and hence a target of - rather than a base of operations

for - leftist reformers.[134] What remains of a movement to use psychotherapy for radical social change may be found in the emergence of a "Theory of Radical Theory".[135] But the radical therapist renounces the community mental health center altogether - he is more likely to operate out of a different store-front type setting - a free clinic.

The Free Clinic Movement

The Health/Pac Bulletin devotes its entire October issue to free clinics. They point out that while economically the free clinics are "but fleas on the hide of the elephantine medical system", they have influence far exceeding their financial impact:

> . . . all free clinics have, with varying clarity, focused on a vision of good health care, which they try to represent in their activities. This vision came together in the 1960's in what the media has labelled 'The Movement for Social Change'. It is distillation of the experience and beliefs of the New Left, underground culture, Black Power advocates, and OEO.

Besides having roots in the"distilled vision"" of the 60's, the history of the free clinics is also bound up with the development of the "counter-culture". The first free clinic, established under the license of Dr. David E. Smith in 1967, was a "hippie" type facility - the Haight Ashbury Free Medical Clinic. It was founded during the summer of 1967, and hence received widespread attention and publicity. Its founders claim it was a model for other similar facilities;[136] whether a "model" or not, it must be agreed it was an instigator. By January, 1971, when Jerome Schwartz published a survey of free clinics, there were over 126 such facilities functioning in 25 states.[137] By October of that year, the Health/Pac Study reported "upwards of 200" free clinics which "see tens of thousands of patient annually and are staffed by many hundreds of community activists and health workers."[138] Schwartz classifies free clinics, in his survey, according to the type of population they serve. He discusses "neighborhood", "hippie", and "youth"

type facilities. The first type - the neighborhood free clinic, tends to be operated by minority group communities, and to provide their medical, dental, and (in one fourth of the sample) psychiatric care. The second type of facility, "hippie clinics", cater to a clientele aged 19-24 years, and treat such problems as hepatitis, VD, urinary tract infections, difficulties around pregnancy and abortion, and drug-related difficulties. The last type, "youth" type services, are often organized by adults and serve a teenaged population. They offer counseling about problems related to adolescence (parents, school, and so forth), as well as drug counseling and drug education. All three types of free clinics are relevant to the development of therapeutic heroin careers: free clinics, like family health services and community mental health centers, offer practitioners the opportunity to refine skills which are useful in treating addicts. But the second and third types of clinics - particularly the type which Schwartz has termed "hippie" - have special significance. These clinics - 66% of Schwartz's sample - have served as sites of innovation and training in the treatment of drug-related disorders.

In Love Needs Care, Smith and Luce describe how the progression of drugs of abuse in the Haight Ashbury district (psychedelics, amphetamines, barbiturates, and heroin) dictated what "treatment" was predominant at the Haight clinic. By functioning within a center of youthful drug abuse, the clinic was the first facility to treat emerging types of drug reactions and drug-related problems. Thus, before the end of 1968 the Haight clinic had published the first issue of The Journal of Psychedelic Drugs[139], in 1969 it received funds for an Amphetamine Research Project[140]; in 1971 the National Heroin Symposium was hosted, in part, by the free clinic. Other clinics treating young people gained comparable reputations in the treatment

of drug problems. All, to be sure, did not achieve the academic renown of the Haight clinic. But as Schwartz reports, local medical authorities have come to accept the skills of free clinic personnel in dealing with drug use:

> The expertise with drug problems was acknowledged in several cities when large hospitals brought drug cases by ambulance to the local free clinic.

Through their situation of access to drug emergencies - as soon as each new drug of abuse became popular - free clinics gained more than experience in drug treatment. They gained recognized expertise. Hence the free clinic practitioner received several types of preparation for a therapeutic heroin career. First, in any free clinic, he developed store-front skills which are used in the counseling of addicts. Second, in a clinic which treats emerging patterns of drug abuse, he became an authority on drug treatment.

Training in the treatment of drug abuse might not have had the career potential it has today, had psychedelics or amphetamine remained the most widely used abuse substances. They expertise once developed in the treatment of LSD reactions has little resale value now - the therapy fads have changed. But the heroin "epidemic" greatly expanded career potential in the treatment of drug-related disorders. To be sure, most heroin treatment is not carried out in the type of free clinic surveyed by Schwartz. Health/Pac reports that most free clinics are getting out of the addiction business:

> . . . those clinics (with the exception of the Haight Ashbury Clinic) which have tried to help heroin addicts are giving up. 'We tried to help people kick but it was impossible. They needed a place to stay, food, and a shrink. We couldn't just give them pills to lighten the monkey for a while. We'll help junkies with other problems, but a lot come in here asking for pills; unless they're really in bad shape we don't give them any'[141]

Nevertheless, those store-front type practitioners with expertise in the treatment of drug-related problems have access to other institutions in

which to carry out their work. Since the upsurge in middle-class addiction became evident, government and medicine have collaborated in directing a flow of money, resources, and manpower toward the treatment of the heroin addict. Hence, enterprising health workers, with the appropriate "storefront" backgrounds, may pursue therapeutic heroin careers.

Resources for Heroin Treatment

A therapeutic heroin career cannot be pursued in isolation. The health care worker requires some base for enterprise, some institutional support, in order to proceed upon his occupational path. True, certain types of practitioners can "treat" addicted clients without a setting designed specifically for that purpose. Physicians, for example, or clinical psychologists, are free to include addicted patients within their private practices, so long as they adhere to the laws regulating prescription of narcotic drugs. But the isolated practitioner can only incorporate the treatment of a few addicts into what is essentially a medical or psychotherapeutic career. To have a heroin career, the individual must be able to move within an occupational system which is defined by it relationship to heroin. As recently as the 60's, the opportunities for therapeutic heroin careers were limited. The only "non-sick" heroin careers with much of a future were in the area of law enforcement. David Smith points out that during the past decade a police approach to drug control was dominant. He also notes that this approach failed to curb addiction:

> During this decade [the 1960's] we have witnessed the launching of the 'big government crackdown' in an attempt to control international narcotics traffic. This approach, although widely heralded at its inception, wound up as a major disappointment even in the eyes of such conservative publications as the U.S. News and World Report which in its December 7th, 1970, issue on 'Blooming Traffic in Drugs' described our latest law enforcement efforts as 'a failure'. Despite

> intensified efforts at control in which, for example, customs agents made 3,000 seizures involving 37,000 pounds of 'illicit drugs' in the third quarter of 1970, thus more than doubling the amount taken in the same period a year earlier, heroin has never been more available in the United States than at the present time.[142]

With the stunning failure of the police approach arrived a new era for those pursuing therapeutic heroin careers. It cannot be said with any certainty that the inadaquacy of law enforcement (which is far from ended as one approach to drug control) caused new opportunities to open for the treatment of addicts. The medical approach to drug control which rose to prominence during the past few years has been attributed to diverse causes. Yorick, for instance, approaches the whole idea of heroin careers from an economic perspective. He finds the growth of the treatment approach merely one of the "sybarition spin-offs" of the expanding heroin business:

> Medical and drug company growth accompanies the use of heroin. Doctors come up with varieties of cure for the problem. Under the lash of competition, drug companies are led to allocate more and more resources to the production of competing drugs, such as barbiturates and amphetamines. The production of methadone, presumably useful in the combatting of or substitution for heroin has grown enormously. . . Millions have been invested in the purchase of sites, deteriorated, decayed, or deserted buildings for rehabilitation centers. . . There is of course, a fantastic rise in the therapy market . . .[143]

Maxine Kenny traces the treatment approach to the fact that the children of the middle-class are becoming addicts:

> Confronted by an alarmed, middle-class public, most politicians are adopting a modified line about addiction: the Establishment is shifting the onus of criminality from the drug user to the drug pusher, while searching frantically for a medical 'fix' with which to treat the victim.[144]

Whatever the "true" reason - failure of police tactics, economics, politics - it is plain that the medical approach to drug control has come into favor of late. With it have come resources for the medical treatment of the heroin user: facilities and funding for treatment programs. Thus, occupa-

tional systems are available for those workers choosing to build careers around the issue of addiction. The increased potential for therapeutic heroin careers derives from increased support from two sources - government, and medicine. Obviously these two categories are not mutually exclusive, but they will serve as basis for classification. First to be considered will be government: the allocation of resources for heroin treatment by legal and political means will be examined. Next to be considered will be the role of the medical "establishment" in facilitating the development of therapeutic heroin careers.

Resources From Government

The flow of resources to heroin treatment situations is due in large part to government. In order to appreciate the degree to which such resources have increased, it is first necessary to consider first the historical position of American government with regard to the medical treatment of addicts. Since the Harrison Act, of 1914, the Treasury Dept. has intimidated those physicians who continued to treat addicts. Originally, the Harrison Act merely regulated the non-medical use of opiates. It was a revenue measure with no stipulations for the prosecution of physician or patient:

> its ostensible purpose appeared to be simply to make the process of drug distribution within the country of a matter of record. The nominal excise tax (one per cent per once), the requirement that special forms be used when drugs were transferred, and the requirement that persons and firms handling drugs register and pay fees, all seemed designed to accomplish this purpose. There is no indication of a legislative intention to deny addicts access to legal drugs or to interfere in any way with medical practices in this area.[145]

John Kramer, in an article entitled "Introduction to the Problem of Heroin Addiction in America", points out that at the time the Harrison Act was passed it was assumed that doctors would continue to treat opiate addicts as usual - that is, to prescribe maintenance doses of medication.[146] It

was not until 1915, according to Kramer, that physicians prescribing for addicts in this manner were liable for prosecution by the government. At this time the Treasury Department began its history of policing drug use:

> . . . Treasury Decision 2200 . . .stated that physicians' prescriptions for narcotics for addicts must show decreasing doses overtime; were this not the case the physician would be presumed to be violating the law.[147]

This was followed by further restrictive Treasury Department decisions: finally the prescribing of any narcotic to an ambulatory addicted patient became a criminal offense.[148] The Supreme Court played a role in forcing addicts out of treatment. In the wake of Treasury Department prosecution of MDs, the court ruled in several cases where the department's interpretation of the Harrison Act was challenged or disputed. Lindesmith, in The Addict and the Law, presents a thorough history of the court's involvement in shaping governmental policy with regard to narcotics. He discusses the Webb[149],Jin Fuey Moy[150], and Behrman[151] cases - all of which involved prescription of large amounts of drugs. These cases ended in decisions which precluded prescription of opiates to a non-hospitalized addict. Lindesmith points out that even in the later Linder decision (where the Supreme Court, in 1925, reversed the conviction of a physician who had prescribed small amounts of drugs to a police informer[152]) the federal government's policy essentially remained unchanged. After spending a reported $30,000 and losing his license to practice for a two year period, Dr.Linder had the small satisfaction of pushing the court to admit that addicts were diseased. Functionally, however, the treatment of addicts remained a crime, unless it was accomplished within an institution. According to Hentoff:

> Even if most doctors had not already been frightened off by 1925, there is a catch in the safeguards for physicians outlined in the Linder, Strader, and similar court decisions . . .

He quotes Judge Morris Ploscowe in defining that "catch":

> 'A physician who treats and/or prescribes drugs for an addict patient in good faith according to medical standards will be protected from conviction. But his good faith and adherence to medical standards can only be determined after a trial. The issue of whether a 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 a physician, the latter may be sent to prison or deprived of his license to practice medicine!'[153]

It was during this period (1919-1924) that some attempts were made to provide institutional treatment for ambulatory addicted patients. Lindesmith and Hentoff both report on the fact that more than 40 cities in the United States made an attempt to set up clinics for the treatment of addiction. While some clinics were plagued by problems such as confusion and poor planning, Nyswander claims that none of them were given adequate time to work out their difficulties, Rather, they were all closed by the Treasury Department.[154] (As lately as 1955, the alledged "failure" of these early clinics was used as the argument to oppose a plan for outpatient dispenaries proposed by the New York Academy of Medicine.[155]) With the closure of these facilities the addict was cut off from both private and public out-patient treatment. In 1930 the Federal Bureau of Narcotics was created.[156] From this point on, federal law became even more strict with regard to heroin treatment - and state laws modeled after federal ones were enacted. Lindesmith asserts that the Bureau was instrumental in securing the passage of the Uniform Narcotics Law[157], prepared between 1927 and 1932. Accepted by most states, this law set up federal-type systems on the state level, and promoted cooperation between various levels of narcotic officials. Prison sentences were not uniform; states chose various penalties. However, in 1951 (the Boggs Bill[158]) and in 1956 (The Narcotic Drug Control Act[159]) when the federal govenment escalated penalties for drug offenses, most states followed suit on their legislative level. Even in the 1960's - when socially enlightened, progressive

type causes were in vogue - there was little change in the government's condemnation of the heroin user. The Narcotic Addict Rehabilitation Act of 1966 - which at least directs funds for the construction and operation of treatment centers - is a civil committment program which raises serious questions with regard to the civil liberties of the addicted person. According to the New York Civil Liberties Union:

> The basic proposition underlying it is that addicts are dangerous to others. Because they are dangerous they must be removed from society and certified to places where they can inflict no harm. The fallacy in all this, is that in the absence of any other evidence, addiction, standing alone, is no proof of dangerousness. To deny a person liberty, to confine him for a period of up to three years, when he may not constitute any threat at all to society, should shock the conscience of anyone dedicated to freedom.[160]

Maxine Kenny, in "Drug Law History, Politics, and Prohibition", gives an account of how NARA was translated into "lock-then-up-for-their-own-good" programs in several individual states.[161] From the enactment of the Harrison Act, through even the liberal push of the 60's, the government's actions with regard to opiate use discouraged therapeutic heroin careers. Physicians were frightened away from addict-clients; dispensaries were closed; only prison-like treatment facilities received substantial assistance. Yet suddenly, in 1971 the government appeared to have done an "about-face" - it began to direct vast resources toward innovative and voluntary drug programs, thus facilitating the development of therapeutic heroin careers.

When the govenment's position on heroin treatment is examined closely, it appears to reflect less of an "about-face" than a "slow-turn." The sensational allotments to heroin programs in 1971, the creation of a federal agency to deal with addiction - these, to be sure, happened with sudden drama. But slower and less dramatic changes occurred earlier in the atti-

tudes of and public statements of leaders in government. Kenny traces some interesting changes in the pronouncements of public officials, during the period when middle-class heroin use began to draw attention:

> Even President Nixon, who as recently as the summer of 1969 was calling for increased punishment of drug users, has realized such laws can be applied to the sons and daughters of his constituents . . . After due consideration he said in a message to Congress in the fall of 1969: 'It has become a common oversimplication to consider narcotics addiction or drug abuse to be a law enforcement problem only.'[162]

Kenny claims that Nixon's change in position is "nothing" compared to those of other politicians. She cites Governor Rockefeller, of New York:

> The same Rocky who in 1967 ran unabashedly on a 'sweep the addicts off the streets of New York' platform told a conference on drug abuse in 1970: 'Curing addiction in one of the toughest jobs in our society. It would be a tragedy if their were those who tried to make political gain from the suffering and degradation of narcotics addiction.'[163]

As the 60's drew to a close, changes in attitudes of officials, and their subsequent non-intervention in some areas, permitted resources to flow toward heroin treatment situations. In other words, while large govenment subsidies had not yet begun, innovative approaches to treatment were permitted to seek and except support from both the public and private sector. The use of methadone presents a good example. Fort explains what methadone is:

> . . . methadone, or dolophine, was synthesized during World War II and came into general medical use after 1945. Its general actions and properties are similar to those of morphine, and it has similar side effects . . . Habituation, tolerance, and addiction can develop with regular use, but seemingly more slowly than with morphine so that its overall abuse potential must be judged as lower. Its major use is in medicine as an analgesic and in the treatment of those other narcotics, especially heroin. For the latter, methadone is used in two ways, one involving substitution and gradual withdrawal as the treatment of choice for the abstinence syndrome; and the other, involving long-term administration to former heroin addicts and known as the methadone maintenance program.[164]

In March, 1967, the first experimental methadone maintenance program devised

by Dole and Nyswander was expanded, with New York City support.[165] Permission for programs to provide daily doses of narcotics to chronic addicts had been obtained. According to Dr. Nyswander:

> When my book came out in 1956 I was considered a heretic whose license should be taken away. Now look at the sources of support those of us are getting who believe that an addict doesn't necessarily have to be 'clean' to become a functioning member of society.[166]

Other states allowed limited trials for maintenance programs. In California, for instance, although no money was appropriated for programs, two bills signed in 1970 at least made them possible. These bills legalized methadone treatment outside of penal institutions or state mental hospitals.[167] The politics of methadone programs have come under considerable fire and remain highly controversial.[168] Some sources would consider drug maintenance no more progressive than the civil committment programs spurred by NARA, since they run the danger of establishing "the state as your connection". Nevertheless, what must be remembered in assessing the government's permissiveness in allowing experimental programs is this: in supporting regular doses of opiates for confirmed addicts, the government virtually withdrew a group of Supreme Court decisions dating back to the Webb case; the pre-Harrison Act practice of maintaining addicts was given new life. Other programs proliferated during the period from 1967 - 1970. Free clinics, half-way houses, and the like remained essentially alternative drug services without the financial backing of the state - but the fact that practitioners in these settings were less harrassed and intimidated than in previous years reflects the change in attitude of the government. In San Francisco, for instance, such programs as the HAMC one, Half-way houses (Walden House, Reality House, etc.) were left in relative peace. Public Health officials, once hostile to HAMC, attempted to form some positive relationships with the clinic's MDs. As lately as 1971, there were instances of governmental harrassment of

physicians treating addicts (for example, the accusations of unprofessional conduct filed against Drs. John Koning and Samuel Frazier for issuance of non-opiate prescription drugs to addicts in Corona, California[169]). But such cases such as this one were shocking precisely because they were out of step with the times. Doctors and other workers treating addicts were to be consulted with - not prosecuted.[170] Treatment of addicts would have been allowed to continue on a small scale, no doubt, without massive U.S. aid - and a certain number of therapeutic heroin careers would continue to develop. But treating addicts is an expensive proposition - hence, substantial sums directed by government to medical control of addiction contributed enormously to facilitating therapeutic heroin careers. In 1971, President Nixon called for the establishment of a Special Action Office of Drug Abuse Prevention, to provide a central agency overseeing drug-related programs. Jerome H. Jaffee - who pioneered methadone use in Illinois - was named to head the Office. The Washington Bulletin (july 28, 1971) gives the figures - the amounts of money - requested by the President for drug programs. Overall, a total of $371 million was provided to carry out Nixon's programs. Some of this amount goes to the support of non-therapeutic heroin careers - police activity, herbicide research, and so forth. Even so, a full $105 million was appropriated "solely for the treatment and rehabilitation of drug addicted individuals." $14 million more was directed toward Veterans Administration programs for expansion of clinical facilities. "Education and training in the use of dangerous drugs", an activity of many treatment programs, received $10 million. Altogether, from the federal government alone almost 130 million dollars have been directed toward the medical treatment of addicts. The creation of the new federal agency and the generous fund allocations appeared to be sudden moves - to come quickly on the heel of news dispatches about addiction among the troops in Southeast Asia.

Perhaps this was the thrust behind the federal move to support treatment. But it can be seen that in the late 60's - with middle-class addiction on the rise - attitudes about heroin had softened. Through both changes in public attitudes - hence non-intimidation of practitioners - and through large amounts of money, the government has channeled resources into heroin treatment situations.

Resources From Medicine

The medical "establishment" - that is, the physicians organizations, the professional groups, the medical-industrial interests who strongly influence the formulation of health care policy in the United States - has shifted position with respect to the addict. Or, as it will be shown, they have re-shifted position. Once the problem of heroin abuse was defined as lying outside the sphere of medical responsibility: it was a matter for the police and the courts to deal with. Presently, the medical establishment sees addiction as very much their concern - so much so that they have voiced resentment of "administrative and legislative encroachment"[171] into their occupational territory. If drug control rests in the hands of the law enforcement establishment, little drain is placed on medical resources. However, when drug control becomes a matter of treatment, it draws manpower, money, and support from the general pool of medical resources. Hence, the redefinition of addiction as a medical matter during the recent past has provided an increase in resources in the drug treatment area. The therapeutic heroin careerist can rely on continued support from the powers that be in organized medicine.

Before passage of the Harrison Act, doctors routinely prescribed opiates for addicts. Addicts, of course were different then. While no records were kept which give a complete statistical picture of the pre-1914 addict, the studies of Kramer [172], Lindesmith[173], and others indicate that

he or she (and women outnumbered men two to one[174]) was white, middle-class, and law-abiding. The only minority group represented disproportionately among addicts was Asians. It was not until after the criminalization of opiate abuse, that black and adolescents became "typical" addicts. According to the records of Dr. Charles Terry, who treated addicts from 1911 to 1914, not much was known about withdrawing addicts, or about "curing" the addiction.[175] But at least the addict had access to medical help for sustaining of his habit - hence avoidance of suffering - or for attempting a cure. Kramer asserts that the Harrison Act need not have precluded further ambulatory care for the addict. He feels physicians failed to resist restrictive moves by the Treasury Department:

> Had American physicians been more determined to resist unfair and politically inspired interpretations of the Act, it seems likely a reasonable approach could have been found to supply those addicts intractable addicted in such a fashion that serious abuses of the system would have been avoided. When doctors lost their privilege of prescribing for addicts they lost also the opportunity for treating addicts whether with drugs or without. Although hospital treatment was permitted there were virtually no hospital facilities. A breach was made between the addict and the physician which has been narrowed only recently.[176]

To be fair to physicians, it has been suggested that medical protest was dealt with severely. King, referring to early court decisions, says the State had launched a "reign of terror":

> Doctors were bullied and threatened and those who were adamant went to prison. Any prescribing for an addict, unless he had some other ailment that called for narcotization, was likely to mean trouble with the Treasury agents.[177]

Through lack of resistance, or fear of Treasury Department terrorizing, doctors washed their hands of responsibility for a population of persons who were no longer to be defined as patients. Lindesmith reveals that "privileged addicts" were treated privately[178], but the criminalized addict had no recourse to medical assistance. The American Medical Asso-

ciation was instrumental in discrediting the early narcotic clinics which the Treasury Department closed in 1920. Lindesmith claims that the prohibitionist tone of statements issuing from the AMA strongly supported moves against treatment. For example, he cites a member of the AMA committee on narcotic drugs:

> The shallow pretense that drug addiction is a disease which the specialist must be allowed to treat, which pretended treatment consists in supplying its victims with the drug which has caused their physical and moral debauchery . . . has been asserted and urged in volumes of literature by the self-styled specialists.[179]

Official pronouncements did not always have the zealous ring of the one just quoted, but the medical establishment kept "hands-off" heroin treatment for many years to come. As an outgrowth of this policy, little is known today about addiction. Hentoff quotes Dr. Theodore Rosenthal, former Narcotic Coordinator for New York City:

> For two generations, American medical schools have lost all interest in dealing with the problem. The average medical student goes through medical school, internship, and residency - and I include those is Grade A schools and hospitals - and by the time he gets into private practice, he hasn't learned a single, solitary damn thing about addiction. When a sick addict knocks on his door looking for help, he knows only one thing - kick him the hell out.[180]

Some events in the early career of Dr. Marie Nyswander serve to illustrate how very recently addiction treatment remained outside the scope of medical education and practice.[181] Today Dr. Nyswander is recognized as a prominent and innovative physician - precisely because of her work with addicts. However, she remembers that in the 1950's, by virtue of having some experience with addicts at the Public Health Service facility at Lexington, Ky., she was one of the <u>three</u> physicians in New York City with some knowledge about withdrawal from opitates. Her first paper on that subject established her as an "authority" on the subject. Since addiction even then was not defined as a disease, withdrawal was not defined as part of standard medical practice.

Beginning in the 1950's, the medical establishment began to modify its stand on addiction. Opiate dependence was redefined as a disease - hence the addict again could claim some attention from health workers. The changes in official opinion in New York State provide a good illustration:

> In 1954, the New York State Medical Association proposed to the American Medical Association that narcotics clinics be established under the auspices of the Federal Bureau of Narcotics. . . The next year, the New York Academy of medicine advocated, as one method of treatment of addiction, that drugs be supplied to addicts at low cost under federal control . . . In February, 1962, the Medical Society of the County of New York ruled that physicians 'who participate in a properlly controlled and supervised clinical research project for addicts on a non-institutional basis would be deemed to be practicing ethical medicine . . . The New York Academy of Medicine, in another report on drug addiction , in April, 1963, again reccomended strongly that addicts come under medical supervision and that a doctor should be able to prescribe drugs legally if they appear in his judgement to be necessary.[182]

Hentoff states that the medical establishment remains basically opposed to legalization of opiates, and ambulatory programs which dispense them.[183] But, as he points out, their reasoning in taking this position is that maintenance does not really "cure" the addiction. This is an important point: the physicians do not reject prescription of opiates because of legal factors; rather they assume a negative stance toward one form of treatment for a group which they have defined as diseased - a population for which, as doctors, they bear some responsibility. Psychiatrists, for example, tend to prefer psychotherapy to maintenance on narcotic drugs as the treatment of choice for addiction. Thus, they might oppose legalization of drugs - but <u>not</u> drug treatment. Indeed, in 1969 the American Psychiatric Association published a position paper on "Drug Abuse and the Need to Separate Medical Research from Law Enforcement in Combatting It."[184] Some doctors have embraced the idea of maintenance programs wholeheartedly. There are such programs in existence in many major cities - New York[185], San Francisco[186], Chicago[187], and elsewhere - which have support and access

to manpower through the medical establishment. For those who oppose this type of treatment, there is still a role to play. Spokesmen for academic medicine urge allocation of time and resources to research.[188] Doctors and drug companies search for chemical agents which will reduce the care of the addict to the kind of office-and-pharmacy practice which is employed for other health problems. Mandel states:

> . . . the modality pushed by such medical establishments would be a tool with which the doctor feels most comfortable: chemical agents. Agents such as methadone, whether in fact it turns out to be operating by blocking or what appears more likely nowadays by substitution, cyclazocine, and other drugs have become the avenue with which the medical establisment has become involved with the treatment of the junkie. Funding for such programs are now, even at a time of short money supply for new programs, available both nationally and locally. A remarkable amount of staff support, research support, and other fringe benefits that come attendant on the organization of narcotics treatment programs within a medical context make the setting up of such organizations very seductive indeed.[189]

Further, doctors are voicing resentment at the types of programs -self-help services-which feel they can do well without medical assistance:

> Numerous self-help groups formed initially on the model of Alcoholics Anonymous and evolving to Synanon, Daytop Village, Narcotics Anonymous, and numerous indigenous worker staffed and community supported programs have grown like topsy over the past decade . . . Running principally on the 'mystique of the dope fiend' (which I am beginning to feel has the same validity as the expectation that the trained analyst in fact knows more about people than other people), the self-help movement has pretty consistently attempted to disenfranchise the medical establishment as competent to deal with these problems,created and promoted resistance to pharmacological substitutive or blocking treatment strategies, and . . . has more or less sold the idea to all of us that the only people who can treat or understand dope fiends are other dope fiends.[190]

The medical establishment, it seems, is not only willing to invest it resources in the treatment of heroin dependence - it is willing to compete for that priviledge. The AMA, via its newsletter, The American Medical News, has given attention and support to programs like the one at the Haight clinic.[191]

Since the AMA maintains its anti-free clinic position to date, it must be assumed that it was the heroin treatment which they found attractive enough to cover, and to report on in a positive manner. Pfizer Drug Co. contributed $24,000 to help support a meeting of the National Free Clinics Council - and at that meeting Dr. John Kramer (Associate Director of Program Development of Nixon's Special Action Office On Drug Abuse Prevention) urged the Council to accept $1 million of funding for treatment programs.[192] Clearly, the medical establishment wants part of the heroin treatment action, and is willing to invest some its influence, money , and manpower in drug treatment programs. Of course, the medical powers do not have to use their own resources exclusively. The funding now available through government comes to programs from agencies such as HEW, NIH, and NIMH. The individuals who control these agencies and direct funding to individual programs are, by and large, MDs. Thus the medical establishment directs government money to heroin programs. We have seen that on the federal level alone, appropriations for heroin treatment run to the hundreds of millions of dollars. The new definition of the addict as a patient - and the investment by the medical establishment of time, money, manpower, and attention in drug programs, creates infinite opportunities for therapeutic heroin careers

Visibility of Therapeutic Heroin Careers

All the other factors which make for therapeutic heroin careers have a combined effect: they make the worker with an addicted clientele highly visible. The worker treating addicts inherits some of the dash and glamour of the early poverty program and community mental health years, as well as the excitement of the free clinic movement. Medicine and government have their eyes on him, giving him support and attention. Hence he is visible to a wide audience. Once, the two routes to prominence in health care were

closed to the individual dealing with addicts. His patients were poor - he could not have a lucrative practice. The health professions were not concerned with addiction - he could not use his expertise to achieve professional prominence. Further, he ran the risk of condemnation, perhaps even criminal prosecution, from society at large. Today, in contrast, the health worker with an addicted clientele is highly visible to an admiring audience. He has the attention of the public at large; he enjoys the respect of his colleagues. He is an "expert" on a national problem of the highest priority.

Public Attention

The visibility of the individual pursuing a therapeutic heroin career can be seen in his presence in public media, in professional publications and gatherings, and in high level positions. Public interest in drug treatment is wide-spread and intense. The average man on the street probably could not say who heads up the Cancer Institute, but if he reads the papers he might surmise that Jaffee is Nixon's man on heroin. Daily newspapers carry headlines about heroin with impressive frequency. During the past few months the San Francisco Chronicle has regularly carried articles with titles such as the following: "Broad Attack on Bay Heroin Traffic"[193], "Heroin Casts Pall Over Berkeley"[194], "Success at Haight Clinic"[195]. Feature stories on newscasts give attention to methadone programs and their struggles, to self-help programs, and so forth. ABC alone, during winter, 1972, has offered publicity to a private maintenance program beset with financial problems (Fort Help) and to an addict-residential program (Chrysallis), in their news broadcasts for the San Francisco area. Public service messages on TV, radio, posters and billboards deal frequently with "dope" - hence the latent message that he who treats addicts is a person of rare ability and social value. Drug treatment agencies devote time and energy

to public speaking, and have no need to solicit audiences. Parent's groups, school teachers, people from diverse backgrounds all feel they need information about addiction. The educational television station in San Francico, in collaboration with a national network, set up a program last winter which involved recruiting "drug experts" to talk to community groups after telecasts of drug education films.[196] Books published by drug authorities for a general readership sell well. Consider Joel Fort's The Pleasure Seekers, or David Smith's Love Needs Care. An advertisement for Smith's book, from the book review section of a Sunday supplement, shows the kind of exciting knowledge the "drug expert" is assumed to possess:

> Begun in San Francisco, in the Summer of Love, 1967, the clinic has become a model . . . The complete, gripping account of its pioneering fight against drugs and disease is now told by one of its co-founders in collaboration with the former editor of San Francisco magazine.

Professional Attention

Heroin publications also catch the eye of the professional community. Journals carry drug articles as a matter of course. Publications diverse as Family Process[197] and Emergency Medicine[198] feel an obligation to inform their readership about addiction. Heroin business is everyone's business it would seem. Technical material or theoretical articles are not all that reach professional audiences. Newsletters and the like also present material about treatment programs: the AMA News, for instance, on December 21, 1970, focused most of its coverage on drug treatment in New York and San Francisco. Sometimes "coverage" is highly critical. For example, the Health Policy Advisory Center, in the February, 1972, issue of Health/Pac Bulletin, strongly criticizes the influence of drug companies and governmental drug agencies in free clinics. They lambast the "drug experts" who use their reputations to achieve personal prominance. Nevertheless, they simultaneously increase

the visibility of those experts with statement such as: "Whether you like it or not, Smith is seen as the expert on free clinics and the expert on drugs." An enormous amount of time at professional gatherings is being given to drug-connected subjects. By 1970, New York City hosted the third national conference on methadone. Three heroin-oriented meetings have been held in San Francisco in the past year: The National Heroin Symposium[199], the first International Symposium on Hard Drugs[200], Drug Abuse 1972: A National Symposium[201]. Even the midwest participates: by 1970 the University of Michigan sponsored a Conference on Drug Abuse.[202] The therapeutic heroin career - especially the professional one - gets noticed, is taken seriously. A good number of health workers recieve academic titiles or government posts to support their work. A quick glance at the authors of articles in the "heroin" issues of the Journal of Psychedelic Drugs (Fall and Winter, 1971) reveals a liberal sprinkling of "professors", "clinical faculty" and so forth after the names. A worker treating addicts may get attention - be visible - whether or not he accomplishes anything in the way of "cure". Most new programs could not do worse than the federal residential programs (with a cure rate of 3% [203]) - but no ones has as yet established a "sure-fire" treatment. Methadone programs maintain addiction - and it is not clear whether methadone blocks heroin or merely substitutes for it.[204] Self-help groups have great success with those addicts who stay in their programs - but this is a very small percentage of addicts at large.[205] Nevertheless, all these programs are encouraged to publicize themselves through speaking engagements, journals, and so forth. According to Yorick:

> . . .each psychosocial theory of the cause and cure of the habit doesn't have to be valid: what is valid is the ability to sell the theory, to get funding for the theory, to convince some legislator (and possibly addicts) that the program works, to demonstrate some success and to generate in the wake of failure still further programs.[206]

Prior to 1950, the federal hospitals which treated addicts knew something about gradual withdrawal - yet no one knew of their work. Undoubtedly, single practitioners treated addicts occasionally - but they were liable for prosecution if they reported on their activities. The individual treating addicts was, for practical purposes, the invisible man. Today, association with heroin addicts wins public attention and professional recognition. Any treatment method for addicts is likely to find audiences and journal space. The new visibility of the therapeutic heroin career helps attract, recruit, and train health workers for work with addicts. Hence, a care-taking group is ready to meet the needs of the epidemic numbers of new American addicts.

Heroin Careers in San Francisco

In reviewing the conditions giving rise to new sick and therapeutic heroin careers, it can be seen that all these conditions converge in the San Francisco Bay area. San Francisco, like other cities, has a high rate of middle-class drug abuse and "legal" addiction. In fact, Fort claims that there are more alcoholics in San Francisco than there are narcotics addicts in the entire United States.[207] The movement later to be termed the "counter-culture" of course reached its height of sensationalism in the Haight Ashbury district, during the summer of 1967. Since that time, the Haight area has been purported to house a lively street trade in illicit drugs. Within this flourishing market, the person with a predilection toward drug abuse has access to heroin. With regard to the problem of military addiction, the large number of Army, Navy, and Airforce bases near San Francisco which serve as points of departure and return from Southeast Asia ensure that this city will contain more than its share of GI addicts. According to Jon Stewart, who studied drug abuse at the Navy's Treasure Island Base in San Francisco, "over 5,000 addicts will be settling in the

San Francisco area alone during 1971."[208]

Conditions basic to therapeutic heroin careers converge here, too. The free clinic movement - a final development in the rise of store-front health services - was born in California with the establishment of the Haight Clinic in 1967. Indeed, at the time of Schwartz's survey, almost half of the clinics compromising his national sample were in California - with 21 clustered in the Bay area.[209] Clinics providing drug treatment services have access to increased resources directed toward them by medicine and government. For example, the practice of sending health science students to free clinics for clinical training has provided the Haight Clinic with additional manpower. Government, at its lowest level of support, at least practices "benign non-intervention" in allowing drug services to function. At best, officials hold out promises of grants and financial assistance. In fact, in August, 1971, the Haight Clinic's heroin program was awarded an eight-year grant of $320,000 per year from the National Institute of Mental Health.[210] Certainly therapeutic heroin careers in San Francisco are visible: several physicians at the Haight Clinic hold University of California appointments; the heroin service hosts national conferences; a book about the clinic has met with success from the lay and professional public.

Out of all these conditions, it can be seen that heroin careers emerge. Thus far, sick and therapeutic heroin careers have been conveived of as developing in a parallel fashion - that is, proceeding reciprocally but separately. They have been distinguished in terms of the conditions or forces exerting primary impact upon them. For example: the war primarily affects addicts: resources from medicine primarily affect workers, and so forth. But in order to pursue their careers further, the addict seeking care and his therapist cannot continue to move along parallel lines. Rather

they must interact. Their two career paths must cross each other at the intersection of the treatment service. The Detoxification Section of the Haight Ashbury Medical Clinic can therefore be seen as an institutional juncture where both sick and therapeutic heroin careers are pursued. This "juncture", or site of interaction for heroin careers, is the Setting of this study.

CHAPTER 2: THE SETTING

The setting of this study, the Heroin Detoxification Section, is at the most basic level a collection of rooms. More meaningfully, it is a place where health services are administered - a site of interaction for sick and therapeutic careers. It is additionally a place where roles and functions exist - a site of social organization. On a level most removed from the concrete, it is part of the history of both a neighborhood and a health care center. The setting will be considered on both abstract and concrete levels. First, the history of the Haight Ashbury neighborhood and the Haight clinic will be discussed. Next - a word about the structure of the heroin service itself: work roles, functions and so forth. Third, a concrete description of the site will be presented - a spatial and temporal map of the heroin service. Finally the actors will be introduced: clients and workers.

History

Accounts of the Haight Ashbury Clinic's history are available - several are written by individuals on the clinic staff.[1,2] Thus, chronicles of the Haight Ashbury district, the free clinic, and the heroin service must be considered to be colored by some degree of subjectivity. Perhaps it is for this reason that they tend toward flamboyance. For example:

> It was 1967 and the Summer of Love was attempting to transform the tenements of the Haight Ashbury into the shrine of what was to be the 'New Society"; a society based on love and freedom and equality of all peoples. But during this ritualistic exercise no one dared imagine that the unfolding drama had that same element of sad beauty reminiscent of the games children played at the entrance to the gas chambers.[3]

> In the fall of 1968, San Francisco's Haight Ashbury district looked like a disaster area. Most of the Victorian houses, flats, and apartment buildings lying in the flatlands . . . had deteriorated badly,and many property owners had boarded

> over their windows and blocked their doorways with heavy iron bars. The original residents of the Haight were in hiding, in self-imposed internment. 'We're frightened', says one member of the Neighborhood Council. 'The Haight Ashbury has become a violent teenage slum.'[4]

> <u>In the history of the recorded epidemology of drug use there has never been the concentrated pattern of multiple drug abuse as that seen and documented in the Haight-Ashbury section of San Francisco from 1967 to the present.</u>[5]

Subjectivity aside, accounts of the clinic's history point out the significant events which affected both the neighborhood's development, and the clinic's evolution. Using these sources, it is possible to get some feeling for the past of the Haight area, the history of the Haight clinic complex, and the growth of a separate detoxification service for addicts.

<u>The Neighborhood</u>

Smith and Luce, in Love Needs Care, trace the changes in the Haight Ashbury from the end of the 19th century, to the present.[6] They point out that originally the district served as an exclusive site of home construction for wealthy San Francisco families. Attractive houses were built on the hills which form the "upper" limits of the area; markets were to be on the flatlands - that is, the area where Haight street runs from east to west. According to the authors, traffic and commerical development interfered with the exclusivity desired by the original inhabitants. However, they maintain that from 1900 - 1940, the Haight Ashbury district remained a thriving middle-class community - predominantly white, undistinguished by "spectacular" residents or events. The effects of the second World War changed the style of Haight Ashbury living: an influx of war labor demanded that housing be provided, that new kinds of residents be accomodated. Older homes were converted into the flats and apartments that many residents live in today. Smith and Luce contend that during this wartime period, first white workers, and then Eastern Europeans and Asians were assimilated into the neighborhood.

Urban development, pushing black people out of other parts of San Francisco, is credited by the authors with creation of a racial mixture of blacks and whites in the Haight. They tell how community groups took action to block freeway construction, and to preserve the integrated quality of the district. It was this community work, and the mixture of races and classes, they propose, that lent the area a "cosmopolitan" flavor - and hence attracted persons who were to create "a small and unpublicized bohemian colony."[7] Smith and Luce see these bohemians as the spiritual forbears of the people who were later to be termed "hippies". (The analysis in Love Needs Care leans heavily on psychopathological statements about both groups - for a better sociological analysis of the "beats", and their relationship to drug use, alienation, and so forth, the reader is referred to Polsky's "The Village Beat Scene: Summer 1960".[8]) Several sources point out that at least some Haight residents took steps to try to plan for the influx of young people expected in 1967.[9,10] Sensationalization of the Haight was at its peak; residents feared the neighborhood was ill-equipped to accomodate thousands of visitors. City officials, however, were unsympathetic to the needs of the district, and refused to support service programs for those visitors. After serving as the reluctant host for a transient summer population of over 100,000, the neighborhood had indeed "run down":

> . . . over fifty grocers, druggists, and other straight merchants had moved off Haight Street since the 1967 Summer of Love; property values had fallen twenty percent in the same period, and none of the remaining businessmen could find buyers for their stores.[11]

As shown earlier, the clinic writers tend to emphasize the "desolation row"[12] character of Haight Ashbury, post 1967. It must be agreed that the drug trade on Haight Street has thrived more than local businesses; that there is an unsavory aura about much of the shopping district; and that the crime

rate there is high.[13] However, in concluding this review of the neighborhood's history, a few other items should be mentioned. First, the events from 1967 to the present were not all destructive - as evidenced by the existence of the clinic itself. The Haight Ashbury district continues to house a Switchboard service, a Children's Center, a legal aid facility, a Woman's Center - all positive community organizations. Moreover, business is improving on Haight Street:

> There are 165 storefronts along Haight Street. In August of 1969, 40% of them were vacant. In November of 1971, 35% of them were empty. By May of this year, however, there were only 40 vacant storefronts for a vacancy rate of 25%.[14]

Further, while Haight Street dominates the center of the district, its decay does not reach out to the boundaries of the neighborhood, where fine old Victorian dwellings are still to be found. In short then: the once exclusive Haight Ashbury district has seen some common urban changes; it has also seen a catastrophic alteration in property values and commercial possibilities in the area of Haight Street. Nevertheless, the district continues to provide some attractive housing and community services for its residents.

The Clinic Complex

The Haight Ashbury Medical Clinic was founded in June, 1967, by David Smith (a physician and pharmacologist), Robert Morris (a pathologist), and Robert Conrich (a local businessman).[15] The founders gained non-profit, tax-exempt status for the clinic by joining a parent corporation: "Youth Projects, Inc."[16] Several sources point out that these three individuals were not the first to try to set up some kind of medical facility in the Haight for the summer population. Community groups attempted treatment of minor problems and drug reactions independently, concerned physicians appealed to the public health department for a city-supported treatment

facility.[17] With community groups overburdened, and no help in sight from the public sector, Smith reports that he was prevailed upon to establish a treatment service.[18] Clyde Gardner, former Chief Adminstrator of the treatment service, has written "A Special Study of the Haight Ashbury Medical Clinic"[19] which follows the evolution of the clinic complex. He sees the organization's development as a series of responses to changing consumer needs, punctuated by financial crisis and temporary closings. To begin with, a volunteer staff of local professionals and lay workers treated minor medical emergencies. As consumers arrived demanding counseling services, they attracted psychotherapists - thus creating a Psychiatric Section. By summer's end an estimated 10,000 patients had been treated[20] - and the clinic had depleted its fund of donations. Thus the service closed for several weeks in the fall of 1967. It reopened in time to meet the demands of a new sort of customer: the user of intravenous amphetamine. The clinic secured a large grant to study this type of drug problem (The Amphetamine Research Project[21]), and consequently opended a Drug Treatment Section to provide services for the amphetamine users. It was toward the end of 1967 that some workers devised the idea of staging a huge rock concert as a benefit for the clinic. Planned for Labor Day, at the San Francisco Palace of Fine Arts, this concert was intended to refurbish the clinic's finances. Gardner presents a detailed account of the planning - and the subsequent failure of the benefit. He blames the poor outcome on sabotage by city officials, as well as inadequate organizational work. At this point the clinic was heavily in debt and closed its doors once more. According to Gardner, donations arriving at the opportune moment allowed the service to reopen in the fall of 1968. He claims some types of services were offered on a smaller scale than previously, but says the Medical, Psychiatric, and Drug Treatment Sections were all functional. In June, 1969, the clinic rounded out its services with the establishment of a Dental Section, where dental students from

local schools provided care. Gardner, and others[22] mark November, 1969, as a significant date in the clinic's history: at this point heroin began to usurp amphetamine as the drug-of-abuse in the Haight. The clinic's Drug Treatment Section offered care to some of the addicts who arrived in search of detoxification services. The Drug Treatment staff operated out of the basement of a building across the street from the Medical Section building, sharing a house with the psychiatric Section and Publications Office. Other addicts were treated on the original clinic premises: the building where medical and dental services were provided. It was the froup of addict treaters in this building who were to become the Heroin Detoxification Section.

The Detoxification Section

From the time of its inception, November, 1969, Heroin Detoxification was destined to become a large-scale operation. Like other sections of the clinic, the heroin service was born out of consumer need. However, its special clientele creasted differences. Unlike the Amphetamine Research Project - whose subjects disappeared in late 1969 - the heroin service's clients proved to be enduring. And unlike the Dental Section - which provides "one-shot" treatment to a changing population - the addicted client returns over a period of time. Because the workers at the Heroin Detoxification Section treat a physiologically addicts client, they are assured of an expanding and constant group of patients. According to Luce and Smith[23], it was in October, 1969, that addicts began to place a strain on services at both the Drug Treatment and Medical Sections. They report that the chief of the Medical Section requested that Dr. George Gay set up a program for addicts. This was formally established as a clinic "section" in November. As the heroin section originally functioned, screening was carried out by

workers at Drug Treatment, and medications were dispensed (non-narcotic oral medications for symptomatic relief of withdrawal discomfort) by Dr. Gay and his associated, across the street in the Medical Section building. During its first ten months of operation, the Heroin Detoxification Section gave service to more than 1000 patients -fifty per day.[24] Eventually, the Drug Treatment people were to drop out of the picture altogether: they formed an independent drug treatment facility and severed ties with the Haight Clinic "family". Luce and Smith discuss the separate history of Drug Treatment in Love Needs Care.[25] Suffice it to say here that after a series of meetings between the two heroin groups in December, 1970, it was acknowledged that ideological differences and disputes about money were not to be resolved. Dr. Gay's group became the only section of the Haight Ashbury Clinic serving the needs of heroin addicts. It was at about the time of this schism that the Heroin Detoxification Section moved into its own house, thus establishing the third building in the Haight Clinic complex. Here, the only treatment was heroin detoxification. By June, 1971, this facility had treated - and medicated - over 1800 clients.[26] In order to support the enormous expense of medicating addicts, the detoxification workers compiled statistics on their clients to use in applying for funding. In the process, they have become well-published and well-known. Large scale funding was not in the office until recently. During the period when this study was conducted, the service still lived a hand-to-mouth existence, a scrounging for donations, gifts, public speaking fees, and so forth. But the hope of massive grant support was a constant theme in worker discussions through 1971: the possibility of imminent assistance boosted morale. Coinciding with the end of this study, the heroin service was awarded a huge grant from NIMH. Its stability - indeed, its options for expansion of services - was assured.

Structure

A most striking feature of the organizational structure at the Detoxification Section, during the period of this study, was how very little there was of it. Gardner, who reports on the clinic from the perspective of an administrator, finds that the rules for structure-analysis do not apply here:

> When the writer was invited to join the staff of the Haight Ashbury Medical Clinic and given the initial, but undefined responsibility to organize and coordinate the activities of the clinic, he expected the task would require a vast amount of effort, but expected no major difficulties not ordinarily found in such an undertaking. He expected to accomplish this task, as he had in the past, by utilizing the problem solving approach and by application of the principles of basic administration, i.e., planning, organizing, staffing, directing, coordinating, ordering, reporting, and budgeting. Needless to say, the writer had taken on a task where 'normal' administrative procedures did not apply.[27]

Gardner had difficulty finding the expressed organizational objectives of the clinic. He does offer a list of the goals of the original medical section - which he admits were largely lifted from the charter of Youth Projects, Inc.[28] - but he fails to discover any stated committment to specific objectives and procedures. He feels the clinic's organization has never been outlined in a conventional manner:[29]

> . . . little emphasis was placed upon the definition of duties and responsibilities of any clinic personnel and therefore, the operation of the clinic continued to be organic in nature, and at times, chaotic.[30]

Some semblence of formal structure of course derives from the heroin service's - and all the clinic's sections - tie-in with their parent corporation. Youth Projects, Inc. has a Board of Directors, composed mainly of white male professionals. Below this board, the clinic complex itself has a Director (an MD), and an Executive Sommittee, composed of representatives from each clinic section (Medical, Psychiatric, Dental, Heroin Detoxification, and Commune Health divisions of the clinic). Until spring, 1971, these

representatives were largely professionals. A later move to "democratize" the Executive Committee allowed an additional non-professional representative from each part of the clinic to join the Board. It is through this Executive Committee that decisions filter down to the "rank and file". But the roles and functions of individual workers are largely left to develop at will. For example, some people received subsistance salaries (about $200 per month), and might be assumed to be paid for a delineated function. Yet one person might accomplish on a volunteer basis what another worker is paid to do. Looking at the heroin service, it can be seen that what formal structure - formal role assignment - there is grows out of legal restrictions on medical practice, and out of the need for a stable economic arrangement. Other roles and functions are assigned informally, and according to criteria so flexible that they almost elude definition.

Formally Assigned Roles

In a treatment situation like heroin detoxification, which relies so heavily on the use of medications, certain legal standards with regard to drugs must be maintained. Also, where treatment is expensive and money is scarce, someone reliable must have ultimate responsibility for funds and spplies. Hence, the two important formally assigned positions at the heroin service are those of MD and administrator. The MD is the only type of worker authorized to perform certain essential tasks: writing of prescriptions; performing certain emergency procedures (such as intubation on administration of intravenous narcotic antagonists); diagnosis of medical problems of addicted clients (for example, cardiac problems or hepatitis). In addition, a physician must oversee all dispensing of medications: any doling out of pills by other types of workers (i.e. nurses, counselors) is done under the legal cover of routine "orders". The administrator need not

be a professional, nor is his role bound by legalities or matters of licensure. Nevertheless, he too is a single individual to whom certain crucial functions are assigned. First of all, he keeps track of clinic finances: he knows what the bank balance is and how far it will go in meeting the expected expenses; he signs checks; he pays those individuals who receive salaries; he is aware of sources of income (donations, possible grants, etc.). He also checks the ebb and flow of supplies: he knows what medications are in low supply, at what rate they are being depleted, and at what cost they may be replaced. He knows about debts - about how the Section stands with regard to the electric company, the pharmacy, the telephone company. He, like the MD, has special and discrete knowledge; he bears formal responsibility for important tasks which must be accomplished.

Negotiated Roles

Other roles and functions at the Detoxification Section are not necessarily less precise or important than those of the administrator and the MD but they are not formally assigned. Indeed, there are workers at the service with impressive titles - Coordinator of Psychological Services, Chief Nurse, Research Associate - but these are negotiated titles. The clinic operates if the Coordinator takes a vacation. And if such negotiable positions are left vacant they are not necessarily filled. Titled or untitled, most clinic jobs are assigned in a manner which is informal and vague. No standard set of criteria dictate what type of person, with what qualifications, will perform a certain job. Rather, work functions are negotiated by the individual (who wants to perform some type of activity) and the group (who weigh the individual's desires against his qualifications in terms of work experience, education, personal characteristics, etc.). In addition, the amount of available manpower appears to influence role assign-

ment: less negotiation is required for highly valued jobs if there are few people to share the overall work load. To provide a description of informally assigned work functions at Heroin Detoxification, it will be helpful to first outline the actual types of activities which are carried out at the treatment service. Next, the kinds of individuals who may perform these activities will be discussed.

Work-Roles

1) Desk receptionist: The worker sits at the desk in the clinic's front room, where patients make first contact with the service. The worker instructs the patient to "sign in" on a list (the number on the list indicates the order in which patients are seen); and assembles a "chart" (permission for treatment sheet, medication record, paper for progress notes) for the patient. May administer "intake" questionnaire (see below). The desk worker also answers telephone calls, responds to visitors, and so forth.

2) Intake worker: this is not a constant work task: "intake" can be done by desk workers or by counselors, as well as by individuals responsible only for this job. It consists of administering a lengthy (3 page) questionnaire to patients at the time of their first visit. The questionnaire inquires as to the person's social, medical, and drug-taking history. At the beginning of this study, a shorter one-page form of the questionnaire was used. The counselor completed this form during the course of his first session with the patient. After the longer form was devised the practice of having it completed prior to counseling, with the help of a special "intake" worker, became more common.

3) Counselor: This worker in the pivotal person at the treatment service; his work accounts for most of the direct care given to patients here. The counselor may or may not administer the intake form - but he receives it in each new patient's chart, and assesses the responses. From the history therein, he plans the patient's care, including the medication schedule for withdrawal from heroin (if necessary, he checks on this with an RN, MD, Pharmacist). The counselor spends time talking with the patient: this may consist of anything from a casual conversation to depth psychotherapy, depending on the needs and desires of the patient as well as the level of skill of the counselor. The counselor makes referrals to other agencies, for example, referrals to the Department of Social Services. Ideally, a counselor sees "his" or "her" patients consistently - while this is not always the case, most counselors endeavor to provide some continuity of care for patients who visit the service regularly.

4) Group therapist: This is a counselor who runs therapeutic groups for patients. Staff are sometimes also admitted to these groups. During the time of this study, at one point or another at least three counselors ran therapy groups. The only constant group, however, was the weekly psychodrama group for patients and staff. When the psychodrama "director" left the treatment group, another counselor assumed leadership of this group.

5) Pharmacist: This worker dispenses medications to each patient according to the withdrawal schedule indicated by the patient's counselor. The pharmacist also checks over prescribed drugs for errors on the part of the counselor. He instructs the patient on proper use of medications, and warns him about possible side-effects and adverse reactions. When a skilled person occupies this role (i.e., when a professional pharmacist or pharmacy student is available), he bears an extra responsibility for "catching" medication errors made by other staff members, as well as for teaching and consulting with staff on drug-related matters.

6) Data Collector: This worker gathers information to be used in clinic research. A person gathering data usually does other types of activities as well. The job may consist of categorizing and quantifying information in each patient's chart (intake form, medication record). It may also involve psychological testing (MMPI, Rorshach).

7) Secretary: This worker performs clerical functions - typing, duplicating of materials, etc. - needed by the treatment service. This worker may also do clerical work in support of research activities of professional staff members.

8) Specialty counselor: This worker has a special type of skill to offer - vocational counseling, perhaps, or consulting about problems of children - and offers to use this skill with any individuals among the patient group who might need such specialized service. The person in this role "talks" to patients, as do all counselors - but he or she does not meet with every patient who visits the service. They offer a specialized service and see only those individuals in need of it.

Types of Workers

A) Psychologist: This type of worker generally does counseling (3) or group therapy (4). He may wish to do psychological testing (6) or some sort of specialty counseling (8). The person called"psychologist" at the service is in the process of obtaining, or has, an advanced degree in psychology. He may do various counseling and testing activities after a relatively brief orientation period. Having some educational grounds for his claim to therapeutic expertise, he need not go through a lengthy period of negotiation in order to practice.

B) Registered Nurse: Nurses are considered "safe" people - they may do all non-skilled jobs as well as pharmacy activities without negotiation. Nurses tend to fall into two categories: one group remains at non-counseling activities (1, 2, 5, 7); others negotiate for counseling work (3,4) on the basis of education and/or experience. RNs may serve as sources of consultation on general health problems for the non-medical staff.

C) Lay workers: These workers may do any clinic job, however, they are rarely involved in data collection (6) or specialty counseling (8). While they eventually may do counseling (3), group therapy (4), and so forth, they must go through a more complicated process of negotiation than credentialed workers do. For instance, before a lay worker is permitted to become a counselor, he must usually demonstrate responsibility doing

non-clinical jobs, show safety in handling medications, and exhibit general good judgement in dealing with clients. He usually "sits in" with more experienced counselors before seeing his own clients as a therapist. Non-treatment, non-research functions (2,7) are generally handled by lay workers.

D) Ex-addicts: Ex-addicts are hired to do one-to-one counseling, in the main (3). Since it is something of an assumption in the world of drug treatment that "only an addict understands an addict", individuals with a history of heroin dependence are hired to both treat patients, and to share their special knowledge with "straight" counselors. Addicts-counselors have been screened fairly carefully before admission to the staff group: they are considered to be insightful and motivated, before coming to work. Hence, they need not actively negotiate for counseling roles. They do, however, undergo a period of orientation to therapy, and are supervised at other clinic jobs - particularly pharmacy activities (5).

E) Students: Health science students working at the clinic in some sort of internship arrangement may do all clinic jobs. They tend , however, to do counseling (3), specialty counseling (8) and data collection (6). (Psychology students have been discussed under "A"; it should be mentioned here that they do much of the more intensive psychotherapy carried out at the service.) The amount of negotiation carried out by students varies according to their level of skill. For instance, medical students with little clinical experience might be limited to data collection activities, unless they chose to negotiate for counseling roles. A medical student with advanced training assumes many MD functions, and may do counseling after a brief orientation to the service.

F) Secretarial workers: These are women with clerical skills who differ from other non-professional workers in that they do not perform other non-clinical jobs. While it is true that any clinic worker may do clerical jobs (7) without negotiation, secretarial workers do them more competently and consistently.

To review: a description has been offered of the usual work roles at the Detoxification Section, and of the types of individuals to whom such jobs are generally assigned. No formal rules of clinic structure dictate which worker will perform which activities. Rather, the individual negotiates on the basis of experience, education, and personal characteristics to be allowed to function in his preferred role(s). Only the MD and the administrator are formally assigned to a defined role which carries explicit responsibilities.

The Site

To provide a complete picture of the Setting, it will be helpful to place these types of workers performing their various jobs within the physical confines of the treatment service. First, the clinic will be discussed in terms of space: room placement will be presented as well as the sights, sounds, sensations which accost the individual in various parts of the building. The site will also be discussed in terms of time: a temporal map will be presented showing where activities are carried out in the course of a working day at the clinic. It has been mentioned previously that until December, 1971, Heroin Detoxification shared quarters with the Medical Section of the clinic. During that time, couseling of the patients was carried out in small treatment rooms, where medical equipment (dressing supplies, etc.) were visible. The lay-out of this building in shown in Figure 1. However, the following discussion will concern itself with the newer building, shown in Figure 2. Since this building served as the site for treatment during most of the months of observation, and further, since it provides an environment given over totally to the treatment of addicts, it will serve as the focus here.

Space

The Detoxification Section is located just off Haight Street. The outer building, like Haight Street, has seen better days: the grey facade of the structure displays peeling paint; occasional pieces of paper and litter blow by the stone front steps. Signs hanging above the entrance announce the name of the section, the name of the medical doctor, and the clinic hours. Upon entering the house, a long hallway can be seen running

the length of the first floor. (The clinic owns the upper flat of this building as well, but tenants occupied it until Spring, 1971. Thus, the hall covers the expanse of the treatment area.) Immediately to the right, at the front of the hall, lies the room where intake activities are carried out: patient sign-in, etc. The open door at the entrance to this room bears a colorfully painted sign advising visitors about the house rules and sentiments: "No holding"(possession of drugs), "No dealing", "No pets" - "We love you." The room , on closer inspection, is revealed to be the former front room or parlor of a Victorian style home: it has a fireplace, mantle, and bay window. The mantle serves as a repository for patients' charts - as the counselor calls each new patient he picks up that person's chart from above the fireplace. Near the mantle, on the left side of the window, sits the intake desk. Here is one of the two house phones. A large file for charts, situated between desk and mantle completes the office type atmosphere in this room. The other walls contain couches where patients, visitors, and occasional staff members sit - perhaps talking, perhaps reading one of a pile of "used" magazines. Here, as throughout the building, there is a mustiness in the air deriving from two sources: the dampness of old houses; the constant smoking of workers and clients. Behind this room - in fact, separated from it by sliding doors - is a counseling room. On a busy day, any space in the house becomes"counseling space", but this area has the advantage of being closed in, hence private. The only furniture here are several chairs, an elderly couch, and a well-used desk (circa 1930) donated by the widow of a private practitioner who "broke up" her husband's office. Farther back along the hall is a curve in the line of the building which creates a kind of alcove: here are several chairs. The next room to the right of the hall doubles occasionally as a bedroom for live-in staff (visiting students, for example). When occupied, it is well-furnished:

bed, desk, etc. Otherwise, it contains several mattresses, some old chairs. Directly behind this room - at the back of the building - is the "Doctor's office." In reality, it is a group room , but the MD locates himself here most of the time. The desk here is used for official clinic business, as opposed to the patient care activities carried out at the front desk. This is a comfortable room: it contains a shag rug, a sofa, built-in bookshelves of dark old wood. Staff enjoy congregating here, for this reason. Additionally, this room has the second phone, and is thus used for making business calls and referrals. The hall ends in the kitchen - a spacious room with windows overlooking a backyard. The back door to the kitchen leads to a porch, to back stairs, and finally to a basement. Stairs, basement, and yard resembled a "disaster area" when the detoxification group first occupied the building, but over a period of months they were repaired and made available for use as counseling and office space. The former pantry closet has been converted into a pharmacy. Inside are shelves, holding various donated medications (antibiotics, vitamines, etc.), and a safe, holding substances used to treat withdrawal symptoms (sleeping medications, pain medications, tranquilizers, etc.). The Dutch door permits the pharmacist to talk to patients while preparing their envelopes of detoxification medications.

Time

The physical plant of the heroin service appears different, at various times of the day. The clinic opens its door at about 10 AM, although treatment hours do not begin until after 12. The doctor may not have arrived as yet; if he has, he could be on the phone or in the back room, involved in research or official business. The kitchen is probably empty; the pharmacy door is locked. The first few staff members to arrive

might be re-filing charts in the front room, making phone calls, or simply sitting in any of the counseling areas consulting and/or relaxing. By 1 PM patients are trickling in: a worker sits at the front desk and greets them, preparing thier charts for the counselors. There is no backlog of patients as yet - but until the doctor arrives some patients may have to wait (no medication may be given out without an MD on the premises). Counselors and addicts occupy the rooms off the hallway. The pharmacist is "opening-up shop" - taking routine medications from the safe and preparing for the afternoon's customers. The MD sits in the back room; in case of an over-dose case he might rush from here to any part of the house to perform emergency procedures. At 3 PM, the building is full: the waiting room contains a large group of patients waiting for counseling: all therapy rooms are in use, with an overflow of therapists and clients holding sessions in the hall, in the kitchen, on the back porch; the kitchen is cramped as a result of the many clients waiting to receive medications. The flow of staff, patients, and visitors creates a traffic jam in the hallway. Those individuals trying to exit must maneuver their way out carefully. At 5 PM, the house is quiet. A few workers cleaning up and filing charts - some final counseling sessions could be ending - but no new patients enter. The pharmacist puts the drugs away, and locks the pharamcy door. In the back room a staff meeting might be in progress. If so, the MD takes the lead, and will wind up the meeting shortly. By evening, patients and workers have left.

The Actors

The actors - the individuals who give and receive treatment at the Heroin Detoxification Section - complete the picture of the setting. Casual observation of this group reveals some general characteristics of both patients and staff. For instance, the group is predominantly white, al-

though racially mixed. Also, while men and women are represented, a larger number of the actors are male. The addicts and their therapists look alike: a casual, unconventional style of dress, hair, and so forth prevails here. In fact, for the new observer, it might be difficult to distinguish patients from staff - except by attending to those who appear to be sick. To be sure, there are no patients in the throes of agonizing withdrawals in the manner of the Man With the Golden Arm. However, many of the patients display signs of withdrawal - runny noses, agitation - as well as a general air of poor nutrition and debilitation. An occasional patient may be "nodding out" - under the influence of heroin. To understand these actors, and thus to gain some feeling for the place they occupy, it is necessary to go beyond casual observation, and to examine them in some detail. The client group will be discussed first, in terms of social characteristics and drug-taking histories. Next, the staff will be considered.

The Clients

In "The Changing Face of Heroin Addiction in the Haight Ashbury"[31], Shepard, Gay, and Smith present a statistical picture of the clinic's clientele. They draw on a sample of 773 intake questionnairs completed by patients during the service's first 10 months of operation (November, 1969 - September, 1970). The figures used in this article are reproduced in Figures 3 and 4 for reference. The authors divide their sample into three descriptive categories, basing classification on the time when the subject first used heroin. The "Old-style Junkie" (OSJ) began heroin use prior to January, 1964. The "Transitional Junkie" (TJ) began using heroin at some time between January, 1964, and January, 1967. The third type, the "New Junkie" (NJ) did not use heroin until after January,1967.

The first group, the OSJs, are obviously the oldest of the clinic's

clients. It is not surprising then, that they report more marriages, divoces, dependent children. This group contains the highest proportion of non-whites (33%) of all three categories, as well as the highest proportion of males (81.7%). More members of this group report habits costing over $100 per day than their younger counterparts do. It is worthy of note that this grouping - termed "ghetto style" addicts by the authors - do not show prior "heavy" involvement with other drugs to the degree that TJ or NJ addicts do. Of course, this would be expected in response to the question about psychedelic use before heroin addiction: some of these subjects were addicted before LSD was synthesized. But even in the case of alcohol, OSJs claim less involvement than do the NJ or TJ groups. The OSJ has a higher average number of withdrawals (the average OSJ has undergone complete withdrawal a total of 3.43 times). He also shows a higher percentage of "cold" or unmedicated withdrawal experiences.

The authors cite the Transitional Junkie group as the smallest and the "most ambiguous" category of addict treated at the heroin service. It contains more whites and more women than the OSJ group, but less of each than the NJ category. Many TJs spend less than $50 per day on heroin - but almost half have more expensive habits. What is most striking about this group is the heavy incidence reported of involvement with other drugs prior to heroin use. In contrast to both the OSJ and (to a lesser degree) the NJ, the TJ reports abuse of all available illicit drugs: hallucinogens, amphetamines, barbiturates, and so forth. (As pointed out in Chapter 1, this group reports very heavy use of amphetamine - 54.4% - prior to addiction.) Since this group began heroin use before the "epidemic" had fully expanded to the opiate market, it might be surmised that they are multiple abusers who select drugs on the basis of easy availability. While the TJ group

shows an average of 2.47 withdrawals per member, only 49.5% of these withdrawals were "cold". The authors claim this type of addict is a "self-treater", who medicates himself with illicit drugs.

The New Junkie is the second largest category reported on in this paper. However, since the members of this group would appear to be the "victims" of the present epidemic, it may well be that characteristics of this portion of the study sample apply to a growing number of addicts. The NJ group, like the TJ, shows increases in white addiction (81.2%) and female addiction (335). A very high proportion of this group (63.5%) report habits costing less than $50 per day. Only 9.5% of the NJs pay more than $100 a day for heroin. The individuals comprising this youngest of addict groups claim to have used many drugs heavily. However, in the case of every type of drug, they show less involvement that the TJs. This difference is especially apparent with regard to alcohol (NJs - 21.2%; TJs - 27.5%) and amphetamine (NJs - 46.4%; TJs - 54.4%). This group averages 1.38 withdrawals per member; 41.6% are attempting to withdraw themselves, with the clinic's help, for the first time.

It can be seen that the clients at the detoxification service contain something of the old and new. To be sure, there are addicts using the service who approximate the stereotype of the pre-1960 addict: non-white, male, supporting a large habit, suffering through withdrawal without medical attention. Yet, in the pictures of both the transitional and new addict, some changes can be seen. Both groups contain more whites than the first category - the NJ group shows this most clearly. And, although men continue to dominate the picture, women addicts are evidently increasing among the younger groups. Habits appear to be diminishing in expense, if the TJs and the NJs are truly indicative of heroin's "changing face". Both these groups seek treat-

ment during withdrawal - (clinic treatment or self-treatment) - more than those in the OSJ group. Speculating as to the reasons for this is beyong the scope of this discussion. However, two points might be made with regard to what appears to be an increased use of medication during withdrawal. First and most obvious - there are more services offering drug treatment today than at the times of the OSJs early withdrawals. Second, it might be considered that the two younger groups (TJs and NJs) have access to therapists who are much like themselves. It should be borne in mind that the characteristics of the heroin unit's staff more strongly match those of the TJs and NJs than those of the "ghetto addict".

The Workers

Induction into the staff group is a flexible affair: isolating "staff" from short-term volunteers, consultants, and so forth is difficult. In addition, the staff turnover during the period of study was high. Nevertheless, in reviewing the eleven month period when observations were made, 41 workers emerge as those who provided consistent service for at least a month, at most, several years. Looking at this group, it is possible to define some characteristics of the staff at the heroin service. It must be remembered that all 41 members did not work at the clinic together. Thus, when it is said that seven staff members have a history of heroin addiction - it must be understood that these seven were not all present at the service at the same time. Rather, during an eleven month period of observation, seven individuals with a history of addiction passed through the clinic as workers.

Clinic writers claim 1970 as "the year of the middle-class junkie"[32]. In the Haight Ashbury, it may also have been the year of the upper middle-class therapist. Looking over the characteristics of the worker group at

the Detoxification Section, they appear to be a generally young, white, well-educated group. As in middle-class America, power rests chiefly in the hands of white men. Most individuals range in age from 20 to 25 - but two are closer to 60 years of age. The medical director is 40; the administrator and coordinator of psychological services are under 25. Out of the group of 41, 31 are white; three are black; one Latino is represented. The level of education for the group as a whole is quite high: twelve have had some college background, up to and including a Bachelor's degree; 15 are garduate or professional students (9 medical students; 2 graduate students in nursing; four graduate students in schools of psychology, vocational rehabilitation, counseling); 11 are full-fledged professionals (5 RNs - 2 of whom are also graduate students - 3 MDs, 3 psychologists). Taking into account the college background of even the unskilled workers, it appears that there is negligible working class influence here. (Out of the total group, seven individuals are former addicts - hence less "middle-class". However, neither are they working-class: as addicts they held no jobs and generally would have been classified as lower-class.) Looking at the distribution of power and influence within this staff group, white men appear to be dominant. Only about one-tenth of the group are non-white; this explains some of the dominance. But 17 of the 41 are women; seven of these 17 are professionals or professional students. No women wield formal influence through intrastaff positions or through membership on the Executive Committee of the clinic complex. Few women are involved in research and publication: at the National Heroin Symposium hosted by the section in 1971, no scheduled speakers from Heroin Detoxification were women. Some interesting questions in regard to power, race, and sex are raised in reviewing characteristics of the ex-addicts on the staff. According to Shepard et

al.[33], more than half the clients are male, and many of the older clients are black. The medical model for heroin treatment is challenged most strongly by male ex-addicts - many of them Third World men - operating within self-help programs such as Synanon and Daytop.[34] In rejecting "medical" treatment, hence, in deposing the MD as the addict's therapist, such individuals take power out of the hands of white men. Out of seven ex-addicts working at the Detoxification Section, one white man and one black man are represented. The remaining five are white women - four of them under thirty years of age. This might be seen as a selection of relatively "submissive" types of individuals for potentially threatening positions.

The actors - people pursuing sick and therapeutic careers at the heroin service - share some common characteristics as well as common occupational territory. The addict group shows a broad range of ages, from the "old style junkie" to the younger addicts. The staff group too ranges in age from about 20 to almost 60. The younger addicts, like their therapists, are frequently white and often female. Many young addicts come from middle-class backgrounds, but have de-escalated in terms of social class. Thus, like their therapists, they show little working-class influence. To be sure, there is at least one glaring differenc between the two groups - one is addicted and one is not. <u>But both require the existence of the phenomenon of heroin addiction as a condition for pursuance of their careers. The actors in this setting are two independent groups, interacting on shared ground.</u>

This, then, is the setting: a down-and-out Victorian house in the center of the formerly elegant, presently notorious Haight Ashbury district. Within the house an autonomous "section" of the Haight Ashbury Medical Clinic conducts business, giving care to thousands of addicts who have sought treatment for withdrawal since 1969. Workers here negotiate for the right to perform therapeutic heroin careers. I entered this setting in October, 1970,

and remained until August, 1971, for the purpose of conducting a study of the staff group. The goal - the "research problem" was to discover the distinguishing characteristics of a group who choose to ground their careers in the core issue of heroin addiction. Plans for method were vague at the outset - it was not clear what investigative tools would best serve to dissect this particular slice of reality. If Gardner found the usual tools of organizational analysis inapplicable for his study of the Haight Ashbury MedicalClinic, so the procedures of objective and detached social science were equally inappropriate for this setting. Special qualities of the treatment service - deriving from its sensational history, its elusive organizational structure, and its fluid cast of actors - dictated that special strategies for gathering data be devised. Characteristics of the observer too - a nursing background and a sociological perspective - created a need for methods in keeping with such a dual orientation. In short, like all roles at the Heroin Detoxification Section, the observer role was not formally assigned, but was instead negotiated. A method of investigation was devised to meet the needs of both the treatment service and the individual pursuing a therapeutic (investigative) heroin career.

CHAPTER 3: THE OBSERVER

The research problem in a scientific investigation determines the method. Or - so it would seem from accounts of social scientists who report with cool precision on their delineation of "the problem", selection of method, and collection of data - followed in an orderly manner by data analysis and results. But strategies for research are not chosen purely on scientific bases, nor do all investigations in the social arena proceed along a linear path from problem to results. For instance, while it is true that the problem under study affects the choice of a method , it is after all the observer - the investigator - who selects the problem. By picking out one area in which to invest time and energy, the observer surely meets some of his own needs - lays down some of his own terms. He then must come to terms with the properties of that chosen site of research; he must, in the end, negotiate a research method which both serves his interests and is applicable to the problem at hand. My "terms", my objectives as a nurse undertaking a piece of research, were strong factors behind my choice of the Heroin Detoxification Section as the site of my efforts. The Setting laid down terms - made demands upon me which forced alteration of my original "design". Data collection and analysis proceeded simultaneously during the course of this study. In fact, the two processes stimulated and directed each other: new observations raised theoretical questions; new ideas directed a search for further observations of one sort or another. Thus, to describe the method employed in this study in terms of neat, mutually exclusive "stages" of research would be misleading. I will try instead, through a discussion of The Observer, to report on the manner in which this study was actually conducted, and to what theoretical ends, from the initial process of role negotiation to the final development of a hypothesis about

about the nature of the setting.

Choices

This study was undertaken as a requirement for the degree of Doctor of Nursing Science. The DNS program, like the Nurse Scientist Graduate Training Programs[1], and other projects for the doctoral education of nurses, is based on the belief that a person with a nursing background can benefit from research training and make some sort of intellectual contribution which is enhanced by a dual orientation to the clinical and the theoretical. Nurses in such programs can - and do - choose any number of approaches to research, from physiology to cultural anthropology.[2] Often, they must put aside the skills of nursing practice while serving an apprenticeship in a new craft. Hopefully, the fruits of their labor will be brought home to nursing in temrs of research findings with clinical significance - but they may have in the process become alienated from health care institutions and nursing practice. It was my belief that certain qualities of nursing practice, certain skills used by the registered nurse, are tools for research as well. The clinical practice of nursing involves skill-training in certain methods which are learned with the objective of patient care in mind — but which may be used with equal success in exploratory, descriptive studies which focus on the routine activities of people's lives and try to derive meaning from everyday social events. A discussion of three distinctive qualities of nursing practice, and their relationship to research, should serve to clarify this point.

1.) Direct observational skills:

Social scientists, particularly those who concern themselves with the sociology of deviance, lament the lack of descriptive data from which theory may be built. Becker, for example, feels theorizing about deviant

groups has been hampered by insufficient and unsatisfactory data about the everyday lives of groups being studied:

> First, there simply are not enough studies that provide us with facts about the lives of deviants as they live them. Although there are a great many studies of juvenile delinquency, they are more likely to be based on court records than on direct observation. . . Very few tell us in detail what a juvenile delinquent does in his daily round of activity and what he thinks about himself, society, and his activities.[3]

Polsky very forcefully speaks out against the "scientism" and concomitant lack of good reporting skills among criminologists:

> Successful field research depends upon the investigator's trained abilities to look at people, listen to them, think and feel with them, talk with them rather than at them. It does not depend fundamentally on some impersonal apparatus, such as a camera or tape recorder or questionnaire, that is interposed between the investigator and the investigated. Robert E. Park's concern that the sociologist become first of all a good reporter meant not that the sociologist rely on gadgets to see, hear, and remember for him; quite the contrary it asked the sociologist to train such human capacities in himself to their utmost and use them to their utmost in direct observation of people he wants to learn something about.[4]

Polsky further warns his colleagues that research instruments such as questionnaires, tape recorders, and the like contaminate the subject's environment. He urges developement of skills at recording the results of direct observation after leaving the field:

> It is quite feasible to train yourself to remember details of action and speech long enough to write them up fully and accurately after you get home at the end of the day (or night, more typically). Historians accpet an account by a disinterested eyewitness written immediately after the event as decent evidence, even when by an untrained observer, and there is no good reason to deny validity to dimilar accounts by trained observers.[5]

Vidich, Bensman, and Stein point out that community studies - relying on direct observational skills - continue to produce rich data and therefore justify "gadgetless" investigation:

> In spite of the grandiose elaborations of research methodolo-

> gies and abstract theories, it appears that the ear and the eye are still important instruments for gathering data, and that the brain is not always an inefficient mechanism for analyzing them.[6]

None of the authors quoted above would argue that all social scientists should limit themselves to the kinds of methods they propose - but all indicate that there is a lack of rich, descriptive data from which testable theories may be generated. Further, they lament the lack of training for sociologists in gathering and recording information obtained through direct observation. Nurses, as an occupational group, undergo rigorous training in seeing, hearing, and recording human appearance, attitudes, behavior. Perhaps because of their traditionally low status, nurses have not generally been schooled in the use of esoteric measurement devices to assess changes in human situations (except for the intensive care unit elite - a relatively new development). Yet, they are charged with the responsibility for recording changes - for noting both impressions and objective facts and recording them as such. With such responsibility, and virtually no hardware, nurses must become expert at direct observation and adept at keeping records without any obvious note-taking which alters the field (upsets the patient). True, these direct observational skills are learned for use in the management of disease and the promotion of health - but as social scientists indicate, these <u>same</u> skills are of great importance in accumulating a body of descriptive data on human beings for research purposes. It would be, in a sense, wasteful to put such skills aside - to allow them to grow fallow - in favor of other, more technical research techniques.

2.) <u>Intimacy</u>

To know something about a social group, it is necessary to gather information about their lives - their behavior, thoughts, feelings - which may be termed "intimate". This is not to say that the investigator develops intimate social relationships with his subjects, but rather that he learns

about facets of life which are personal, private. Gold brings up the matter of "intimate content" in his discussion of the "participant-as-observer role", in "Roles in Sociological Field Observations"[7]. He advises that the observer (who is open with the subjects about his role, and hence the field relationship) must strive to elicit information of intimate content, while at the same time avoiding intimate form with his subjects. Gold bases his distinction between content and form on George Simmel, whom he cites on this point:

> . . . certain external situations may move us to make very personal statements and confessions, usually reserved for our closet friends only, to relatively strange people. But in such cases we nevertheless feel that this 'intimate' content does not yet make the relationship an intimate one . . . That 'intimate' content, although we have perhaps never revealed it before and thus limit it entirely to this particular relationship, does nevertheless not become the basis for its form, and thus leaves it outside the sphere of intimacy.[8]

Polsky is suggesting something akin to gathering data of intimate content, when he admonishes criminologists to study the criminal within his natural surroundings and throughout his usual activities.[9] Polsky advises that so long as the investigator is honest about his role as a social scientist, he can observe intimate events (such as illegal activities) without developing intimate relationships with his subjects (such as being asked to store guns). This, of course, is not as simple as it sounds - it takes a great deal of skill to know where intimate content threatens to move to intimate form. Polsky finds that the field worker undertaking this type of investigation must be very clear as to his own identity:

> The problem, which criminology texts ought to talk about but don't, inheres in the requirement of telling criminals who you are. In field investigating, before you can tell a criminal who you are and make it stick, you have to know this yourself - know especially just where you draw the line between you and him.[10] [emphasis added]

Nurses are skilled - some might say too skilled - a "drawing the line". Nursing practice requires the ability to witness events of an intimate nature; to elicit information with intimate content; while preserving the non-intimate form of the interpersonal relationship between client and clinician. Indeed, the novice may be shocked at the amount of "intimate content" that is directed her way, simply because she is identified as a nurse:

> It does not matter how young and green you are. When you wear this uniform a woman who could be your mother calls you over and says, 'You're a nurse and so you'll understand . . . ' And then she'll tell you problems she wouldn't share with anyone else.[11]

After some time in practice, the woman who has worked as a nurse is adept at giving cues which facilitate frank, personal discussions, but which protect her investigative role. Further, in the type of participant observation role which Gold discusses, the researcher may be identified as a person who is "also" a nurse. This tends to create a feeling among the actors that she is indeed a safe person in whom to confide matters of intimate content. She will not mistake such information for a situation of intimate form - of real social intimacy.

3.) Empathy

Empathy is the result of "mentally entering into the feeling or spirit of a person or thing."[12] Two disciplines, to my knowledge, make great use of this concept: acting and nursing. In acting the concept refers to the actor's ability - not to react to a character - but to become that character. In nursing, the concept is used to stress the difference between understanding - putting onesself, for a moment, in the place of the "other" - and sympathizing or over-identification. For example: a novice might be taught

that to sympathize with a person in tears can be destructive: the nurse could over-identify with weeping herself. To empathize, however, that is, to really step into the role of the other for a time, would enable the nurse to gain some knowledge about the source of the patient's tears. Stepping back into her own role, she could take constructive action to help the patient - the other. This idea of stepping into the place of the other, and then stepping back to objectify the other's experience, is used widely in social science too. Empathy has much to do with what Gold refers to as "role-taking" in field research:

> While playing a field work role and attempting to take the role of an informant, the field observer often attempts to master hitherto strange or only generally understood universes of discourse relating to many attitudes and behaviors. . . He continually introspects, raising endless questions about the informant and the developing field relationship, with a view to playing the field work role as successfully as possible.[13]

Empathy allows for successful role-taking, for stepping in and out of the "shoes" of the other, so to speak. In this respect it has common elements (although they are not identical) with the ideas of such theorists as Garfinkel[14] and Cicourel[15], who make the "routine ground of everyday activities" and the "background understandings" of the actor part of the data from which theory is generated. Of course, these writers are in the tradition of Alfred Schutz in acknowleging that the human observer registers not objective fact, but intersubjectivity.[16] Accepting this notion, a basic characteristic of social science - as opposed to natural science - would be the use of empathy. Types of studies employing the empathetic point of view would, it seems, be those which acknowlege the value of the concept of "verstehen", of subjective interpretation. McCall and Simmons point out that there is a long-standing debate among sociologists about the value of this type of study, versus those which rely on more objective sociological

methods, such as statistical analysis.[17] Truzzi discusses this debate in The Sociology of Everyday Life. He refers to an empathic point of view as one which involves "subjective understanding":

> By subjective understanding we mean a special insight into the social situation taken from the perspective of the actors through an empathic process by the investigator. It is this sympathetic understanding of the role of the social actor that numerous sociologists have seen as a critical part of sociology.[18]

The point here is not to continue the sociological debate of the relative mertis of objective and subjective methods. Rather, it will be sufficient to point out that the debate exists - to emphasize that there are schools of social though which value empathy, subjective understanding; which value too the type of theory which may be generated through methods which use subjective understandings as data. Nurses are trained to use empathy in the assessment and planning of patient care. The nurse's ability to mentally enter into the feelings and thoughts of the individuals she observes can be used for other objectives as well. It may, for instance, be used for the purpose of describing human beings and developing social theory.

Direct observation, intimacy, empathy - these were part of my nursing background. They also promised to be of use in a sociological field study. Thus, if I did not, strickly speaking, design my method according to the research problem, I at least found the problem "by design". The Heroin Detoxification Section is a setting where deviants are"treated". Even the unit's staff, because they work inan alternative facility and because of their close association with addicts, tend to see themselves as deviants. Thus, the unit provides a perfect setting for an investigator who is skilled at direct observation and adept at recalling information to be recorded out of the field. Recoding "gadgets" are anathema to the addicts, and would not be permitted by the staff. My training in handling intimate content was important here: the lack of formal structure could easily push an in-

vestigator without practice in role-definition into a situation of social intimacy. In addition, being known as a nurse in a health care setting provides the investigator with easy access to types of information (medical records, clinical consultations) which the non-medical observer might be denied. As in many psychotherapeutic situations, at the heroin service the major activity is talking. Further , the individuals doing the talking inhabit a special, deviant world: they talk in argot, with special meanings attached even to everday language, sharing private understandings. An observer lacking in empathy - in the capacity to register subjective understandings - could not discover the rich meanings which are exchanged during this endless and visually monotonous dialogue. Heroin Detoxification Section of the Haight Ashbury Medical Clinic was a site for research which allowed me to capitalize on the skills I developed in nursing practice. In this setting I could employ direct observation, intimacy, and empathy - rather than abandoning them in favor of a more objective perspective and more technical skills.

Negotiation

Terms of the Observer

The negotiation process began when I made my first "official" contact with the treatment service, to state my terms. However, some preparation for negotiating had been carried out prior to this "contact": I interviewed a nurse who was a former clinic volunteer with some knowledge about the heroin service. It was upon her advice that I began "at the top", with the medical director, and I entered with a patron of sorts, the chief of psychological services (whom I knew from work in another setting). Her information warned me about conflicts between workers, and possible subplots that were being acted-out at the time of my entry. I asked - first in a

conference with the MD, later with any worker I met - to conduct a descriptive field study of the heroin service, which would focus on the staff group. I explained that my objective was to "raise ideas" rather than to prove a pre-stated hypothesis - and I restated this many times upon being pressed with regard to what theory I was "testing". I informed the staff members that I would keep daily records of any and all clinic activities; I also assured them of the confidentiality of my records and promised to avoid any intrusive equipment (notebooks, tapes, etc.) in gathering data. What I proposed was a role very much like the one Gold describes as "participant-observer":

> Although basically similar to the complete observer role, the participant-as-observer role differs significantly in that both the field worker and informant are aware that theirs is a field relationship. This mutual awareness tends to minimize problems of role-pretending . . . Probably the most frequent use of this role is in community studies, where an observer develops relationships with informants through time, and where he is apt to spend more time and energy participating than observing.[19]

I wanted to be both openly identified as an observer, and also identified as a participant, a group member - a person who shared in the inner world of the staff group. In proposing this type of role, I was careful to mention the factors in my professional background which rendered me eligible for "membership" as a participant: I was a psychiatric nurse; I had experience in drug treatment (and some of that experience had involved New York addicts - a mark of status in this business). I envisioned my participatory role as consisting of errand-running, general kinds of non-clinical work (checking supplies, assisting with intake), and some consultation with counselors on questions of therapy and/or general health care. Basically, my objective was to establish myself in an ambiguous staff role which granted me access to all phases of work at the clinic, but kept me clearly removed from any decision-making. In this regard, I wanted the kind of observing-

participant position described by Caudill, in "The Psychiatric Hospital as a Small Society"[20]. He notes that as an anthropologist on a hospital unit, he performed certain functions (i.e., helping on patient outings). However, he declared no allegiances and remained aloof from decision-making processes which would alter the hospital environment. I wanted a flexible time committment - though I proposed to remain in the setting no less than three months, for three days a week. Interpreting my methods and goals was difficult: while the staff group produced a great deal of research themselves, the concept of a descriptive field study appeared to leave them confused. The worker group tended to see all research in clinical terms: statistical examination of the patient group; psychological testing and so forth. The most successful way to explain myself to them was to state that I would view the setting "like an anthropologist". This explanation "clicked":

> "Oh . . . then wait'll we get the house. We're going to have a tribe, a real tribe."

Terms of the Setting

The next step in the negotiation process was dealing with the "terms" of the setting. Only one explicit "term" of the Detoxification Section was stated at the outset. Other, implicit demands of the setting were to emerge later, but at the time of my first contact with the service, a single demand was made which forced alteration of my plans for becoming a participating observer. This was the matter of work. As it was interpreted to me, the clinic practice with regard to would-be investigators was as follows: if you take something out (data) you put something in (work). And for a nurse, work meant patient care. Complicating matters was the fact that the heroin section had always counted on one RN among its clinicians - and the one RN was making departure plans. The MD impressed upon me the

need to have someone to rely on for emergency assistance, for "treating symptoms", and so forth. First of all, it meant stepping into an established RN role which, evidently, had always been filled by someone. In this sense, the nurse role made my entry into the clinic as non-obtrusive as possible. And, in addition, there were precedents for this type of role-playing: Cicourel, for example, became a "parole officer without pay"[21] in order to study background expectancies and understandings among the actors in the juvenile justice system. I once conducted a field study myself in a situation where I had clinical responsibilities, and found that the problem of method this entailed were more than compensated for by the amount of rich, intimate data I was able to obtain. As for actually taking on "my own" patients - I prolonged this for as long as possible, trying out all non-treatment functions during my initial days in the setting. Eventually I paid heed to the clear messages from top to bottom of the staff hierarchy, which said, "Nurses see patients; psychiatric nurses do counseling." The non-professional staff, who must negotiate slowing for counseling work, seemed confused by my reluctance to assume a high-value function. They continually asked "Are you going to see patients today?" Professionals expressed similar thoughts: "We're going to get you out of this rinky-dink stuff and have you see some patients." Finally, I assumed a counseling role, although I avoided taking on many patients for long-term treatment. The nurse role worked out well: it allowed me to experience the perceptions and feelings of the addict-therapist in a manner which could never have been accomplished by observation alone; it assured my inclusion in the staff group and justified my presence at meetings, conferences, and so forth. The role worked out well too, I believe, for the staff group who gained a licensed RN for the time of the study. With regard to explicit terms, all parties to negotiations seemed satisfied. Implicit demands, from the setting, were to follow.

Involvement

Induction into the staff group proceeded slowly. It wasn't until some weeks had passed that I began to appreciate the implicit demands for involvement which were placed upon me. These implicit demands had to do with the fact that the workers constituted not simply a group - but a group which approximated a community, in the anthropological sense of the term. Kurt Wolff calls a community "a group of people whose lives are bounded in some significant ways by that habitat".[22] Certainly the lives of the Detoxification Section workers were not bound by their work habitat in the same manner that primitive tribesmen are bound by the dimensions of a remote village. Yet, the section laid down boundaries to the same extent that modern community forms do - say, an urban neighborhood. Perhaps, with the sense of "community" almost gone in the places where urban man sleeps, centers of meaninful work will be a new site for such human groups to emerge. Redfield, in The Little Community, offers a conception of the small community as a prevalent and enduring form of human organization, which may be seen in many ways: as an ecological system, a history, and so forth.[23] He offers four definitional characteristics: in his view, the community is small, distinct, homogeneous, and self-sufficient.[24] Redfield, of course, is describing a true primitive community, not an occupational setting. But by applying these four criteria to the Detoxification Secion, it can be shown to what degree and in what manner the heroin service approaches communal form. The communal properties of the Setting, and some unique features of this paticular "community", placed special demands for involvement on the participating observerer.

Communal Properties

Size

About forty individuals made up the staff group, during the period of time in which this study was conducted. At any given time during this period, there numbered about twenty "regular" staff members, with five or more persons entering or leaving the group. The staff is too large to be considered a small group, but Redfield's terms, it is small enough so that it is "in itself the unit of personal observation."[25]

Distinctiveness

When Redfield describes the little community as "distinct", he means that "where the community begins and where it ends is apparent . . . to the outside observer and is expressed in the group consciousness of the people of the community." The Detoxification Section shows this quality of being distinct - from the outside and inside. Through its publications, the heroin service has its own unique reputation in the eyes of the larger medical world. At the Haight Clinic, it has its own, limit-defining territory - its house. Further, members of other clinic sections see the heroin service as distinct, apart. While the Drug Treatment Section was in existence, two heroin units virtually "worked the same street", yet each was aware of the boundaries of the other. Indeed, there was, for a time, an intense rivalry between the two services: both groups emphasized their differences to foster their separate and distinct identities. From the inside, the heroin unit workers demonstrate a community consciousness. There is a sense of "we - ness"; the community is defined by members of how others see "us":

> 'The pigs don't like us . . . the mayor's office likes us . . . Synanon doesn't like us . . .'

The community consciousness is manifest in its history, written (articles, portions of Love Needs Care) and spoken (discussions of the "old days" recounted to newcomers). Indeed, some of its spoken history might be classified as folklore: colorful anecdotes are told and retold - such as the tale of the schism between Detoxification and Drug Treatment. The community certainly points out where it begins and ends, when admitting - or "kicking out" - a member. Especially in the latter case, the decision may be made during a staff meeting. Mentioned in grounds for dismissal have been practices which betray the community: "badmouthing" the service, breaking the law of "Omerta".

Homogeneity

Community consciousness links, in a sense, with the section's homogeneity - for the staff identity serves to reinforce shared ways of behaving and appearing. According to Redfield, a community is homogeneous when "Activities and states of mind are much alike for all persons in corresponding sex and age positions."[26] He sees homogeneity reflected where generations are slow to change, and resemble the ones existing before them. Generations do not exist in a real sense at the heroin service, but the turnover of staff is high. Successive groups who pass through the service come to resemble those before them. Thus, metaphorically speaking, the community remains largely the same through "generations". Despite constant conflict and in-fighting, staff members show startling similarities in actions and beliefs. Just how the staff members are homogeneous, similar, will be discussed at length in "The Culture". For now it will be sufficient to say that people entering the staff group tend to become like other members in terms of appearance, behavior, and beliefs. The individuals change, but the life of the "community" endures.

Self-sufficiency

The last of Redfield's criteria for small communities - self-suffi-

ciency - is interesting in two respects, when applied to the Detoxification Section. In one respect, it is the criterion least applicable to the treatment service, in the way that Redfield defined it - that is, as a "cradle to grave arrangement".[27] At the same time, it is the most significant characteristic for ascribing communal properties to the unit. I was prepared for certain features of the Detoxification Section: its size, its distinctiveness, its homogeneity. However, I was unprepared for the capacity of the setting to meet the social needs of its staff members. The Section, of course, takes care of the occupational needs of its workers - and, for those who received a subsistence salary - the economic needs. In addition, it provides for interpersonal needs of varied intensity, from work-colleagueships, to close friendships, to long-enduring, intimate relationships. It sees to the spiritual needs of its members as surely as any community can in the secular age: members provide crisis care, counseling, and general support for each other. Medical care - at least health counseling - can be provided on the premises, and referral services for other kinds of care are easily arranged (in the course of my stay I was treated for an infection and was referred to a medical center for diagnostic work). Within the Detoxification Section, an individual can gratify not only his occupational needs, but also most of the social needs that are a part of living. Redfield claims his four criteria for the small community are ideals - that these qualities are present in differing degrees in one type of community or another. He acknowledges, for instance, that the modern town is very far from being "all-providing".[28] Certainly, the extent to which the heroin service can meet its workers' needs surpasses the self-sufficiency of many urban neighborhoods.

The Heroin Detoxification Section is not a true community, in the

ideal sense. Nevertheless, with its small size, distinctiveness, homogeneity and self-sufficiency, it has many communal properties. Hence it is referred to here as a "community". Certainly the implicit demands for involvement made by this setting were like those placed on the investigator in an "community study".

Community Studies

Community studies entail several types of problems for the Observer, with regard to involvement. First, they threaten the socially marginal position of the observer. It is relatively easy to remain aloof and distanced from a situation where short-term field observations are made; entering a community for long-term study produces not distance, but closeness. Gold points out that relationships involving intimate content are likely, if they continue through time, to involve intimate form as well.[29] Even where the investigator is skilled at defining and maintaining field relationships, in a community study he must at some point locate himself within the existing social structure. After thus defining himself (for example, as I became identified as a nurse) he limits the kinds of data he will be able to obtain. Vidich discusses this point, asserting:

> All the information which the participant observer secures is conditioned by the meaningful context into which he is placed and by his own perspective as being shaped by his being socially marginal . . . the observer's data are conditioned by the basis upon which subjects respond to him.[30]

In a work situation, like the heroin service, people working most closely with the observer may offer highly personal kinds of information; other workers may limit what they say to the observer because of "who his friends are." Certainly, in the context of relationships which proceed over time, people will want to know the observer rather than being known by the observer. This, of course, places an energy drain on the investigator who takes the time to let himself be known. More important, it removes the possibility

of maintaining a value-neutral position. Personal history is, after all, a statement of committments and beliefs: a person who offers information about himself for interpretation can no longer be considered "neutral". This leads to the second problem in community studies: the degree to which the observer chooses to adopt the values and standards of the community. There is no inflexible rule governing the degree to which "local customs" should be adopted, but the issue of group values must be reckoned with. In the case of the heroin service, many of my own values were reflected in the beliefs and standards of the community. However, situations arose where there was conflict with regard to clinical values. My final decision was to stand with my judgements in terms of patient care, and make those judgements part of the data. Thus, self-analysis was added to direct observation, as a research strategy. As for the question of closeness, a special feature of this community protected my marginal social position.

A curious quality of this group took care of some of the difficulties mentioned in the literature as pitfalls for community observers. This was the class content of the group. It has been mentioned that the staff is on the whole young and well-educated. Many a Ph.D. observing in a factory, or primitive village, reports difficulty in interpreting his role and objectives to his subjects. Miller, for instance, reports that in his study of union leadership, he found interest was seen as friendship - and disagreement as betrayal:

> They accepted the observer as an individual, a friend, not as one playing a delimited social role. Friendship connotes an all-accepting attitude; to probe beneath the surface of long believed values would break the friend-to-friend relationship . . .[31]

While I formed many friendships at the heroin service, they never precluded probing for information about accepted beliefs, nor did they pull me into

one camp or another. For while Miller was a sociologist among the workmen, I was a nurse, among my social equals or betters. Even among the "college drop-outs" in the staff group, there was a high degree of sophistication with regard to research. Despite my initial difficulty in explaining a non-clinical research approach to staff members (at one point I began taking obvious notes during staff meetings to make the research process visible), eventually most people realized that they were "subjects". Once this idea was understood, the group reacted -not with reticence or fear - but with participatory enjoyment:

'When's my turn, when do I get to get interviewed?'

Perhaps because of the high educational level of the group, perhaps because of the fact that many of them were post-war babies reared on science and research, they were quick to appreciate the ramifications of the field relationship. Indeed, they took an active part in objectifying my perspective. For instance, during a lunch-time conference a small group of lay staff discussed a possible minor insurrection, and voiced their feelings that the community was polarized into two opposing factions. I asked, "which side am I on"; the reply was a firm - almost reproving - "in the middle!" Vidich claims that a community observer will be asked "Who do you speak for?"[32] - I was told: you may have friendships and may hold certain values, but with respect to the decision making you are neutral. Several community members appeared aware that the confidentiality imposed by the field relationship made me a safe person with whom to test out thoughts and ideas. Thus, informal interviewing took place with little or no effort on my behalf. Even when the actors "backed off", they acknowledged the field relationship: "I want to tell you something, but I'm afraid you'll write it down."

The detoxification service is an institution which takes on communal

properties. Thus, the observer at the heroin service is faced with the kinds of demands for involvement which confront the investigator during the course of a community study. I developed continuing relationships with staff members; I was known as a person with beliefs and values. Nevertheless, the staff participated in defining the field relationship and in distancing me from in-fighting and descision-making.

Operations

The research operations - collection and analysis of data - were simultaneous and mutually supportive processes. Categories for analysis were derived from the description of the community; observations were directed and focused by emerging analytic propositions. Thus, in a sense it is artificial to discuss the two operations separately. Nevertheless, it will be helpful to first outline the way information was gathered - that is, what kind of observations were made, how they were recorded, and so forth. After presenting the kinds of "data" obtained in this study, the analysis process can be shown more clearly.

Collection

Types of Data

The main source of data was direct observation in the field: observation of patient care situations, meetings and conferences, and informal staff gatherings during the working day. Initially, much of this observation concerned itself with activities at the heroin service. I noted the flow of people, the jobs they performed. For example:

> Most patients seen by 4 today. I was told that this was a very light day - usually new patients are not taken on a first-come first-served list after 3:30 . . . saw only two patients with medical problems treated in addition to addiction . . .

Later, I focused more attention on the group's attitudes and beliefs. Hence, later notes are filled with dialogue:

> "I have one thing which bugs me . . . I get upset with our training program for volunteers - one day someone's doing intake and the next day they're counseling - it's a disservice to the patients . . ."

Self-analysis formed part of the data too: when my own reactions, thoughts, or feelings seemed significant, I recorded them. For instance, in the following note, I discovered my belief in - and the fallibility of - the "all-knowing" ex-addict:

> Person came up to intake desk claiming to be "a student". Was carrying a tape recorder. Requested to see "someone being treated for a marijuana problem". My first impression was to suspect that he was a cop. Was assured by L [an ex-addict] that he wasn't: "He looks like one, but he's too stupid." I took her word for it, assuming that ex-junkies have a mystical ability to smell-a-cop-a-mile-away. That myth was exploded later, when everybody else - including J - a N.Y. addict and therefore one-up in these matters - said he was . . .

My field notes were relatively free of references to my clinical practice at the clinic, except where other staff members were involved - for example, in cases where several counselors provided treatment for the same patient.

After some analytic categories began to emerge from the data - as the study became focused - I carried out some interviews. These provided a vehicle for two things: obtaining biographical information, and probing in depth about aspects of the setting which appared to be significant. The respondants constituted a "selected" sample. By this it is meant that they were chosen - not because they were representative in a statistical sense - but because they were significant in relation to ideas that were emerging from the data. To clarify this further: the respondants each represented a "type" of clinic worker who seemed central to an idea, event, or conflict which affected the entire group. The respondants were: one middle-aged male physician; one young male psychologist; a young male administrative worker with a history of political activity; one young male non-professional

with extensive counseling experience; one professional student from a working-class background; one female ex-addict. by the time the interviews were scheduled (after January, 1971) I had come to know a great deal about most of the respondants, as they appeared in a work situation. To encourage them to speak freely and at length about non-clinical issues, I held the interviews in a closed counseling area, on non-clinical time, whenever possible. I questioned the respondants about their personal careers; their work and school backgrounds; their treatment philosophies; their feelings about work at the heroin service. No fixed interview schedule was adhered to, but certain types of focused questions were asked, such as: "how did you come to work here", "what are your beliefs about treatment", "What are the problems here". The following excerpts from an interview should help to clarify what kinds of questions were asked, and what type of information was obtained, during respondant interviews:

> (How did you become involved in the clinic?)
>
> "I came here in March of 1970. I was writing a paper investigating all facilities dealing with adolescent drug problems . . .using questionnaires to asses attitudes . . .
>
> (What did you like about it here?)
>
> " . . . it was open, free person to person - instead of the doctor to patient stuff, which I'm sick of. At S_____ if your hair's long, you're crazy . . . I discussed it with T . . . he said "you need less structure" - and less structure is what I was looking for. Also, I was sick of the violence at ________ . . . one of the first days I was here I saw someone kicked down the stairs and I realized I didn't have to be responsible for that - it was a great relief . . .
>
> (Has working here affected your life?)
>
> (nods "yes") 'Did your eating habits change after coming here? I used to eat 3 meals a day and all that . . . then I started eating M&Ms and things . . .'
>
> (What are the problems here?)
>
> 'A problem here is "saving" people - it fucks things up because it's condescending . . .'

In addition to this respondant type of interviewing, I had some contact with an "informant". During my first month at the service I established a relationship with one person who agreed to discuss my ideas, but keep our conversations confidential. Besides helping me to refine my ideas, for several months this realtionship served as something as a pressure valve, providing a safe place to voice confusion, frustration, disagreement.

Finally, data was also obtained through the analysis of clinic documents: publications about the clinic; articles written by community members. These were helpful in showing how the writers viewed their patients and their work. For example, the flamboyance of several articles attests to the excitement the authors find in the world of drug treatment. Documents were useful in another way: they helped clarify aspects of the section's history which were conflicted or muddled in spoken accounts.

Recording

All data was recorded and stored in the form of typed, dated field notes. During most of the direct observation, taking obvious notes was impossible. Most of the straighforward description which is included in this study was therefore recorded (onto tapes or typed directly) immediately after leaving the field. In the follwoing chapters, dialogue recorded in this fashion will be presented in a single quotation marks (' . . .') to indicate some degree of paraphrasing. Also generally recorded out of the field were notes with regard to method, and notes which made theoretical statements about what was observed - for instance, notes speculating on the meaning of staff behaviors. In situations where no patients were present 9staff meetings and interviews) I was often able to take direct and copious notes. The staff group became so accustomed to my note-taking that during my absence from one meeting notes were taken for me. On only one occasion did anyone on the staff request to see these notes - and at time the request was quickly withdrawn when I explained the confidential

nature of my records. I was, however, used as a reference person for facts in my notes: on several occasions community members asked for neutral information (what was announced the week before last, for example) which I was known to have filed away. Information from meetings and interviews contains a great deal of dialogue which was recorded directly. This data will be presented in regular quotations (" . . . "), to distinguish it from the paraphrased conversations recorded some time after their occurrence.

Analysis

Proceeding concurrently with data collection and recording was data analysis - or attempts at data analysis. During the course of this study several schemes for organizing the data proved to be theoretical false-alarms. It was only after a few such false starts and wrong turns that descriptive categores emerged from the data which adequately served to present the Detoxification Section. It was then that some propositions could be put forward about the relationships of those categories to one another. My first impulse was to try to impose any classifications on the data which would give them some cohesiveness - for no unifying strand appeared to run through the notes. Rather, the description of the heroin service showed a series of crises, conflicts, and personnel changes - nothing seemed constant. Looking for some unifying scheme to give shape to what appeared to be a progression of upheavals, I misinterpreted this "parade": I saw the people and events "passing through" the heroin service as manifestations of some sort of institutional evolution. Therefore, I tried to fit what I saw at the Detoxification Section to theories about institutional development, particularly Weberian notions about charismatic institutions and bureacratization.[33] No doubt these theories "fit" in some respects:

there are charismatic qualities which attend the free clinic movement, as well as charisma attached to heroin. And the process of institutional expansion at the service involved development of levels of hierarchy, with consequent moves toward increased bureaucracy. But while ideas about institutional development may have had some application to the service, they were not central - theories about developing organization and hierarchical structure did not convey the essence of the world of the detoxification workers. Indeed, when the one worker who discussed institutional evolution left the community, the subject seemed to disappear from the consciousness of other members. Complicating matters further was the fact that the larger clinic structure was undergoing changes: Detoxification would be a separate section - no, it would be part of the Medical Section - it would not, it were merge with the Drug Treatment Section - and so forth. All these threatened changes in the larger structure of the clinic complex were to have minimal impact on day-to-day activities at the heroin service, yet I waited to observe the effects of Executive Committee pronouncements. After some time of waiting for organizational structure to evolve, or be imposed from above, the data began to say something significant. From the description of months of day-to-day living at the service, it appeared that the one constant feature of the community was the behavioral similarity between "generations" of workers. It appeared that the staff community was not the sort of grouping who could best be seen in terms of social structure, or organization. Rather, in Redfield's terms, the community could best be presented in terms of "conceptions that lie on the axis of the self"[34]:

> Ecological system and social structure do not call upon the student of a community to remain for long inside the mind of any particular native . . . As we now move to the human career, group personality, and system of values or ethos ,

> we move to conceptions in which the self is the axis. Now the investigator must stay within the states of mind of somebody in the community . . .[35]

Details of staff attitudes, behaviors and beliefs <u>were</u> the constants in the setting; they were the elements from which descriptive categories could be derived and a hypothesis proposed. They were the expressions of a strong and pervasive <u>community culture</u>: a netowrk of shared meanings and understandings which gave wholeness to the community. Indeed, this culture had the power to maintain the community as a cohesive unit <u>despite</u> the constant conflicts and crises which threatened it as an organizational unit.

The data, based on day-to-day description of the staff, presents a piece of a culture. Thus, in a sense, I found what I had set out to look for, with the observational skills, the intimate viewpoint, and the empathetic perspective of a nurse. That is, I found everyday behaviors which reflect a network of subjective meanings and understandings. My involvement with the community was fruitful in producing a record of the actions, feelings, and beliefs which typified its members. The shared staff behaviors will be presented in "The Culture". Following this, a hypothesis will be put forward about the attitude toward life - the ethic - which underlies the staff behaviors. But to gain some appreciation of the impact of the staff culture on individuals in the community, it is necessary to first examine the type of participants who come to the detoxification service. The clinic attracts individuals in search of varied and conflicting rewards from their work with addicts. It is important to examine the conflicts among these participants - The Observed - in order to fully assess the effect of the community culture in producing cohesion and homogeneity.

CHAPTER 4: THE OBSERVED

The Detoxification Section attracts participants who may be distinguished in terms of their personal reward systems - that is, by the kinds of pay-offs they seek in their work with addicts. During the time of this study, it could hardly be said that community members were rewarded economically: most staff were unpaid and the top salary for full-time, paid staff ran at about $250 per month. But individuals want some sort of compensation for their work, some reward. Compensation, of course, came about differently for different people, and herein lay a problem for the detoxification workers. The "reward systems" of various members of this community are not alike - nor are they always complimentary. Rather, different individuals seek varied and often conflicting types of rewards from clinic work. To the extent that each work activity at the service compensates or rewards an individual, he will prefer that activity. But - since reward systems differ - each activity is not equally rewarding to all members of the group. Thus, individuals try to do the kinds of work which compensate them; they prefer activities which are rewarded in their "medium of exchange". An analogy may serve to clarify this: imagine a situation in which one person wants to paid in pesos, one in rubles, one in dollars. Suppose too, that in this situation there are a number of possible activities to perform - some of which are paid for in pesos, some in rubles, some in dollars. Workers would promote activities which are paid for in their preferred currency. To the extent that activities paid for in rubles become dominant, the workers valuing pesos or dollars would feel short-changed, and so forth. Similarly, at the Detoxification Section, problems erupt because of conflicts between the reward systems of individuals in the worker group. To be sure, the conflicts which disrupt the service are not seen by the participants as "reward-

system-problems". Usually they are perceived as disagreements as to work philosophy, treatment ideology - or as personal power struggles. Nevertheless, community conflicts may be seen as problems between four reward types: the entrepreneur,the missionary, the seeker, and the professional volunteer.

Reward Types

Community members will be discussed in terms of a typology: entrepreneurs, missionaries, seekers, and professional volunteers. These categories will be helpful in understanding the basis for intrastaff conflicts - clashes between the reward systems of the community members. Before describing these four types, however, certain points should be emphasized. First, the typology offered here is an abstraction grounded in empirical data, and is rendered in somewhat pure terms in order to highlight interpersonal and institutional process. Few members of the community are "pure" types. That is, the type of work compensation a community member seeks is not the full measure of that person. Indeed, in discussing the community culture, it will be shown that group behaviors of the participants in the community testify to their ability to go beyond their reward-needs in their interactions with each other. Further, the types presented here are surely no exclusive to this setting. Some will be recognized as familiar characters encountered in other kinds of groups and institutions - particularly service institutions. The difference here is that conventional institutions channel or drain drives toward entrepreneurial,missionary, or other types of personal rewards. They may be pursued mainly as they are consonant with institutional goals. And, in conventional work settings the common goal is usually economic compensation. Community members come to the heroin service (deliberately or by chance) to pursue their career lines - and seek out work rewards - unencumbered by conventional institutional restrictions.

Hence, here the entrepreneur, the missionary, the seeker, and the professional volunteer are seen in clear focus. Bearing these points in mind, the defining characteristics of each "reward type" may be considered.

The entrepreneur

The entrepreneur seeks fame and fortune. He by-passes established routes to "success", and invests his resources in the heroin service. Success, in his terms, is defined largely in the same way it would be in a "name" hospital or university - in terms of "expert" status with the primary goal of professional admiration and recognition. What distinguishes the entrepreneur at the treatment service, is the manner in which he pursues his brand of success. Schaw points out that entrepreneurial types manipulate the external world in order to achieve their objectives, rather than seeking to change the self to fit the environment. The entrepreneur does not work toward success through established pathways to distinction: working one's "way up" in a prestigious medical center; working for university tenure, etc. Rather, he finds a new and untapped situation through which he can realize his goals for reputation and influence:

> "P and I have come to admit, at least to each other, that we're here for professional advancement . . . I'm going to get into graduate school . . . he's becoming a famous man."

The entrepreneur bolts established success structures - yet he works toward familiar ends - renown and respect in professional circles. Hence, his pay-off requires that his activities be visible to the proper audience. With this in mind, he gathers statistics; he publishes; he speaks at professional gatherings; he courts the media. He performs visible activities and sees to it that they get exposure - in this respect he is single-minded about his work. Yet this single-mindedness should not be confused with ruthlessness. While he demands that jobs which claim professional

attention should be given high priorities, he does not object to other, less noticeable activities. Further, he isn't selfish: it must be pointed out that entrepreneurial activities bring recognition and support to the entire community. Moreover, he encourages and supports the entrepreneurial activities of other community members. So long as there is payment in his preferred currency, he is willing to share the wealth. For instance: an entrepreneurial individual, in the face of complaints about his psychological testing of patients, offered to teach administration of the Thematic Apperception Test to non-entrepreneurial staff. This offer, however, was not taken up. The generosity of the entrepreneur in extending a "piece of the action" to his peers may go unappreciated. For other types, like the missionary, such an offer is meaningless. He is after altogether different stakes.

The Missionary

The missionary believes in something - a treatment method, or work philosophy, or therapeutic goal - and wants to spread the word about it. To the extent that he may do so, he is rewarded. The missionary's belief needn't involve religion at all. However, he does testify to some state of moral good. This could be self-acceptance:

> 'If people could look at themselves . . . and dig themselves...'
>
> "Accept where you're at, cause it's just as good as anywhere else."

Another missionary type could be convinced of the benefits of a drug-free existence:

> "needing doctors is a delusion society suffers from."
> "He only wants it [methadone] so badly because of all he's been told about it . . . he could have been told he needed sugar water . . . "

Or, the message could have to do with building a truly alternative style work setting:

> "I don't want a hierarchy where people pull charts for doctors and nurses . . . "

Whatever his message, the missionary is "paid-off" in situations where it can be expressed - and especially in those where it might be understood and accepted. He does not "play" to a distant audience of eminent professionals, but to himself and his fellow community members. Whether the treatment service is famous is not a "bad" issue to the missionary, but it is a somewhat irrelevant one. He wants to be known to the staff and to the clinic clientele - for they can receive his message:

> "The whole world views us, but the Haight Ashbury community doesn't know us at all!"

The missionary is compensated by - and therefore grants highest priority to - situations where he can refine, explain, and communicate his beliefs. It follows then, that he places a high value on activities such as therapy, consultation, group meetings. Here is where he directs his energy; he wants to be taken seriously, given time and attention. For the missionary, activities which involve discussion of values are not in the least frivilous, but constitute important work. Consider the following transaction between an entrepreneur and a missionary, during a staff meeting:

> "E: Does anyone have any comments and suggestions for improvements right now?
> M: I tend to get into a judgemental bag . . . feeling like 'this person doesn't appreciate what I'm doing.'"

Missionary type activities are conceded to have intrinsic merit by other staff. However, activities such as discussion of values do not convert to qualifiable data in the manner than MMPIs and medication records do. Certain qualitative aspects of treatment rarely become visible to professional audiences via publishing. Nor do they help to provide clear answers to the

cold questions of funding agencies. In terms of pay-off, the missionary and entrepreneur occupy opposite poles. But they share one characteristic: each is single-minded. Each knows which activities should claim first priority in terms of time, energy, and resources.

The Seeker

Seekers are persons in search of some career goals in which to commit themselves. While the label "seeker" may imply idealism, it should not be assumed that the seeker is drawn into the missionary camp. He could as easily be attracted to the idea of professional recognition, and cast his lot with the entrepreneurs. For the seeker, the discovery of what "currency" will satisfy him is his work reward. Since he has not as yet committed himself to particular goals, the seeker lacks the single-mindedness of the entrepreneurial and missionary types. He evaluates the resources which should be allocated to an activity according to individual criteria, rather than in terms of a general preference for certain classes of activities. Some seekers try to keep their options open. Such individuals want to live in the present, and forestall committments to entrepreneurial or missionary type reward systems:

> "I don't have any fantasies of the future - I haven't dreamt in a year . . . I used to think of, oh - being rich, a woman. When my mind wanders now, its developing a thought . . . I might like to work for an underground paper . . . I want to learn as much as possible about as much as I can." " . . . I wouldn't mind falling into something, but I don't like going somewhere where it might be fucked up."

Others seekers feel some urgency about declaring themselves, some pressure from the community which forces them to examine their beliefs about treatment ideology and work priorities. One way around this dilemma is to try to see "both sides":

> "Nothing should be done for research's sake alone . . .but

> if someone can get a paper out and be helping people at the same time . . . "

If the seeker is naive with regard to therapy and professionalism, the conflicts between reward systems may exist outside of his awareness for a time. According to one seeker who was an ex-addict:

> "I didn't know about the studies. I don't think that sinks down the layers to junkies. I didn't even know there was counseling. I didn't think of it as psychological - just social or physical."

Eventually seekers follow one of two courses. They might find nothing to commit themsleves to at the clinic and move on. Or, they might develop a preference for one type of activity which rewards them more than others. In each case, they cease to be seekers. Individuals comprising the professional volunteers group do not resolve their situation in quite the same way - they are "paid-off" no matter what kinds of activities are granted highest priority.

The Professional Volunteer

The term professional is not used here in a clinical sense. Indeed, there is no reward type which involves professionals or lay workers exclusively. The "professional" volunteer is not a credentialed volunteer, but rather a worker who donates his time to altruisitic enterprises becasue he is rewarded there by meeting new people and finding interaction. Unlike the entrepreneur, he isn't after big professional stakes. Unlike the missionary he has no creed to puch. Like the seeker he judges situations in terms of individual merits when reward system disputes flare up. However, unlike the seeker, no quest for an object of committment is involved in his work at the clinic. Professional volunteers are rewarded, very simply, by immediate and varied events which present themselves. For example, a middle-aged nurse who took private duty cases and lived alone dropped in at the clinic shortly

after this study began. She never assumed an active treatment role, but instead, quietly, began to learn intake, pharmacy,and other non-counseling types of jobs. She remained at the clinic throughout the time of this study and was apparently quite satisfied to chat with patients, attend staff meetings, and otherwise interact with people at the heroin service. Never, during this time, did she involve herself in questions of value, or attempt to enlarge her professional role. She, apparently, was "paid off" by her daily interactions alone. Some professional volunteers slip in and slip out of the clinic quite casually. One reported:

> "I just walked in here one day and saw all this disorganization and put myself to work."

Some express a desire to be part of something that "helps people":

> "I don't know exactly, but I feel like from now on my life is going to be helping people."

Some professional volunteers become involved with the service on a long-term basis, but they do not, as a group, become pivotal people within the community. One professional volunteer's function at the service was so vague that she was introduced in a staff meeting as 'the girl who wears pretty clothes and gets us cokes.' As long as the community is a functioning work unit, the professional volunteer is rewarded. If conflicts arise, the support of members of this group is up for grabs - even more so than is the support of the seekers. They are not looking for a "side" with which to ally themselves.

It is the first of two reward type groups - entrepreneurs and missionaries - who are in conflict most directly with regard to pay-offs. To the extent that the treatment service dedicates itself to activities which reward the missionary, less energy and resources are available for entrepreneurial pursuits. Similarly, if counselors must help gather data on clients every day, they are blocked from spending as much time as they might choose

to in discussing concepts of personal moral importance. A steady tension is thus exerted between these two polar types. The stronger this tension, the more likely that other types of workers - seekers and professional volunteers will be seduced or drawn into one camp or the other. When missionary and entrepreneur clash openly, the service sometimes appears polarized - divided into two factions. Yet these conflicts are not perceived of as problems between reward types. On the contrary, they are seen as disputes over isolated issues. Specific topics which surface reflect a fundamental source of discontent, the problem of people feeling short-changed.

Reward System Dispute

Work priorities

Frequently, reward system conflicts manifest themselves as simple disagreements over work priorities. For example:

' M: Maybe I'll just leave . . . if all we are is an invesgative team . . .

E_1: But we can find therapeutic modalities which will work!

E_2: There are four functions of a drug service - education, research, enforcement, and - and -

S: Treatment.

M: Where does the priority lie?

E_3: Survival.

M: No, we're supposed to be a stable group which has survived. OK! we're supposed to have a doctor here, but he's not treating patients . . .that doesn't mean I like the man any less, but I can't work under these conditions. . .

E_3: We need you to survive.

M: . . . we're whoring! (goes on to criticize the fact that the staff meeting isn't used to discuss treatment, staff relations)

In the transaction presented above, the activities which reward the entrepreneurs are cutting-off the missionary from his compensation. He treatens to leave, if this continues. The entrepreneurs, however, fail to understand the problem. Entrepreneur 1 connects research to treatment (we will find modalities . . .); he does not appreciate that to the missionary it is the act of treating a patient - not a long-range goal - which is rewarding. Entrepreneur 2 forgets treatment entirely when he lists the functions of a drug service, and entrepreneur 3 asserts that maintaining a base of enterprise (in his terms 'survival') claims a higher authority than patient care. Only the seeker backs the missionary, in reminding entrepreneur 3 about the section's treatment role.

Missionaries can be similarly obtuse when it comes to short-changing their colleagues on matters of work priorities. In the following exchange, the missionary - who sees fund-raising, grant-getting - as after all, only a means to a patient-care end - fails to recognize that it _is_ the act of getting attention, recognition, and support which rewards the entrepreneur.

' E_1: Since the beginning the clinic has been service oriented and this has proved dangerous . . . the clinic has closed twice for lack of funds . . .

M: _Other_ people get money.

E_2: They do it politically. We whore less than they do . . we just lost a lot of money to (another service) because of X's political pull.

E_1: (to M) How could we give better care?

M: By devoting more time to it!

E_3: . . . perhaps M is our conscience . . '

Entrepreneur 3 introduces the idea of morality, when he calls the missionary "our conscience". This thought appears repetitively in discussions of work priorities: the missionary is considered to be idealistic,

the entrepreneur is seen as pragmatic. For instance, in the following transaction, a missionary questions the manner in which questionnaires will be administered to patients:

' M: People with masters degrees will be coming in . . .

E_1: What do you have against people with masters degrees . . .?

M: I'm afraid of people going after subject matter like a slab of meat.

E_2: That shows you don't really know what's going on out there! '

The entrepreneurs clearly feal that missionaries live in an ivory tower - remove themselves from what needs to be done. Of course, what must be done - i.e. publish - is a mandate only for those with the objective of professional recognition. For brief instances, the question of work priorities may appear to be resolved. At these times, everyone feels "paid off":

' M_1: There seems to be a conflict in the group between idealism and expediency.

M_2: That's the whole world's problem.

E_1: . . . we mustn't be too expedient . . .

S : How does this all affect your jobs, your patients?

E_1: Everyone complains to me about P [foremost entrepreneur] - he's a man with good and bad points - work around them . . . for instance, everyone complains about P's papers, but as a result we got $2,000 in January . . .

S : And all that money from speaking . . .

PV: P feels that everyone here feels he's ripping the clinic off

S : (to M_1) How do you see the place?

M_1: Chaotic, but things are getting done . . . good feelings, good vibes . . . I'm getting my pay-off, too, my strokes. My sympathies are with the idealists . . . I think the direction is toward idealism today . . . people who stand for expediency are the ones who are having to give . . . idealism . . . is the life blood of this place.

S : This one of the few places where money doesn't hold things together. '

Treatment Ideology

Even in the above sample where things end up on a relatively harmonious note, the tension, the source of conflict is acknowledged. There is not so much an agreement as there is a stalemate. Missionaries - in the majority in the last discussion - must credit the entrepreneurs with keeping the service afloat financially. But they render Caesar only his due: when entrepreneurial activities threaten to alter the quality of interactions between staff and clients, then clashes erupt with renewed strength. The the conflicts between reward types may surface as disagreements over ideology, treatment values:

> E: . . . there has been some friction through misunderstanding. T's students have devised a new intake sheet including social things . . . it may take 1-1/2 hours to complete . . . I think it's vital for us to go along with it . . . I know it may grind some of you people to impose things on patients . . . but it's got to be done sometimes.
>
> M: Any statistics dealing with crime are misrepresented by the people getting them . . .

and after a few minutes of discussion:

> M: They're coming down here to look at low life, they don't give a fuck about the junkies . . .
>
> S: Who came down here for the first time and didn't feel scared:
>
> M; I did - because I used to live here! . . . I feel that we're making the same mistakes that other people have made . . . categorizing the patients as different . . .
>
> E: We're trying to prove we're the same! '

The missionary is threatened by the idea of prolong interviewing of clients, which will cut off his reward in two ways. First, it takes time. Second, it means students will be using patient contact to gather data, rather than to therapize, teach, or otherwise convert them. Therefore, the quality of his relationships with clients is altered. The entrepreneur cannot see

that he is "short-changing" anyone: after all, the goal of the research is to prove similarity between clients and staff (middle-class background). This, in his view, cannot harm the patients. The seeker in this instance supports the entrepreneur. He too, came to the service with some doubts and fears. Members who value some state of subjective well-being want missionary activities to be taken seriously - to be granted intrinsic merit. Thus, in some arguments over treatment philosophy, the entrepreneur grows edgy, fails to "see the point" of the discussion, while for the missionary the "point" - the reward - is that discussion itself:

' M: I've been trying to talk about goals for months . . . what's your goal?

S: To get someone on the way to treatment . . . we don't come up with an end-product here.

M: What's treatment?

S: Usually psychiatric . . . it can also be functioning in some kind of life-style they're not miderable in.

E: That doesn't necessarily mean a drug-free life -

M: If that was the goal, I'd be totally frustrated!

E: (getting annoyed) Goals are individual . . .

S: No. We must latch on to something.

M: [better use of a two-week period of treatment] would help us lower our sights . . . get more junkies.

E: (getting interested) The figures would look good, if we could cut the people who came once out of the statistics.

M: We don't give enough . . .

S: What do you think we need?

M: More time . . . more workshops and staff sessions.

PV: (a few moments later) I came here with a certain amount of optimism and caring . . . helping people be happier about themselves . . . I hear pessimism from everybody - pessimism and cynicism . . .

It is the goal-centered discussion which rewards the missionary. The seeker is drawn to his camp - not becasue the discussion compensates here in and of itself - but because she is indeed looking for goals. The entrepreneur is pleased most when a point comes up which relates to visible, publishable activity. The professional volunteer is confused. She hears only "pessimism and cynicism".

Personal Conflict

When the group is divided with regard to reward system conflicts, disagreements over work priorities or treatement philosophies surface as the issues at stake. Occasionally, however, the conflict between a missionary and entrepreneur becomes intense enough to appear to be a purely personal conflict. Thus, reward system problems are reflected in personal power struggles between two individuals. Indeed, they are struggles over power - but they involve the power to be compensated for work in an acceptable medium of exchange. For example, a missionary who opposed statistical work was surprised to discover an entrepreneur felt personally treatened by his attitude:

> "He thinks I'm out to get him."

Consider the following transaction. Here a missionary wants to discuss philosophy - he presses an entrepreneur to present his "total clinic concept". The entrepreneur reacts as if he is undergoing a personal attack:

> ' E: It's not me getting rich, man - I'm making a third of my old salary -
>
> M: I'm not attacking anyone - I'm just trying to keep a concept . . .
>
> E: I'm frustrated . . . I feel like I'm getting my throat cut...'

A seeker-turned-missionary had previously cordial relations with the service's most enterprising entrepreneur. After his "conversion",he clashed violently with the other worker, over an issue of priorities. When asked to discuss

the issue he said, "I decline to discuss a personality dispute."

Work priorities - treatment philosophy - struggles for personal power - all these are recurrent sources of conflict and division among members of the Heroin Detoxification community. They surface as reflections of fundamental differences between the reward systems of the participants. Searching for personal work rewards which may be in conflict with the desired rewards of their fellows, the staff members come into constant and intense dispute. They are pulled into factions by the tensions exerted between two polar reward types - the entrepreneurs and the missionaries. Seekers, looking for some object of commitment, tend to be drawn to one camp or another. Professional volunteers too may be seduced or converted by entrepreneurial or missionary types. With such a constant source of divisiveness, it might be expected that the section would be destroyed. Yet, the heroin service endures and grows. In fact, to the outsider the community members appear not only enduring but homogeneous. During the course of their daily work all four reward types appear to behave in like ways - there are stunning similarities between the entrepreneur, the missionary, the seeker, and the professional volunteer. Perhaps a clue to staff homogeneity lies in the fact that staff behaviors of the clinic's clientele - with the notable absence of actual heroin using beahvior. Addict-like behaviors demonstrate that despite dissension over matters of rewards, the community has a quality of oneness, wholeness - unity.

<u>Reward-type behaviors versus Community Behaviors</u>

There is an important difference between behaviors which center around reward systems, and shared addict-like behaviors of the staff.

Reward preferences derive from the characteristics of _individual_ participants. They are brought _into_ the community by single actors, and are _divisive_. Shared addict-like behaviors, in contrast, appear to be the _result_ of membership in the community, and are _unifying_. It is crucial to stress this fact: addict-like behaviors are _consequential_ to membership in the staff community. Whether they "really" are more than consequential is open to debate; but for the purposes of this study it can only be established that addict-like behaviors are observed among staff members after induction into the clinic community. The logic of this reasoning may be clarified thus:

> Addicts are found to steal. The desire or motivation for theft may or may not play a role in a person's becoming addicted. If it is reported that theft occurs after the fact of addiction, then it can only be established that theft is _consequential_ to addiction.

As consequences of community membership, shared, addict-like behaviors demonstrate the _effects of the community on the individual_. They are _group_ behaviors - manifestations of the force which gives the community a quality of homogeneity, of wholeness. In moving from a discussion of reward type behaviors - which are individual - to a discussion of addict-like behaviors - which are shared - we move to a discussion of culture.

CHAPTER 5: THE CULTURE

When we speak of the culture of the Detoxification Section community, we refer to the system of meanings and understandings shared by the staff group. To be sure, in the sense in which it is used here, the term "culture" does not refer to the all-encompassing symbolic worlds which typify small, primitive societies. Like all members of modern industrial society, workers at the Detoxification Section have associational contact with diverse cultures - or, if you will, subcultures - and also share to some degree in "standard American culture". Nevertheless, the workers have a community culture which is distinct. As Becker points out, in Outsiders:

> . . . the term, in the sense of an organization of common understandings held by a group, is equally applicable to the smaller groups that make up a complex modern society. Ethnic groups, religious groups, regional groups, occupational groups - each of these can be shown to have certain kinds of common understandings and thus a culture.[1]

To show these common understandings, the student of culture must look at action.[2] Shared meanings and understandings of a group cannot be seen directly - rather, they must be inferred from what is observable: behaviors, statements of belief, use of language, etc. Therefore, to make the community culture visible, it will be necessary to describe observed action at the heroin service and to discuss the meanings which these actions imply. Shared, addict-like behaviors of the staff group will be presented in terms of nine descriptive categories. This is a formidable list, but it is these categories to which the data lends itself best. The logic of this arrangement should become clear in "Conclusions". Each of these nine groupings infers a particular type of meaning to the behaviors which it includes. Behaviors in the first groupsing demonstrate immediacy; those in the second seek excitement; actions in the third grouping reenforce a sense of nega-

gative identity; those in the fourth conform to the rules of the heroin marketplace; the fifth grouping shows practicality; the sixth shows a facility at living by wits alone; the seventh demonstrates the art of successful failure; behaviors in the eighth grouping are anti-authoritarian; the last grouping includes behaviors with a pornographic quality. Seeing staff behaviors in terms of these categories should help to make visible the types of meanings and understandings which the community members share.

Immediacy

The idea of immediacy, of experience rooted in the here and now, is often linked with addiction. Clinical explanations - pejorative ones - call this an inability to delay gratification. But it is more - it is an approach to a quality of experience. The detoxification staff share behaviors which demonstrate the quality of immediacy. They are at their collective best under conditions with existentially immediate properties. They prefer - and perform well in - situations which are happening "right now"; they mobilize their resources when confronted with a direct presence to which they must react. Attendant upon this thriving on the immediate - the other side of the coin, one might say - is the group's difficulty in handling the non-immediate. They appear to "falter" in situations which call for long-term planning, and which involve an abstraction, rather than a concrete presence.

Immediacy is seen clearly in the group's crisis orientation to work. Medical emergencies are a case in point: in several years of functioning the service has never "lost" an overdose case. Community members approach life-and-death situations, such as emergency treatment of narcotic overdose, with the cool assurance of people seasoned in crisis. For example, an elderly addict was brought to the service by several distraught young people.

The staff reacted with calm efficiency: the emergency "kit" was produced, a doctor informed, a room made ready. The patient appeared to be all but dead - his chest was sunken, his color ashen, his respirations barely noticeable. Treatment was quick: in several moments he was alert.

> Patient: "Hi"
> MD: "That's the second time I've saved your life this week, you son-of-a-gun."

The same assurance, even bravado, is displayed in the community in other types of crisis situations. The community pulls together during instances of clear and present physical danger. For instance, at one point the clinic complex was pestered by knife-wielding intruders. The Heroin Service members were called in to assist the Medical Section workers. Later the staff discussed the fact that <u>they</u> were better able to cope with such threats than their non-heroin-career colleagues:

> '[the other staff group] don't show any support . . . no one backs anyone up . . .<u>this</u> staff <u>is</u> really together.'

They reaffirm their unity under economically threatening conditions too, as when the unit appeared close to financial collapse:

> "It's our collective . . .it has to run for us to stay open - especially now, with no money . . . "

Some community members demonstrate their attraction to crises, when they show disappointment if one fails to materialize. An overdose which turned out to be a false alarm illustrates this point: a "regular" patient stumbled into the back room, expressing the fear that because he had used heroin after taking his detoxification medications, he might have inadvertently harmed himself: "I forgot you're not supposed to take phenobarb and shoot junk". Several staff members mobilized themselves immediately - they contacted an MD while checking on the precise kinds and amounts of medication the patient had ingested. Once this information was obtained it became

clear that the patient was in no real danger - he would not lose consciousness. Annoyed at the outcome of this event, a counselor told the patient: "Just go sit down, you're not going to die right now."

It is indicative of the group's crisis orientation, that while they continually function well in a medical emergency, they were never able to formulate a standard policy for such situations. In a discussion of the need for an emergency procedure, one staff member remarked:

> 'Isn't it funny how we can cope with emergencies, but nothing in between?'

It is the "in between" things -- the situations which are more abstracted or temporally removed from the immediate present - which cause problems for the community members. They have more difficulty carrying out distant projects, or planning for long-term changes. Nevertheless, the community members must come to terms with the idea of change. Their mechanism for coping with the future involves a degree of magical thinking: they do not so much anticipate events to come, as they state and restate a belief that somehow events will be thrust upon them and elicit a reaction from them. When an event becomes imminent enough, it will force a response - it will be immediate. Thus, the community members constantly refer to a "something" that is always going to happen <u>to</u> them. "When we get our new house" was a phrase used constantly to indicate that the event of moving from building to building would make everything - magically -fall into line. During eleven months of hand-to-mouth existence, salaries often went unpaid, emergency loans were obtained to pay off the electric company, and so forth. Yet in meetings, the community members rarely attempted to lay out rational plans for meeting expected expenses. Rather, they spoke about large amounts of money which (who knew?) could be available any moment:

> "Five million national bucks for detoxification and rehabilitation.."

> "The politicians are freaked out of their heads . . . they want to pour $70,000 to $80,000 into us . . . they want to give us money . . ."

> "They're falling over themselves to give us money . . ."

> "$5,000 is assured by the marathon . . . "

> "Things will smooth themselves out as soon as that money comes in."

By pointing out imminent events - such as future financial windfalls - the staff eliminates the problem of planning for change. Waiting - for the next big break, big donation, big grant - replaces actually dealing with the future.

Indeed, this magical process which changes planning to waiting creates some self-fulfilling prophecies. If anticipated changes are something to be waited for, not planned for, when they arrive they may result in crisis. Hence, an event is thrust upon the staff members, and elicits immediacy type responses from them. For example, during a year of poverty, the community discussed the possibility of coming into a large sum of operating money. Not once did they seriously plan for the effects of sudden wealth. Once it bacame apparent that the money would be awarded immediately, a crisis occurred. People could do what they do best - that is, unify in the face of a spontaneous presence:

> "We're going to have to stay close . . . a few people say they have full control . . .if we let them, they'll do whatever the fuck they please . . . don't let anyone get fucked over . . . if one person's pissed, we all get together . . . "

> "A: I can see manipulation with money - money corrupts . . .
> B: That's what we're totally against as a group . . .
> C: Can you see a way out?
> B: It will need a concerted effort - stick together . . . "

The above transaction - to one uninformed about the community's facility at creating and reacting to immediate crises - looks suspiciously like an inability to tolerate prosperity. One incredulous observer remarked:

> "The situation last week was like we haven't got enough money

to buy toliet paper - now you can buy toliet paper from here to New York . . . "

What the person making the above comment failed to realize was that unless the situation was perceived as one involving immediate conditions - one demanding clear-cut and istant response - it could not be dealt with effectively.

Lest it be assumed that the community members spend the better part of their time fomenting crises, it must be pointed out that immediate situations are the stuff of drug treatment. Treatment of drug reactions, confrontation and crisis type therapeutic techniques - these are here-and-now activities which demand a capacity to function on the spur of the moment. Further, such activities are more colorful, more absorbing, than the duller process of planning for long range and abstracted goals. In this sense, immediacy type behaviors are closely tied to actions of the community members which seek excitement.

Excitement

"There are few vocations offered to me in this society that can be as exciting as the vocation of drug addiction." [3]

The above statement, from a young addict, would probably arouse mixed reactions in the middle-class adult: confusion, disbelief, or shock. That same adult would no doubt find it hard to accept the idea that the heroin service has exciting properties. The world of the addicts is probably pictured by the middle-American as colored in the chill gray shades of urban blight and disease. Places for addicts - like the clinic with its shabby appearance, musty atmosphere - seem gray and unappealing. A visiting midwestern physician, for example, seemed confused and disappointed with the service. He looked sourly at the line of addicts waiting for medication and remarked:

"I think this place has outlived its usefulness."

Perhaps he was in search of the legendary flower children, rather than the carriers of the heroin epidemic. At any rate, what is missing in such appraisals of "junkie places" is the excitement they hold for their inhabitants. Events at the Detoxification Section hold drama, glamour, for the workers there. Medical emergencies for example: the rush for the emergency kit, terse exchanges about the patient in street vernacular - it all adds up to excitement. Of course, emergencies are not the stuff of daily work. Heroin detoxification involves more straight psychiatry than medical heroics. But even during rather routine daily work, the staff share a sense of participation in sensational events.

Daily work is infused with excitement because of the service's well-publicized clientele. After all, taking a history becomes more than just history taking, when the client is the focus of national concern, ambivalence, fascination. According to clinic writers themselves, their clients are not "just anyone":

> ". . . you've heard of Janis Joplin and James Taylor. Jimi Hendrix, Joan Baez and David Harris; Bob Dylan and the Beatles . . . Bernadine Dohrn and William Calley . . . Stokley and Huey; David and Julie; Tricia and Ed . . .Luci Baines and Lynda Byrd. Angela Davis . . . Muhammed Ali. That is the generation we are talking about: the 'War Babies', the 'Sputnik kids' . . . the Drug Generation. . .
> . . . the long road they took from the suburbs of America to a Heroin clinic in San Francisco had its origins in the subtle interactions of our history and our people."[4]

Clearly, those mentioned above are linked together in relationship to a "zeitgeist", a spirit of the same era that gave rise to epidemic numbers of young addicts. But what is also clear is that clinic documents illustrate a kind of sensationalism about work at the service that lifts ordinary activities into a more thrilling sphere.

It is not just the individuals pursuing sick careers at the clinic who are well-known. The service itself has claimed some measure of attention. The community members see their facility, not as an ordinary drug

service, but as a motel, a proto-type. Hence, their failures and successes take on extra dimensions - become more exciting. Constant publicity seeking helps to reenforce a sense of specialness, drama:

> "The house will be a model for the country . . ."

> "This is one of the biggest treatment facilities West of the Mississippi . . . "

> [on getting coverage in the AMA newsletter] "We've really hit the big time. . . all the docs in the country get that."

> 'The World Health Organization subscribes to our journal . . . '

> "I was really surprised to find out how famous the clinic turned out to be . . . it's nice to have worked for the HAMC. . . "

> 'The further you get from the Haight, the more important the Haight is . . . it's the capital of the drug abuse world. It represents the most concentrated area of drug abuse in recorded history'

> "It was exciting. . . all the publicity. . . we made to calls to people and said, 'Of course you've heard of <u>us</u>' . . . "

Language at the heroin service demonstrates the manner in which everyday actions are infused with excitement by the workers. A good illustration is found in the frequent application of battlefield metaphors to work. The images of combat, of violent excitement, show the degree to which treatment activities which <u>appear</u> routine hold exciting properties for the worker:

> "This isn't a treatment facility but a front-line emergency intervertion service . . . we're an army hospital in the middle of a battlefield . . . we pick out the fittest"

> "This is really survival of the fittest . . . all get seen . . . some get treated"

> "True, much of our service, by the nature of the transient population and by the financial limitations imposed by our volunteer staff has been of a 'band-aid' or'battlefield' nature" [from a detoxification service publication entitled "The Walking Wounded"[5]]

Unlike other pressing health problems, heroin addiction evokes not such sadness or fear but ambivalence. Addiction shocks, repels - but in some

ways it excites. The worker group at the heroin service partake in some of the sensationalism which surrounds the addict. Hence, their everyday activities take on exciting properties. The worker here is afforded a kind of stimulation which is absent in most other therapy situations. However, if the staff members share some of the excitement of the addict world, they also take on some of its stigma.

Negative Identity:

The speaker here could hardly be presumed to speak for all addicts, but he raises some interesting questions:

> "The dope fiend is one of the lowest things that our society can conceive of . . . be a dope fiend and you have minimal responsibility for what society is. You look at the people on the street, hating what they are (good citizens) and revel in the secret knowledge that they hate what you are (dope fiend)."[6]

The addict quoted above maintains a negative identity. To be sure it is not exactly a negative identity in the clinical sense. That is to say, he does not seem to be in the grips of self-hatred - instead he obviously feels there is something to be said for being at the bottom of the social barrel. He is defined as socially "bad" - but by virtue of that definition he at least sets himself apart from the definers, whom he perceives in a negative light. There is something akin to this attitude underlying staff behaviors which reenforce a sense of being negatively defined by the larger culture. This kind of negative "outside" identity reenforces a positive "inside" identity - an esprit de corps. Like most workers who become intimately involved with deviant groups, the staff members themselves may be seen as somewhat tainted by association: the stigma is contagious. This, they not only acknowledge, but support:

> "We're all psychopathic deviants here . . . "

One way in which the staff affirm this negative identity is by assuming

the role of the "bad children" in their relations with the larger clinic "family". During one period in which the Executive Board tried to arrange the clinic structure, so that all divisions would fall under Medical, Dental, and Psychiatric administrative heads, a long-time worker reported that he felt the move was aimed at bringing the drug treatment parts of the clinic complex into line. He said these sections (Drug Treatment and Heroin Detoxification) have always caused the most "problems". It is likely that many non-drug workers in the clinic family share the sentiments of a doctor who remarked rather bitterly:

> "It's too bad drugs get all the attention, because of course, there's much more to a free clinic"

The staff members take some satisfaction, however, in the manner in which their activities have come to monopolize attention and resources:

> "The heroin program brought a burst of creative energy . . . it is mobilized and polarized people . . . the clinic had been a lagging force"

There is a feeling of alliance against the people of other parts of the clinic who "were unable to work with addicts". Keep the patients here, and not in the Medical section, the group was warned: "those psychedelic kids across the street don't like them". People like the "psychedelic kids" are alluded to in a manner which implies some condescention. They couldn't work with addicts - who are"bad" patients, liars, cons. But it was the heroin treating group who chose to mingle with such deviants - and who saw their careers flourish:

> "The [1969] the program was in the back room, at T's desk . . . the program came from the back of the house to dominate the place."

As part of an alternative health care facility - and as caretakers of a devalued and controversial type patient - the staff members put up with a fair amount of harrassment, suspicion, persecution. Building inspections are a case in point. Clinic houses are subject to inspections

which invariably turn up something which must be repaired:

> "As soon as we move in, they arrive. Even on I_____ St. [building housing public relations type activities] which is non-treatment."

Local residents are sometimes less than accepting. When the publication and public speaking activities related to detoxification were moved to a new house, some blocks from Haight St., the neighbors circulated petitions, and expressed some fear of the clinic people:

> 'The neighbors are all talking about a hippie clinic moving in . . .'

> 'An article in the paper mentioned done . . .scared the neighbors . . .'

A benefit for the clinic, intended to be "a collage of the arts", was cancelled for the lack or appropriate permits. Local harrassment can be more direct. For instance, paitents have complained to staff about possible narcotic agents or police masquerading as addicts, and requesting that clinic clients get heroin for them. Besides posing a threat to individual addicts, this could be seen as an attempt to close the clinic. On one occasion, several policemen situated themselves at the front of the service, and asked people entering or leaving to show identification. They questioned one clinic worker closely because she had gone back to her car several times. Another worker went to the street to talk to police. Her report of their conversation indicates more than a "professional" concern about the staff members:

> 'The white cop came out with a slew of gratutitous anti-Semetic remarks . . . he said, "Are you from New York? Yeah, all you New York Jews come out here and make trouble. . . '

Problems with local officials are mirrored on the services's difficulties with more distant adversaries. For example, it was difficult for the section to get Medi-cal payments for services given to indigent patients. Billing sent from a free clinic was refused payments; further, if an MD

tried to bill Medi-Cal as for a private practice he was refused. The American Medical Association is another example. They support drug services, and development of drug programs - but withhold support from care given in the free clinic situation.

The powers that be have at best been a nuisance - at worst an impediment - to work at the heroin service. The community members take some pride in the fact that they have survived and grown in spite of their Negative identity". Indeed, they remind each other of indignities suffered - they reinforce a group identity born of trouble with the outside world:

> "We're in a hostile environment . . . natural impact is still a way to pay the bills until we get a broader base of community support"

> "We were a big embarrassment to the public health department . . . they wouldn't have been criticized by the media if not for us . . . "

On Medi-Cal and state authorities:

> "They've fucked us over in every way they could . . . "

On remaining open on national holidays:

> "Why should <u>we</u> celebrate <u>Memorial</u> Day?

In a psychodrama, with a clinic worker speaking to someone representing the AMA, and making friendly overtures:

> "Why don't you cut out all this bullshit and tell us what you really want from us!"

Treating a devalued population can be dangerous. It is a matter of pride to the community to note that they endure and grow in spite of being negatively defined by segments of the larger society. Thus, they reinforce their sense of this negative identity and use it as the foundation for a positive <u>group</u> identity. But maintaining definitional boundaries from other parts of the larger culture does not mean that the heroin careerists

isolate themselves. On the contrary, like all individuals pursuing heroin careers, the clinic workers must deal with and interact with all sorts of alien elements in the broader society.

Rules of the Heroin Marketplace:

Heroin careers cannot be pursued in isolation. They are conducted within an occupational system which is far-reaching and complex. It involves not only sick and therapeutic careers, but, for example, mercantile careers and enforcement careers. Many types of individuals develop careers and interact with each other because of the existence of a single phenomenon - the heroin market. Heroin business - hence clinic business - is subject to the rules of the heroin marketplace.

For instance, the workers must know what happens "on the street" in order to operate. When police report confiscation of large amounts of heroin, the addict knows that prices will rise. Similarly, the detoxification workers anticipate an increase in clinic attendence. Also, the workers must take care to remain informed about the quality of heroin being peddled in the district, if they are to guage the extent of their client's addictions - how much heroin is in the "heroin" used by their patients. They must be cognizant of the times when heroin is generally hard to come by. For instance, the service remained open on a holiday, on the strength of an argument from an ex-addict on the staff: "I could never cop on a holiday." If heroin is scarce, expensive, or poor in quality then addicts run a higher risk of becoming sick. Under these conditions the service will treat more customers. Therapeutic heroin careers, like sick ones, are therefore influenced by the price, quality, and general availability of heroin.

Therapeutic heroin careers follow the code and contingencies of the market in another respect. This is with regard to the matter of accountability. Like the person on the buying end of a drug exchange, the customer at the heroin service has no legitimate means of assuring that those who provide services will be accountable to him. He has no legally sanctioned way to regulate the quality of his care. Of course, few patients in conventional medical settings exert much control over care-quality - but some of them have the option of taking legal action against the caretakers if services are inadequate. The addict cannot "sue" his therapist for malpractice any more than he can legally punish someone for selling impure heroin. The staff acknowledges that conventional means to assure medical accountability are closed off to their patients:

> "We're dealing with a non-sueing population (knocks wood) We haven't been sued in four years . . ."

However, the clinic customer - like the heroin buyer - has an advantage that the conventional patient lacks. An informal system of rewards and sanctions operates to assure him some degree of accountability from the workers - some standard of good care. The clinic relies heavily on word-of-mouth methods to attract clients. It must, therefore, maintain a good reputation on the street: it must not "burn" people. Of course, a good name on the street means more than being known for handing out pills. The workers want to be seen as firm but trustworthy:

> "Our style is non-punitive - we worry about our image on the street. We want everyone to like us - we were any easy mark."

> 'We must be firm or be subject to ridicule . . . laughter on the street is irreparable damage.'

The workers try to be known as a reliable source of care - yet must also establish a reputation for firmness. Otherwise, in the words of one worker, they become known as "a dispensary with artistic pretensions."

There are some parallels between the power hierarchy in the heroin

market, and in the world of the heroin workers. To make this clear, some facts about the addict must be considered. Addicts include a disproportionate number of young and minority people.[7] Further, they are often pictured as some sort of societal renegades, pursuing self-destructive but rebellious careers. Yet, it is generally acknowledged that the heroin marketing operates according to the dictates of a wealthy, white, male power elite.[8] Hence it is middle-aged white men who ultimately determine who has access to opiates, and who, to some degree, control the distribution of addiction. Clinic workers too are a generally young, left-of-center group, who are described in terms of "alternatives" and rebellion.[9] But despite pretensions to freedom, the workers acknowledge the fact that they are contolled by a group of powerful white males. The Board of the parent corporation, for example, is exclusively white and male - and generally professional. The Executive Board of the clinic, which controls resources, has never been a truly representative body:

> "The Executive Committee is the final policy making board which has to consider legalities . . . there have been complaints that decisions were 'laid on' staff . . . this was done because of survival . . .we did it to protect people from how fucked up things are at the higher levels."

The paternalism in the above statement is clear: decisions are made for the rank-and-file. Some community members resent the fact that their careers are subject to manipulation by a"bunch of fat cats at the top". Nevertheless, they accept it - they play by the rules. Consider the following transaction:

> A: 'all the doctors on the Executive Board, and we can't get one to work. . . Why is he on the Executive Board anyway?
>
> B: To get money. [raise funds for the clinic complex] '

One worker, in trying to explain the seeming paradox of an alternative drug care center run by bysinessmen and professionals, commented:

"This is a very establishment outfit. There's nothing hip about it - except for some paintings on the wall."

He summed up the situation with:

"It's back to the power to the people trip - the people have no power."

Thw workers may chafe under this kind of structure, but they do not challenge it. For, much as the key figures in the heroin world are removed from the addict's daily life, the white-male-structure controlling heroin treatment is not present at the heroin service. People go about their daily tasks - over which they do exercise a great deal of autonomy - while acknowledging that distanct influences affect their careers. The people "at the top" have other primary interests than daily treatment per se - for instance negotiation of large-scale contracts with federal agencies.[10]

The ehroin market affects more than the addict and his therapist - it involves the police, the probabtion department and the judicial system as well. As an outgrowth of treating categorical criminals, the clinic must interact with all these groups. While police may be "the pigs" on the treatment service ground itself, the workers cannot isolate themselves from the forces of law and order. Rather, they must develop relationships and interact subtly with those with whom they share occupational territory. At the inception of the medical clinic, the police had to be dealt with:

"We made enemies and we made mistakes . . . we antagonized everyone but the police - we talked to them first, because they could have shut us down"

Even in the example given earlier, of the conversation between the worker and the "gratuitously" hostile police officer, things ended on an amicable note. In spite of dislike on both sides, these were individuals who must interact in order to pursue heroin careers - they play by the same rules. On one occasion, a policeman allowed the service to take an unconscious

young man found on the street. According to a worker:

> 'I talked to the cop, and he said I could have him.'

Clinic workers often have contact with their client's lawyers, probation, or parole officers, A counselor who was also a minister made a court appearance to testify in behalf of an addict - and, for the occasion, changed from his usual casual clothes to the black suit and reversed collar of a clergyman. He walked into a staff meeting, smiling, and announced: "It worked". Naturally, when dealing with official authority there is a temptation to go overboard -- to get as much "out of them" as possible. This , however, can boomerang: at one point several state facilities stopped accepting letters of referral from the heroin service. According to one worker:

> "The treatment philosophy has always been anti-establishment, 'let's fuck up the establishment.' It was kind of a game, until I really stopped to think about it . . . now it's gotten out of hand . . . "

Since the group must reluctantly deal with diverse kinds of people, they must be skilled at working with anyone from addicts, to police, to the "fat cats" on top. When choosing a representative, the group demonstrates its preference for diplomats:

> 'A(to the nominee): I approve . . . but you tend to much more radical than the rest of us
> B:(the nominee) That's your problem.
> A: But you're my representative -
> C: A called you a radical - I call you an ultra-liberal - do you promise not to throw any bombs?
> B: I'm not making any promises -
> D: That's the man for the job -
> A: Right - <u>shifty</u> as hell '

Thus, careers which operate in the arena of the heroin market are subject to certain rules of the game: some concern the price and quality of heroin; some concern power structures; some concern relationships with diverse types of people. The workers in the community play by these rules. In this respect, they provide an example of another set of staff behaviors - behaviors

which show practicality.

Practicality

The mystical, religious aura which surrounds the use of many drugs is missing in a heroin atmosphere. As William Burroughs puts it:

> . . . there are peyote cults - 'The Sacred Mushrooms of Mexico enable a man to see God' - but no one ever suggested tha junk is sacred. There are no opium cults. Opium is profane and qualitative like money.[11]

The detoxification staff are generally a practical group who reject mysticism as it relates to drug use, who value pragmatism, and who share the capacity for constant compromise.

In fact, the staff members display something of a contempt for mystical, philosophical approachs to drug use and abuse. As one patient (later a worker) remarked, in complaining about a treatment service with a less practical approach:

> 'The staff there are all psychotic themselves - everyone there says there is no reality - that everyone establishes his own reality. Well, there's still a common warehouse of reality that everyone goes to.'

Another staff member scoffed at a publication which linked heroin and mysticism:

> "They have a picture of some chick fucked out of her mind, and below it it says 'Om.' Om - hah! Fuck Om!"

The group is pragmatic, rather than ideological. This is seen in their "irreligious" approach to treatment - if it works, do it. One staff member said it was precisely the lack of one clinical philosophy or ideology that he liked:

> "It's one of the things I dig about the place. Generally any program for treating addicts is ridiculous - I don't think an 'addict-population' exists . . . "

This is not to say that ideology - about therapy or institutions - is non-existent at the heroin service. On the contrary, conflicts between

reward types may be highly ideological. But workers tend to be pragmatic in that they accomplish practical work goals - do what must be done each day - in spite of tensions and unresolved disputes:

> "What you do when you come to work here is say, 'Fuck it, I'm going to work!"

> "I don't think any bureacracy is going to function the way you want it to - so the thing to do is ignore it. I gave up politics for the same reason."

Pragmatism, as opposed to ideology, is shown in the way the group thinks politically. Political thought at the service tends to focus less on defining group attitudes, or on formulating a collective philosophy, than on clarifying how political events and trends will affect the existence - the survival - of the program. For example, as early as February, 1971 - five months before it became the focus of national headlines - the issue of military addiction was brought into group discussions at the service. As months passed, the group assessed exactly what kind of impact drug abuse in Southeast Asia would have on _them:_

> "A: Everybody in the government from Nixon on down is freaking because of the so-called heroin epidemic, right? . . . The politicians demand instant rehabilitation . . . Nixon promises a 30 day leniency period . . . as B says, this smacks of concentration camps the records will say the junkies are cleaned up-
> B: for 30 days they'll have a 95% cure rate -
> A: In the meantime, the VA hospitals - you've got to give them credit - are trying to alter their image . . . get money - for _us_ . . . "

or, in a humerous vein:

> "Grab the veterans - this is where the money is."

> "I got a line on one that isn't even back yet - if we're lucky, he'll be strung out."

The community members demonstrate their practicality by comromising. Entrepreneurs, missionaries, seekers, and professional volunteers manage somehow to accomodate each other. Work solutions are agreed up which may be philosophically unsatisfying - but are practical. It may be agreed to allow

persons who are seen as unwelcome on principle to remain at the service - if they have practical value. For example, one self-proclaimed champion of the service was seen as something of a nuisance. Several individuals disapproved of her presence, but in the end the group agreed to deal with the issue of prgamatic grounds:

> "look, she's a sharpy - she's using this place - but she's _paying_." [donating money]

Similar financial considerations led the group to make concessions about visitors:

> "Visiting groups can be told they can get a show for a donation."

To be sure, many issues bring out stronger feelings, and are more difficult to resolve than the ones just mentioned. The issue of testing urine specimens of patients of patients, fo example, was the focus of hot debate and strongly opposed opinions. Feelings ran the gamut from support:

> 'Utine testing is better than Nalline[12]. . . in 1967 we fought Nalline . . . we need a compromise - this is a problem for all street programs'

to acceptance:

> "Y doesn't like it, D probably won't like it either. But if junkies are going to get treated, they're going to have to play by the rules of the governing body . . . "

to adamant rejection:

> "I'll just leave."

Yet, in fact, some common gound was reached:

> "A: The big kicker for many of us is the inclusion of urine testing . . . if urine testing is an impingement of human freedom, I can go along with it . . .if being a junkie means you're tested, I can go along with it . . . I will seek the middle ground . . .I wrote it tough for the government - we can use it, and we can hedge on it . . . there are no hard and fast rules - every human being varies...
>
> B: We must work to get the best compromise we can . . .
>
> A: But me must do it
>
> B: But as little as possible."

In spite of the differences in beliefs among the staff group,they are down-to-earth, pragmatic with regard to their daily business. In the view of some authors, it is this "intensive economic behavior"[13] which separates heroin users from mystics and seers who prefer other drugs. Such speculation cannot be dealt with here - but it must be agreed that <u>if</u> the world of addiction is a practical place, so is the world of detoxification. The ability of the community members to compromise, their willingness to use any treatment modality which yields results, their ability to take advantage of any social event which throws something their way - all show practicality. In other words, "You can't always get what you want - but if you try sometimes, you just might get what you need."[14]

<u>Living by Their Wits</u>

The community members live by their wits - literally. The better part of their patient care is taken up with talking - matching wits with a client who is assumed to be verbal, glib - and possibly dishonest. Keeping the heroin service afloat also takes some fast-talking. And, by some accounts, sharpening one's wits is a valued activity in and of itself.

Undertaking talking-treatment with the addict -- given his repuration - presupposes some ability for quick thinking on the part of the therapist. Workers acknowledge that much of what transpires betweenthem and their customers could be called a game:

> 'People come here to kick or else just to cut down their habits - They're playing a game on us. But it's alright - because we <u>know</u> it's a game.'

Given these ground rules, it follows that most workesr at the heroin service engage in some degree of "gaming" themselves. For some, the best treatment for a con is a bigger con:

"I got a better game going than most the people who come in here" (joking)

"If you work with addicts, don't take anything you're doing too seriously - and try to rip them off."

"Anything you can do to get them off guard - anything unexpected - is positive . . . even A - she's always putting herself down and she's probably right, yet her bitchiness and insecurity can work - when you're dealing with that kind of population."

"Our pills are a lure, to get people into treatment."

Quick thinking goes beyond work with individual patients: it pervades all activities at the treatment service. There appears to be a lack of belief in the "work ethic": the notion that rewards are born of hard and honest labor. This is not to say that the staff do not work hard. The fact is that they do - often performing manual labor in addition to clerical or counseling work (i.e., helping to paint the building, moving furniture) for little or no money. But they do not see their rewards - personal or communal - as flowing from that hard work. Rather, they see success - fame, funding - as being the result of sharpness, quick wits, fast thinking. Getting financial support is a matter of manipulating - not deserving. The staff members take some amount of pride in their ability to out-wit money sources:

"The only requirement [for training money] is being poor - you're being rahabbed . . . You're definitely "in" - it's like a scam. We're scamming them into paying your salary."

"This itself has got to be the biggest ripoff in the history of government ripoffs. $12,000 per junkie . . . "

The lack of faith in the work ethic may be related to the class composition of the participants at the heroin service. Many of the client group are termed "middle-class". (This usually means - according to clinic criteria - that they are young, white individuals, born to white collar or working-class parents.) As addicts, this group de-escalates

in terms of social position, and could be considered lower-class. It has beenshown that in the staff group a middle- or upper-middle-class influence prevails. Several workers have lower class origins as well. A few - particularly ex-addicts - seem to adopt both lower and upper-middle-class properties with no stops in between, as when they move from addict to psychotherapist. Working-class influence is noticeably absent. Here is formed a working alliance between two groups of society who do not profit from labor: poor people cannot get jobs, or if they do, cannot "succeed"; affluent people - particularly young ones - have options for success without labor. Both groups know that success does not necessarily flow from a job well done - both take some satisfaction in living by their wits. The only member of the staff group who could truly be described as working-class in origins did not like to see himself as "gaming", manipulative:

> (How did you come to the clinic?)
>
> "I approached one of the teachers- laid down a big spiel about coming here and documenting my experience"
>
> (You laid a game on them?)
>
> "A game? oh -no, I wouldn't put it that way . . . I guess I did."

Other participants, in contrast, take a greal deal of pride in being sharp, fast-thinking. The development of quick wits is seen as a kind of fringe benefit or work with addicts:

> "What salary? I haven't been paid in a month . . . but I really get off working with people. It kind of keeps you sharp coming up with new games all the time."
>
> "Work is something I don't like, I like fun . . . we don't just sit around here and say 'I'm so fucked, I saw 50 junkies today! . . . I think a lot - I try to develop my games."

The staff view of things would probably see everyone as living by their wits, to some degree. Certainly, in their interactions with the larger health care system the staff have received rewards and recognition - not

quality of care - but because of the public furor over the rise in addiction, and the political gains that are to be made through support of drug treatment facilities. In all segments of society,it may that strategy - rather than labor - determines who"succeeds." If this is a possibility, than it is not "living by one's wits" per se which distinguishes the staff members. Rather, it is the quality of honesty - awareness - that attends their fast-talking and quick-thinking. And perhaps, too, the staff are distinctinve in their talent at "sharpening their games."

Successful Failure

There is an addict-like quality to the manner in which the detoxification workers practice the art of successful failure. To many,the condition of addiction implies failure - failure to cope, failure to "make it", failure to overcome the addiction. Indeed, according to one school of of sociological thought the addict is a "double-failure"; inadequate in both the legitimate and illegitimate spheres of enterprise.[15] Yet given the condition of addiction, the addict can be a success: he can manage his addiction well, he can refrain from hurting others, he can have "style". Treatment of addiction too, in a sense is doomed to failure. Despite the proliferation of theories and technical ideas about drug treatment, the most "successful"programs for addicts appear to be those which maintain opiate addiction.[16] The staff, like their clients, are aware that from one perspective their careers are programmed failures. Nevertheless, they find ways within the course of their work to begate feelings of defeat - to feel instead a sense of pride and enjoyment.

The staff member who said "Generally, all programs for addicts are ridiculous" has some evidence to back up his assertion - at least to the

degree that these programs presume to "cure" a "disease" called addiction. Theories about drug dependence abound - what most have in common is that they are difficult to refure but impossible to prove. It was mentioned, in discussing the upsurge in therapeutic heroin careers, that it appears to be the ability of a theory to "catch fire", to "sell", that determines its "success " - not its final results in the treatment of patients. Addiction has been traced to problems such as inadequate masculine identification[17] (what about female addicts?), or ghetto environments[18] (what about middle-class addicts?). Some spokesmen say no program will work unless it is aimed at cutting of the heroin supply:

> "The problem is how to stop heroin from reaching American addicts in the United States and in Southeast Asia. Once the poppy is cut and introduced into illegal channels, the battle to prevent the end product, heroin, from reaching the addict is virtually lost.[19]

Others argue with equal force that it is the individual addict who must be reached:

> The addict in the street who must have junk to live is the one irreplaceable factor in the junk equation. When there are no more addicts to buy junk, there will be nor more junk traffic. As long as the junk need exists, someone will service it.[20]

"Success" rates of even the most hopeful heroin programs are largely inverted failure rates. For instance, "third-community" approaches, who boast 80-90% "cures" reject 90% of their applicants.[21] As for programs who accept all customers:

> The cliché, 'out in the morning, andinto the spoon by noon', is in most instances true. Of the first 1,211 patients seen at the Haight Ashbury Free Medical Clinic, 73 (6.0%) were clean for one month or more . . . [22]

And, finally, no satisfactory definition of physiological addiction exists: Vicent Dole reports that no ideas have been put forward which explain addiction at the cellular level.[23] Against such a backdrop of doubt and

and controversy, the staff members must realize at the outset that the cards are stacked against them.

Staff and patients at the heroin service generally share a resigned acceptance of the fact that heroin is usually stronger than therapy:

> "Out there, things seem better. But when you're here - seeing the failures every day . . . "

> "It's centered around something which doesn't exist - there is no 'treatment for junkies'".

> "There's no answer to junk - it makes me sad because it's a death drug, a pig cult - but unless they can find something better, they might as well do it."

> "I feel a sense of failure. But - for people on heroin, some will be failures . . . "

> "We will continue to use junkies [as counselors, staff] and we will have successes and failures. You don't have failures if you never do anything."

> "'Cure ' is a word no respectable doctor uses - unless he's a surgeon."

To stave off feelings of failure, the staff establish objectives for themselves which are divorced from "curing" addicts in the conventional sense. If a more realistic work objective is kept in mind - helping clients to remain drug-free for short periods of time, or to cut down their habits - then the staff efforts meet with relative success:

> "A:How can we say we think a patient is hopeless . . . all drug programs like ours get frustrated . . . we plant seeds- they don't all grow at the same time.
>
> B:Even cleaning up for a few days is worth it."

> "There are three alternatives in handling patients: success- the least frequent, failure - more frequent, and support - the big middle group. Would it be worse if we kicked him out/"

Another treatment goal which is accomplished successfully is the handling of medical and psychological problems of clients who happen - incidentally - to be addicted. Many of the clinic clients are truly

sick - not only because of the heroin "lifestyle" but also because addicts have little recourse to treatment in standard institutions and must take their general health problems to drug treatment facilities. For example, a patient entered the clinic waiting room and was approached by an acquaintance:

> first patient: 'What are you doing here?'
> second patient: 'There's something wrong with my leg.'

Later, the patient was seen by a counselor:

> patient: 'I can't feel nothing in my leg so they sent me over here . . . There's something wrong with my leg -'
>
> counselor: 'But you want to be detoxified . . . '
>
> patient: 'Yeah . . . It might be a blood clot . . . '

The patient dropped out of treatment before he could be considered fully detoxified - but his leg was treated. Similarly, a middle-aged addict with a huge habit and uncontrolled diabetes came to the clinic for help. It appeared that when her diabetes was diagnosed at a public clinic, the staff did not teach her how to adjust a therapeutic diet to the demands of a prostitute's life. At the heroin service, she was able to work out a satisfactory dietary plan. She was eventually referred to a methadone maintenance program with her habit intact - but the treatment of her diabetes was an unqualified success.

Institutional success provides some feelings of positive achievement. Attracting clients, gaining a national reputation, obtaining grants - these are all absorbing activities which may be done and done well. Fund-raising activity, for instance, may be an end in and of itself. During the winter of 1971, the clinic complex held a "radiothon" on a local FM station to raise money. Considerable worker time was spend carrying out this benefit - including answering phones through the night to take pledges. The event was a celebration of the service as a work activity, producing feelings of accomplishment and satisfaction. The gathering of descriptive data about

the client group has certainly rewarded many workers - whether or not it has had any effect on "cure" rates.

The group's future-centered orientation - their practice of waiting for "something" to happen - helps to combat feelings or failure. By seeing themselves as on the road to - perhaps on the verge of - significant discoveries about the treatment of addicts, the staff members do not fail. Instead, they are waiting to succeed. For example:

> A: 'But we're not doing anything . . . '
> B: 'We are too -- we're developing modalities which will work...'

In the search for an effective method to curb addiction, one has nowhere to go but up. Many methods have proven efficacy with one or another type of addict - but predicting what to do for each individual with a heroin problem is difficult. Hence, future-centered thinking tends to produce a willingness to try anything which might prove helpful - an attitude best summed up with the phrase "could it hurt?". Counselors with an innovative approach may usually try it our - for, could it hurt? This has been known to backfire: on one occasion a disturbed young man was allowed to remain at the service for several days before his behavior became bizarre enough to attract attention (hitting a co-worker). In retrospect it was noted that some of his actions had been inappropriate - for instance, undressing in front of a patient:

> "I was too accepting of him for two days - I don't know - I thought that maybe it was some kind of shock therapy."

This could-it-hurt approach is probably the same idea which underlies the popular "multimodality"[24] approach to heroin treatment. In the face of past failures, the odds for success are greater if every possible method comes into play.

The staff members share an awareness that few addicts will be trans-

formed into drug-free individuals. Nevertheless, thorugh altering their treatment objectives they are able to enjoy some feelings of accomplishment, work success. In addition, a certain syle at the service - a quality of awareness and acceptance - changes failure into a form of success. For instance, the community takes some pride in the fact that they have not "given up". One worker compared the heroin program, which he called dynamic, to methadone maintenance programs, which he described as "gray programs run by gray people in gray suits." The group refuses to take easy "outs" - as by overmedicating clients. The theme of giving help - not pills - was a constant one in staff meetings and discussions. Humor - cynical humor - testifies to wareness of the absurdities of the treatment situation, while at the same time indicating a refusal to feel defeated:

> "I think we've discovered - with one and one half years of experience- that there must be something better."
>
> ' . . .I told him, 'you're not even a good junkie - go back out there and be a good junkie . . .'
>
> "Sick people get well dispite crappy therapy . . ."
>
> "I think everything I say is totally irrelevant and a big lie and I'm having a good time."

The staff members "cure" no more than 6% of the addicts that pass through their service - from one point of view they could be termed failures. Not from their own point of view however - for they manage to transform failure into success.

Anti-authoritarianism

Having committed themselves to the care of the national pariah, it is not surprising that most staff members are strongly anti-authoritarian. Most come to the service out of dissatisfaction with work in more authoritarian surroundings. Indeed, the service's very existence testifies to the

failure of "official" institutions to acknowledge the suffering of the clinic's clientele. Further, the patients are classified as criminals - should they seek care through ordinary channels they run the risk of detention, arrest, loss of freedom. Participants at the service are acquainted with scenes of the most brutal and arbitrary use of authority: penal institutions. The business sector abhorrs the addict - the welfare system doesn't want him either. Health insurance agencies may refuse to support his care. Further, an increased proportion of the clients are embittered veterans - victimized by the federal government and the military. The medical establishment has embraced the idea of addiction treatment of late - but it hardly tends to relinquish authority over the addict <u>or</u> over drug treatment facilities. From the group's feelings about authority springs their distaste for the term "professional". Professionalism - as it is conceived of at the heroin service - has nothing to do with expertise. Skill and knowledge are respected and valued. Rather, the term "professionalism" has a private, derogatory meaning within the community. Staff members who see themselves as professionals are thus a bit self-conscious. An MD once pulled me aside and said in a hushed, conspiratorial tone:

> "You know how <u>some people</u> feel about professionals."

For, within the language of the group, a professional is:

> "A person who puts a person into a category, class, structure, pattern . . ."
>
> "the doctor or psychologist role - a person who takes humanness out of relationships and substitutes a textbook page . . . "
>
> someone "raping the community, so he can drive home and talk about it"
>
> "professionals - people who tend to lean on professional status to enhance their own power thing . . . instead of displaying expertise . . . no one resents someone telling them something they <u>know</u> . . . they aren't approachable . . . alienate themselves . . . use status for power moves - holding on to knowledge - mysteries of their own professions . . . "

Professional behavior is defined as exploitative, or self-serving:

> "like wanting an office . . . or wanting to discharge a patient because of a professional policy . . . [it's] like wanting to treat the weak little hippie - to diagnose a behavior problem, and because a patient fits into it, not to treat him. . . testing patients and not giving them the results - that should be Standard Operating Procedure . . . "

Professionalism is the basis for criticism:

> "That was so professional it was antithetical to what the clinic is all about"

The lack of it is the basis for praise:

> "If every person in this room was replaced with a Ph.D., you'd have one patient every third day"

> "We're not professional - just transacting."

Community feelings about authority are most clear-cut, most easy to express, when the authority is external - the drug laws, the government, and so forth. When someone mentions:

> "The pigs kicked the shit out of the people on the corner and busted everybody"

- it is simple to pinpoint the source of resentment. When authority is found closer to home, the subject becomes touchier. Usually, it is handled with humor. For example, a student at the service was known for his rather serious view of himself. Almost as an emblem, he perpetually wore a stethescope in his shirt pocket. Upon questioning as to why he needed it he claimed 'I use it to examine patients in the Medical Section' - hardly an adequate explanation. The group dealt with this through joking:

> "We're lobotomizing him! Remove his stethescope!"

> "We'll have a pocket put in his skin."

The problem of handling anti-authoritarian feelings becomes most complicated when - paradoxically - the group itself _is_ the authority. No doubt, many members of the staff would like to see themselves as all-accepting and infinitely flexible. But, in reality, they staff and administer a large

treatment program, and at times must enforce rules. Finding themselves in the enforcer position - the staff members usually react with humor. This kind of response both acknowledges the absurdity of the situation - and betrays an element of anxiety. Setting limits with regard to acceptable behavior at the clinic provides an illustration. The heroin service staff discussed ways to deal with violence - should it be necessary. It was mentioned that "some muscle" might be called for. At this point, the tension was broken with comedy relief:

> "A: . . . .tell them they're assholes . . . man,nobody wants to stay when they think you're an asshole . . .
>
> B: . . . what the clinic needs are classes on the removal of assholes
>
> C: Preparation H "

A discussion of soliciting "donations" from patients ended on a similar note. The service needed donations desperately to buy supplies - certainly there was no question of profit-making. Yet the idea of coercing patients' behavior - especially around an issue of money - did not sit well with the staff. The discussion began with the topic of ridgidity vs. flexibility - and ended in a joke:

> "A: We're not selling medications, we're asking them for a donation to help them through a treatment period . . .
>
> B: . . . some patients who come back should have a credit...
>
> C: We're kidding ourselves about the $10. We're being wheeled and dealed and conned . . . this will continue until we set fast, hard rules -
>
> A: I disagree!
>
> D: So do I - then it's not a donation.
>
> A: A fee for service is wrong when doctors do it and it's wrong when we do it.
>
> D: Even the ASPCA gives credit . . .
>
> E: The con is part of the game we have to expect.
>
> C: OK! The don't spend so much time talking about it.
>
> E: In the middle of heart surgery, do you turn off the machine and ask for money?

The issue of urine testing was an especially loaded one at the service. Many people - including supporters of the idea - appeared uncomfortable about it.

Obtaining supervised specimens involved the notion - not merely of coercing behavior, exercising authority - but of forcing a possibly humiliating activity upon the patient. If discussion of donations brought about joking, discussion of the mandatory specimens brought about hilarity. The entire discussion was dominated by a joking tone with an anxious edge. Indeed, anyone attempting to raise a serious point became someone else's "straight man":

> 'A: This pisses me off . . .
> B: Supervised? In other words, someone would watch you pee?
> . . . .
> C: I don't want to watch someone pee!
> D: Would they audit the figures?
> C: We'll have a full-time statistician.
> B: Let's put his desk in the bathroom.
> F: We may have to install another bathroom -
> (some joking about the use of a two-way mirror - or closed circuit TV)
> C: If the urine is cold, it's a fake -
> D: Cold Turkey!
> F: Let's get to the really important issue - what's the salary for the pee-watcher?
> A: It could be like Altamont - $50 and all the urine he can drink'

When authority is external - clearly beyond the boundaries of the heroin service, the staff members express their negative feelings directly. When authority is internal, however, the staff group experiences more complicated kinds of feelings which are indirectly expressed through humor.

Pornography

Presenting behaviors which show a pornographic quality is difficult, for several reasons. First, the very meaning of the term"pornography" is unclear, despite many attempts to define it. Even with a satisfactory "working" definition,there is still the matter of establishing that pornographic behaviors are "addict-like". The addict's quick wits, or mistrust of authority, are well-know enough to be considered common knowledge, but pornographic aspects of heroin use are not so generally accepted. The

reason for this may well be that people who report upon addicition - writers, researchers, clinicians - so not wish to see themselves as absorbed in a pornographic situation. To admit to the lewd excitement of the subject matter, would be to put oneself in a suspect position - "after all, why are they so interested?" Indeed, it is this lack of recognition which makes it difficult to select examples of data which demonstrate pornography: the staff members do not use the term to describe their work. The pornographic aspects of their actions must be inferred. In spite of the difficulties which the discussion of pornographic behaviors entails, it is most important to devote some attention to this aspect of the staff culture. The qualities which distinguish staff behaviors are important, not only as vehicles for description, but also in terms of their relationship to each other. A description of pornography, with regard to staff behavior, gives closure to a configuration of behavioral sets: this aspect of the culture must be dealt with before the culture can be considered as a whole. Therefore, it is necessary to consider what is meant by "pornography" - particularly the pornography of heroin - and to consider how it is reflected in staff behaviors.

<u>Pornography</u>

Despite many attempts to establish a general definition of what is "pornographic" or "obscene", the meaning of pornography remains a subject of debate and controversy. There are some people who feel pornography is a matter of common sense, something one just "knows":

> This is intuitive knowledge. Those who spend millions of dollars to tell us otherwise must be malicious or misguided, or both.[25]

Morse Peckham, in <u>Art and Pornography</u>[26], reviews various attempts to answer the question "what is pornography?" In considering the opinions of writers such as D.H. Lawrence and Margaret Mead, he finds most definitive efforts

end in confusion. Most mention sexual stimulation - but as Peckham points out, in the post-Freudian era there is very little of an exciting nature that could not be called sexual. The question of context is also important - evidently there are situations where one "ought" to feel stimulated, and there are those where one "ought not." Peckham concludes there can be no final and complete answer to his question: he prefers to develop a "procedural definition" which suits the purposes of his book, one referring to stimulation of sexual organs. Presentations of explicit sex constituted examples of "obscenity" in the report of the Presidential Commission on Obscenity and Pornography too.[27] However, the Commission notes that other kinds of obscene actions exist:

> Material may be deemed obscene because of a variety of contents: religious, political, scatological, violent, etc.[28]

In his discussion of pornography, Polsky ties in antisociality: he claims perverse sex is anti-social sex.[29] It may indeed be an anti-social quality coupled with an arousal quotient, which leads to the labelling of a thing or event as pornographic. Clive Barnes points out that during a period of free undressing and depiction of sexual acts on the New York Stage, only the production Che was prosecuted on moral grounds:

> . . . Che, the only play to be busted in recent years, was not only obscene, it was also political. It attacked American policy in Cuba . . .[30]

Similarly, Peckham reports that a Minnesota Board of review deemed pornographic:

> not only objectionable and offensive representation of sex facts . . . but also anything that smacks of 'disrespect for authority.'[31]

Pornography has been linked with subjects such as death - in this sense it is defined as behavior which breaks the rules of "seemliness" in a given culture. The author notes that while rules of seemliness tend to relate

to sex or excretion, "this is neither necessary nor universal."[32] All definitions of pornography seem to share some core elements. Following Peckhams's example, this discussion will not attempt to develop an absolute definition of pornography - but building on some core elements it will be possible to construct a working definition to use with regard to heroin and addiction:

1) Excitement: all discussions of pornography refer to some state of excitement, some arousal. This may be sexual (if arousal and excitement involve "libido" then it must be sexual in a sense) - but it need not involve explicit genital sex.

2) Shock or repulsion: most discussions refer to the fact that excitement - lust - is somehow unseemly, perhaps provoking reactions akin to shock or disgust. This may have to do with the context of the event or presentation: nudity is expected in a doctor's examining room; it is "shocking" in a public park.

For the purposes of this discussion, pornography will be defined as those events or behaviors which excite or arouse - while carrying an element of of shock or repugnance. Lewd excitement, perverse pleasures - arousal whose source is unseemly - these are pornographic.

Pornography and Heroin

A lewd excitement clings to "heroin places", a kind of titillation which arouses but contains a tinge of disgust. The fact that the public sees heroin as involving depraved appetites can be seen through the portrayals of addiction in films, TV. The same conclusion can be reached by considering the sexual nature of the heroin experience, as described by addicts. Also, the involvement of addicts in sexually deviant activities brings an element of"unseemly" excitement to the drug world.

The general public associates heroin addiction with a lurid mythology: heroin is seen as a sweet corruption, a pleasurable vice which arouses uncontrollable hungers. Addicts are seen to have two choices: abstinence (redemption) or physical and moral destruction (the wages of sin). Consider the dialogue from an episode of "The Interns":[33]

> parents (just told that their daughter is an addict): 'But how Doctor? Pam's a good girl....things like this don't happen in the country.'

And, during the same program, a conversation between physicians:

> 'She'll sell her soul into hell, and yours too - for the price of one bag.'

It would seem that the debilitated young addict is assuming the place in our public entertainment that the syphlitic prostitute occupied in Victorian literature. The addict serves as a "bad" example - and is the focus of considerable attention. The degree to which society advertises against addiction indicates some amount of arousal, excitment. According to Philip Slater:

> From Freud we learned long ago to suspect, when a fear has been blown out of proportion, that it is bloated by a wish; and this seems particularly likely when the danger has been defined as a psychological one- an evil influence.[34]

In a recent interview, Germaine Greer remarked upon the fact that anti-drug billboards and posters serve as a "turn-on." Her interviewer called it "chemical pornography."[35] Much like a billboard saying "Don't Fuck", anti-drug posters and morality plays on television communicate some excitment - some unseemly arousal - with regard to addiction.

According to addicts, the heroin experience is a sexual one. While addiction depresses certain kinds of sexual function (men don't have erections: women don't ovulate), heroin is associated with physical, orgasmic pleasure. Howard and Porges, in their study of "Needle Sharing in the Haight",[36] found that most respondants said there were "sexual overtones to their needle usage." Some attributed this to the drug: they "described the rush as orgiastic."

Others mentioned the penetration of the needle, and compared it to a penis. The element of arousal, excitment is here. When this excitment comes from sticking oneself with a shared needle - it assumes pornographic properties. One respondant said:

> 'There's no need to go into Freudian symbolism. Guys dig chicks hitting them and vice versa.'

According to another:

> 'Using a needle is like screwing your arm.'

In the following passage, the speaker draws an analogy between sexual desire and the lust for heroin. Again, there is a sense of arousal which is perverse, unseemly:

> Heroin is a very seductive drug. To make an analogy - it's like women. In your barely post-pubic years when you've never tasted of the woman's flesh, you don't really get horny....but when you've made love to a woman than you know that there is nothing like it in the whole world. It's that simple. And then you've always got to have more. You'll be horny for the rest of your life. And it's the same thing with heroin. It's a very seductive drug.[37]

Drug laws and heroin prices conspire to force many addicts into "deviant" sexual activities. Prostitution supports a great deal of heroin traffic, for example. This not only involves many women - it involves men (pimps) as well. Addicts may also be paid for acting in pornographic movies. Thus, the world of addiction takes on some of the coloration of these activities - both of which are sexual behaviors which shock "conventional" propriety. An ex-addict claims,"junky chicks...don't know anyone but junkies and tricks."

Pornography and the Staff Group

How does all this drug pornography manifest itself within the community? It is there - but it is difficult to pinpoint. A medical student visiting the service remarked that while, as a former New Yorker, he was accustomed to seeing addicts: "Heroin is very seductive here". He could not put his finger on the reason for his statement; it just "seemed" that way. Staff behaviors which promote pornography are, now and then, rather obvious -

but mostly they must be inferred indirectly.

Most obvious, as a pornographic type behavior, is vicarious living. An argument which might be raised here is that there is an element of perverse sexual excitment to be had in most psychotherapeutic situations. This is probably true - but there is a difference in the <u>kind</u> of behavior the staff at the heroin service may share in vicariously - as well as a difference in amount. The conventional therapist, listening to the sexual accounts of a businessman or schoolteacher, may not find perverse content all that often. The staff, in contrast, come into frequent contact with individuals who have exciting stories to tell. For example, an ex-addict-turned-counselor reports that a co-worker questioned her repeatedly about her former work as a "call girl". She recalled that he seemed to enjoy the conversations:'I could've told him anything.' Of course an interest in the sexual adventures of the client group (particularly the women) is not seen by the participants as a pornographic concern. For instance, a male staff member spent some time with a former prostitute, assuring her that her actions had indicated a 'love for man.' Other staff members told him that this had been very "accepting." Other instances of generating or promoting lewd excitment are seen as expressions of openness, acceptance, and the like. Consider the following exchange. A staff member reports that it was seeing this transaction which caused him to join the heroin service staff. He says a counselor was interviewing a prostitute. She mentioned how much she spent each day on heroin:

> Counselor: "That's a lot of fucking."
> Patient: "Yes, my pussy hurts."

The worker says this drew him to the service: it was so "open and free," so "unstructured."

More obscure behaviors with a pornographic flavor are to be found too. Clinic writing, for example, can arouse and shock. Yorick, in the following passage, parodies the perverse sort of excitment found in "heroin articles:"

> Picture an arm, fisted and knot-muscled....the taut raised vein before the boot comes.......and how some get erections and orgasms.......And do the thing about the kidgirl prostitutes....[38]

But the same pornographic flavor is to be found in the following excerpt from a clinic article, which is serious:

> Your daughter, the lovely clear-eyed child who was going to marry a nice, attractive, sensible, hard-working young man, who was going to give you grandchildren and comfort your old age, well...she ran off with a greasy slob on a motorcycle. When he got tired of fucking her, he split, so now she is turning tricks on the street, hustling for enough bread to cop a balloon.[39]

It has been shown that warnings about heroin can be perversely exciting: dwelling on the perils of addiction can be - unintentionally - seductive. For example, a client confided to me, during my stay at the clinic, that she had been told she wouldn't be "ready for therapy" until she had been "on the street." She appeared more excited than repelled by this prospect - though elements of both reactions were apparent. It might be assumed that the worker who told her this had experienced some excitment himself. The pornographic flavor at the clinic does not derive solely from verbal behavior. Consider the probable effect of this poem, put on the waiting room wall:

> ....
> Well, honey, before you start fooling with me,
> Just let me inform you of how it will be.
> For I will seduce you and make you my slave,
> I've sent men much stronger than you to their graves.
> You think you could never become a disgrace
> And end up addicted to poppy seed waste.
> So you'll start inhaling me one afternoon;
> And you'll take me into your arms very soon.
> And once I have entered deep down in your veins,
> The craving will nearly drive you insane....[40]

Certainly poems on the wall - or, for that matter, dialogues with clients - are not intended to arouse. But probing about prostitution, or a verse entitled "Miss Heroin," may seduce or excite, nonetheless. And we have seen that when excitment is coupled with shock - when it emanates from an unseemly, perverse source - it may be termed pornographic.

Looking back over the staff behaviors, it can be seen that common elements run through many of them. For example, consider language: some of it is pornographic or obscene, but it is also anti-authoritarian, and - by distancing those who find it offensive - it promotes a sense of group identity. Similarly, some categories of behaviors overlap others: pornographic actions are exciting; living by one's wits requires practicality, and so forth. Indeed, all the behavioral groupings interrelate to such a degree that it must be assumed some unifying concept underlies them all. Each appears to be a manifestation or expression of some larger cultural idea. In the next chapter, "Conclusions," some propositions will be put forward about the nature of the unifying strand - the community ethic - which underlies staff behaviors.

CHAPTER SIX: CONCLUSIONS

Retracing the story of the heroin service: social conditions in the recent past launched two groups of people on heroin careers. One group pursued sick careers - members of a drug-dependent society, with new access to opiates at home and in Southeast Asia, became addicted to heroin. Parallel conditions - the rise in the store-front approach to health care delivery, the increased flow of money and resources directed toward drug treatment, the new visibility of the practitioner treating addicts - paved the way for therapeutic heroin careers. All of these conditions converge in the Haight Ashbury district of San Francisco. Here an institutional juncture, the heroin service of a free clinic, provides a site where sick and therapeutic heroin careers may be pursued. The workers at this service share an institution and organization which has communal properties - but the integrity of their community is threatened by repetitive disputes over issues such as work priorities, treatment philosophies, and struggles for personal power. Fundamental to these disputes is the conflict between the "reward systems" of individual staff members, which provides a constant source of tension at the service. Yet, despite this tension, the community of workers endures and grows. Even individuals who come into frequent conflict over matters of rewards share in a quality of wholeness, we-ness, homogeneity, which characterizes the group.

The force producing this quality of wholeness and homogeneity is the group's culture - its system of common understandings and beliefs. The culture is manifest through action: thus shared "addict-like" behaviors of the staff may be seen as expressions of their common understandings. These behaviors have been described in terms of nine categories: immediacy, excitement, negative identity, rules of the market, practicality, living by wits,

successful failure, anti-authoritarianism, pornography. Each of these nine groupings infers some characteristic about the group from its actions, yet the categories link with and overlap each other. The community culture is more than nine qualities - there appears to be an underlying concept or idea which ties all the types of staff behaviors together. Thus, in concluding, some propositions will be put forward about the ethic which sustains the community culture. A hypothesis about the meaning of this ethic for staff members will be discussed, as well as its implications for further research.

Analytic Approaches -"Inside" and "Outside"

The kinds of behavior which characterize the staff community have been discussed elsewhere. It must be remembered that these behaviors are "addict-like": the actions of the addict have been explained many times in the psychiatric and sociological literatures. Indeed, addict-like characteristics are "explained away": the heroin user is seen as childish, rebellious, scheming, and so forth - and the subject is closed. Clinical interpretations, for example, analyze"heroin culture" within the framework of psychiatric theory. Most schools of psychoanalytic thought see "health" or "acceptable behavior" in terms of what is normal in the prevalent culture - hence, that which deviates is unhealthy, unacceptable. Looking at staff actions from the perspective of "standard American culture," it would be easy to misinterpret their meanings - to impose distorting and perhaps pejorative explanations of behaviors and beliefs at the setting. However, such an approach is antithetical to the method employed in this study. The participant-as-observer role was used here to seek out subjective understandings, to focus on the meanings shared by the actors in the setting. To draw out the central meaning, the core idea underlying staff behaviors and beliefs, it is necessary to remain within the world view of the actors. This distinction between interpretation

from within the culture - an "inside" analysis - and imposition of "outside" explanations will be clarified by an example.

Consider the following classification, based on an "outside" perspective. Behaviors of the staff group could be placed under three headings, with interesting results:

Childish:	immediacy excitement pornography
Deviant:	negative identity success-at-failure anti-authoritarianism
Manipulative:	rules of the market living by wits practicality

Childish, Deviant, Manipulative: thus emerges the portrait of the stereotyped addict. Addict-like behaviors may be interpreted from a hostile "outside" perspective and thus be "taken care of." Of course, categories such as the three above have been overused. They seem clichéd, unsophisticated, when blurted out "just like that." But it is the same type of imposition of "outside" explanations which has led to distorted and derogatory interpretations of events in the Haight Ashbury district. For instance, Smith and Luce see the language of the "flower children" and their successors in the district as indicative of a childishness, an "impoverishment":

> Many described their reaction to every experience with such global terms as 'groovy', 'heavy', 'wow', 'far out' and 'too much' and called everybody, including women, 'man'. McLuhan and others may have assumed that this was part of a secret tribal language. Yet its vagueness and constant usage suggested to Dr. Dernberg [a psychiatrist] that some hippies could not particularize their thoughts and feelings, that they assumed everyone saw the world as they did, and that they had neither the ability to communicate nor the desire.[1]

In the same vein:

> Men and women alike related to their contractual or common-law spouses as <u>pseudoparents</u> and called them

'my old lady' or 'my old man'.[2] [emphasis added]

Imputing these sorts of meanings from argot may provide support for an "outside" analysis of a group, but this analysis might have nothing to do with the actual feelings and beliefs of those "inside" the group. Polsky warns precisely against this type of interpretation of field data, calling it a kind of "parlor version of psychoanalysis":

> I have seen it seriously argued, for example, that heroin addicts must unconsciously feel guilty about their habit because they refer to heroin by such terms as 'shit', 'junk', and 'garbage'. Actually the use of any such term by a heroin addict indicates, in itself, nothing whatever about his guilt feelings or the lack thereof, but merely that he is using a term for heroin traditional in his group.[3]

Just as outside impressions about language are distorting, so the imposition of categories such as childish, deviant, and manipulative would serve to distort the culture of the staff group. Even if such headings have some application, it can be seen that they fail to take account of too much - they cannot explain the elements of pride and humor that are implicit in the actions and comments of the workers at the heroin service. Thus, they must be rejected here in favor of an "inside" approach. It will be necessary to step inside the community and share the perspective of the staff group- to assume, for the purpose of analysis - the world view of the actors.

The Community Perspective

Looking over the description of the treatment service, it is possible to extract some ideas about the world view of the actors. For instance, the country has reacted dramatically to the "heroin problem" - all sorts of crash solutions are proposed. To the workers, who know the complexities of this problem, this reaction must appear somewhat childish. After all, the so-called drug crisis is the result of a multiplicity of long-existing factors. It will require steady, long-term efforts to understand and deal

with it. Indeed, American society searches constantly for magical, simple solutions to problems which require a more mature approach. As Slater points out, in The Pursuit of Loneliness:

> Whatever realism we may display in technical areas, our approach to social issues inevitably falls back on cinematic tradition, in which social problems are resolved by a gesture....Asking us to consider the manifold consequences of chopping down a forest, draining a swamp, spraying a field with poison, making it easier to drive in an already crowded city, or selling deadly weapons to everyone who wants them arouses in us the same impatience a chess problem would in a hyper-active six-year-old.[4]

Certainly a leaning toward quick solutions - as well as a preference for sensation, excitment - can be inferred from the country's high incidence of "legal" drug abuse, particularly alcoholism. The staff realize that opiate addiction is not the nation's foremost drug problem. As for condemnation of the "perverse", and public fears about illicit drug use - it has been pointed out that anti-drug campaigns reveal at least an element of attraction, curiosity. The workers at the heroin service are aware that their association with addicts focuses a spotlight on them: they are invited to speak, to publish, to share their experiences. Thus, their view of the larger culture would recognize ambivalent and conflicted feelings about heroin.

We have seen that the staff members interact with diverse types of people in conducting their daily business. Their practicality and quick wits come into play not only within the community, but also during encounters with the medical "establishment", the criminal justice system, funding agencies, and other strongholds of the larger culture. Certainly during these encounters the larger culture demonstrates its preference for the pragmatic, rather than the idealistic. Some physicians, for example, might disapprove of the kinds of skill-transfer that take place at the treatment service (non-MDs "treating" patients); but they would rather support the detoxification service than treat addicts themselves. The public outcry about addiction has made support of drug treatment expedient. It is not so much the hard work of the staff

group which is rewarded - their years of patient care - so much as their ability to promote themselves via publicity, publications, etc. Society may pay lip service to the Protestant Work Ethic, but it confers "success" in the form of recognition and resources upon those who play the game and play it well. As for the question of who establishes the rules of the game - it would appear that the same elite which influences American policy in Southeast Asia is involved in heroin production and distribution.[5] A group with some knowledge of heroin traffic might conclude that most occupational systems, like the system for heroin "careerists", are subject to manipulation by a white, male power structure. Even in the area of social reform, individuals must deal with the rules of the power elite, in order to acheive their objectives. As Slater says: "In the hard reality of everyday life...the incorruptable man is at best an inconvenience, an obstacle to the smooth functioning of a vast institutional machinery....the man who cannot be bought tends to be mistrusted as a fanatic..."[6]

Periodic problems with "authority" beset the treatment service - for instance, harrassment by local officials. There is a sense of solidarity with the underdog: a feeling of "we" (the community) being alienated from "them" (the larger culture). Yet, as evidenced by their publicity seeking, the workers realize they evoke a certain amount of admiration and respect from society. The fact does not escape them that as the underside of the larger culture's stress on obediance and order, there exists an attraction toward rebellion. While the staff members are identified as something different and vaguely suspect, they are also treated as an important group, as people to be reckoned with. In part of course this is explained by the widespread concern over the "health problem" the clinic treats. But some of this attention might be seen as deriving from a kind of envy, a supressed desire. Slater compares the mixture of interest and outrage with radical trends in American society to "the hopes that tinge the old maid's search for the

ravisher under her bed."[7] The larger culture labels the staff members as deviant - simultaneously it courts them. The implications of this "double message" must be apparent to a group who are, after all, psychotherapists.

The Ethic

From the perspective of the community members, the larger culture can be seen as short-sighted, self-indulgent, in search of immediate sensations - while extolling the virtues of will-power, delayed gratification, sobriety. This culture promotes an ethic which says success flows from hard, honest labor - but it bestows rewards upon those who manipulate wisely and compromise when necessary. It is preoccupied with issues of authority, law and order. Yet, in its attraction to those who by-pass or oppose authority, it exposes its doubts, its ambivalence. It short, the larger culture does not hold values so much as it <u>holds-on-to corrupted values</u>. A morality based upon maturity, honesty, authority, has been eroded, eaten away. From the viewpoint of the actors in this setting: childishness, manipulation, and the wish to "deviate" are the rule, not the exception, in the larger culture.

In this context - that is, taking into account the world view of the community - staff actions do not differ <u>categorically</u> from social behavior in general. What marks them as distinct is their quality of <u>awareness</u>. The staff group consciously choose behaviors which are part of the background in the larger culture, and by virtue of this element of aware choice, push them to the foreground. Thus, the staff culture provides a reflection of the larger culture which is not unlike a carnival mirror: it is the emphasis of existing elements - not the introduction of new ones - which creates a "different" appearence. Staff behaviors look "worse" through emphasis: they make obvious what usually exists in the background of the larger society,

and in doing so they violate rules of propriety, of seemliness. Taking this unseemliness into account, it is not surprising that a current of pornography runs through some staff behaviors - these actions say out loud what is usually whispered or ignored. Yet, what "looks worse" is "better", from an ethical point of view. Slater claims that young, middle-class Americans make ethical decisions on the basis of "meta-rules" - standards for judging diverse moral codes.[9] A person with a less abstracted view of right and wrong might see actions based on meta-rules as forms of immoral behavior, delinquency, lawlessness. Nevertheless, such actions are grounded in a firm morality: unseemly or outrageous behaviors are ethical if they adhere to the dictates of a "higher" code. The higher code here has to do with awareness and choice, freedom and responsibility. From the community perspective we are all, to some degree, corrupt - such is the nature of our society. But some of us exercise free and aware choice over our forms of corruption and therefore occupy a morally preferable position. Indeed, this may point out the essential difference between the heroin addict and other types of drug-dependent persons: the first consciously chooses to habituate himself to an addicting drug; the second rarely becomes addicted. Taking all of this into account, the staff behaviors emerge - not as expressions of some kind of group pathology - but as moral choices. The idea which underlies group behaviors, the statement of culture, is an ethic.

Examples of this kind of ethical position exist in literature. For example, consider the following excerpt from Herzog, by Bellow. In this passage, the naiive hero, Moses Herzog, watches a courtroom scene. He realizes that the degenerate defendent is a moral instructor. His actions reflect a code of ethics:

> 'Well, what's your boy's name?'
> 'Aleck, your honor. Otherwise I'm Alice.'
> 'Where do you work?'
> 'Along third Avenue, in the bars. I just sit there.'

'Is that how you make your living?'
'Your honor, I'm a prostitute.'
Idlers, lawyers, and policemen grinning, and the magistrate himself relishing the scene deeply....'Wouldn't it be better for your business if you washed?' the magistrate said.
Oh these actors! thought Moses. Actors all!
'Filth makes it better judge.' The icy soprano voice was unexpectedly sharp and prompt....

....Herzog tried to guess the secret of this alert cheerfulness. What view of things was this Aleck advancing? With his dyed hair, like the winterbeaten wool of a sheep, and his round eyes, traces of mascara still on them, the tight provocative pants, and something sheeplike too, even about his vengeful merriment, he was a dream actor. With his bad fantasy he defied a bad reality, subliminally asserting to the magistrate, 'Your authority and my degeneracy are one and the same.' Yes, it mustbe something like that, Herzog decided. Sandor Himmelstein declared with rage that every living soul was a whore. Of course the magistrate had not spread his legs literally; but he must have done all that was necessary within the power structure to get appointed. Still, nothing about him denied such charges, either. His face was illusionness, without need of hypocrisy. Aleck was the one who claimed glamor, even a certain amount of spiritual credit. Someone must have told him that fellatio was the path to truth and honor. So this bruised, dyed Aleck also had an idea. He was purer, loftier than any square, did not lie.[9] [emphasis added]

Certainly the community members are not prostitutes like Aleck, nor is the larger culture simply a courtroom. But there are some parallels between Aleck's ethical position in the court, and the staff's ethical position in the broader society. In the courtroom, in society in general, corruption of standard values is ignored, played down. Hence, it appears muted, acceptable. With Aleck, as within the community culture, the corruption of values is made obvious - it is flaunted. It is then more offensive from one point of view - more shocking to propriety. Nevertheless, from a moral standpoint, "flaunting it" may be seen as superior. Staff behaviors differ in kind from Aleck's actions, but they too offer "comedy for comedy, joke for joke," and defy a "bad reality." Their actions and beliefs convey a feeling of humor and pride because they are examples of aware, moral decisions. They express the community ethic: In a corrupt society, it is responsible - hence morally preferable - to exercise choice over one's form of corruption.

<u>One Side or the Other</u>

Heroin has become such a pervasive presence in our society that almost all Americans are somehow exposed to it. To be sure, most people get their "heroin exposure" second hand: in articles, lectures, films, television, and so forth. A smaller number find direct involvement through heroin careers. It has been shown that as a consequence of membership in the detoxification section community, workers take on behaviors which are "addict-like." We have seen that these behaviors express a culture, which is based upon an ethic. Going one step further, a hypothesis might now be put forward about the relationship of the worker group to the phenomenon of heroin addiction. It is suggested that <u>the therapeutic heroin career affords the health care worker the opportunity to share in the existential ethic associated with the addict, without running the risks and dangers of addiction.</u>

Lest this hypothesis be misconstrued as glorifying or making light of addiction, some qualification is necessary. Certainly, whatever the "draw" of heroin, most people would prefer their heroin exposure at a distance. The hazards of heroin use outweigh its benefits - philosophical or otherwise. There is nothing attractive about the increasing number of adolescent deaths by overdose, nothing admirable about the abuse of addicts in our jails and hospitals. Indeed, in the long run the physiologically addicted individual probably forfeits the free and aware choices associated with the community ethic, and acts according to compulsion in his efforts to obtain sufficient amounts of heroin. But this is precisely the point: a heroin career need not be a sick career - a dangerous or humiliating way of life. On the contrary, it can be a successful helping career. The force which sustains the detoxification service appears to be shared addict-like behaviors and beliefs. Heroin culture appears to afford the community members a means of sharing the existential values associated with addiction, without sharing in the dangers of the heroin dependent life. Consider this observation, made by an

ex-addict who joined the clinic community:

> "It's like the seductive siren - all of the people who work at the treatment service are in search of her. Like in mythology, there's an elusive goddess which is death. They want to hold her, but her touch is death - so they wait on her."

Implications

This hypothesis suggests several kinds of further research. It would be of some interest to test it in other settings - to investigate the degree to which other groups of health workers participate in "heroin culture." It may be that the type of behaviors seen at the detoxification service are most frequent in settings where the clients are young, with low grade habits of short duration. In settings where more "hopeless" and debilitated clients are seen seen, the patient culture might well be less attractive to workers. In the face of the present "epidemic," it would surely be of some value to examine in depth the various meanings heroin addiction has for different segments of our society. A large number of heroin studies are in print or in progress, but most focus on the addict himself. Further, many approach the problem of heroin dependence from a purely clinical perspective. It still remains unclear what the addict represents to the larger culture. Drug treatment remains an emotionally charged specialty - funds are awarded or withheld on the basis of ill-defined feelings about various programs. Yorick points out that many approaches to heroin treatment are still based on a sin-and-redemption type model.[10] A better understanding of the addict-as-symbol might offer us some leverage over emotional issues, and thereby aid in the development of rational approaches to drug education and drug treatment.

However, the hypothesis is not merely a statement about addiction. It also suggests a relationship between the health care worker and the patient culture. In this sense, it has implications for studies in a number of patient care settings. It should be obvious, at this point, that the findings

of this study confirm "folk knowledge": people who treat heroin addicts are facinated or attracted by some aspect of addiction. Similarly, it is a commonly held belief in psychiatry that therapists seek out clients with whom they share some characteristic: acute schizophrenics attract therapists who are drawn to mystical experience; adolescents interest those who are concerned with issues of identity, idealism - and so forth. Would it not be important to find out what facts, if any, underlie this "folk knowledge?" And if therapists are truly sharing important experiences with their patients, would it not be of value to learn more about them? Field studies exploring the relationship of worker to patient culture could extend beyond drug treatment or psychotherapy. To be sure, in many patient care settings workers appear to be arbitrarily assigned, and to be minimally concerned with beliefs and behaviors of their patients. But in devalued settings - where only concerned individuals seek employment, or in highly valued settings - where competition selects for the extremely motivated, there appears to be some draw, some source of attraction for those who pursue therapeutic careers. Special qualities of treatment services would differ - all would not involve ethical issues, as at the ehroin service. But other settings might contain elements of cultures - sets of meanings built around core health problems or types of care. For example, individuals choosing to care for terminal cancer patients might be concerned with concepts such as grief or death. Surely the maternity unit attracts some individuals who are absorbed with the idea of birth. Or, what of the world of emergency room workers - people who share the most "immediate" treatment setting short of the battlefield. Health problems, after all, are life problems: to the extent that one facet of living is the focus of treatment, that part of human experience becomes the site of intense involvement. For the worker, as well as the client, a large amount of personal resources - energy, time, emotion - is centered on a circumscribed part of existence. It should be worthwhile to examine the special features

patient cultures hold for those who need not be sick themselves in order to share in them.

If any group of health care workers "live" most within patient cultures, it would be nursing service workers. Traditionally, they have no offices, nor is their work day over at 5 PM. It has been pointed out that the skills developed by nurses for use in patient care - direct observation, the ability to deal with "intimate" material, an empathic perspective - are also the tools of field research. This type of investigation, the study of health care workers and patient cultures, would seem tailored to the needs of the nurse investigator. Thus, a final implication of this study would be that nurses turn their investigative skills from their patients - for a moment - and focus them on themselves and their co-workers. In this way, information might be gained about the worlds which health care workers and patients share - systems of understandings grounded in the core issue of a health problem.

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FOOTNOTES

Chapter One: Background

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[192]"The Selling of the Free Clinics," Health/Pac Bulletin, 38(Feb., 1972), 1-8.

[193]The San Francisco Chronicle (friday, May 5, 1972).

[194]"This World," Sunday Examiner and Chronicle (Feb. 28, 1971).

[195]The San Francisco Chronicle (Mon.,Jan. 10, 1972)

[196]"The Turned On Crisis," KQED TV, San Francisco.

[197]David K. Wellisch, George R, Gay, Roseann McEntree, "The Easy Rider Syndome; A Pattern of Hetero- and Homosexual Relationships in a Heroin Addict Population," Family Process,IX,4 (Dec., 1970), 425-30.

[198]Gay, Smith, and Sheppard, "The New Junkie," Emergency Medicine.

[199]this conference was held at the University of California, San Francisco in June, 1971, and was sponsored by the Haight Ashbury Medical Clinic and Continuing Education in Medicine,UCSF.

[200]Hosted by Fort Help, San Francisco.

[201]Held at UCSF and supported by the Diane Linkletter Fund.

[202]Conference on Drug Abuse held at the University of Michigan, November 9-13, 1970.

[203]Kenny, "Drug History..." 115.

[204]Mandel,"The Sociology of a Multi-Modality Strategy..."133.

[205]Mandel, 136.

[206]Yorick, "The Political Economy..." 139.

[207]Fort, The Pleasure Seekers, 36-37.

[208]Stewart, "Treasure Island..." 29.

[209]Schwartz, "Free Health Clinics..." 13.

[210]The San Francisco Chronicle (Mon., Jan. 10, 1972).

Chapter Two: The Setting

[1]David E. Smith and John Luce, Love Needs Care (Boston: Little, Brown, and Company, 1971).

[2]Clyde E. Gardner, A Special Study of the Haight Ashbury Medical Clinic (unpublished Masters dissertation, Department of Safety and Health Education, San Francisco State College, 1971).

[3]Gardner, iv.

[4]Smith and Luce, 3.

[5]George R. Gay and Ann C. Gay, "Haight Ashbury: Evolution of a Drug Culture in a Decade of Mendacity," Journal of Psychedelic Drugs, IV,2 (Fall, 1971), 82.

[6]Smith and Luce, "From Old Community to Bohemian Colony," Love Needs Care, 76-80.

[7]Smith and Luce, 76.

[8]Ned Polsky, Hustlers, Beats, and Others (Garden City, N.Y.: Doubleday and Company, 1969) 144-82.

[9]Smith and Luce, 139-41.

[10]Gardner, A Special Study... 3-5.

[11]Smith and Luce, 3.

[12]For example, the title of the first section of Love Needs Care is entitled "Desolation Row,"(pp. 3-5). The authors quote a post-1067 Haight resident: "'The Haight is dead,' she said. 'It's lonely out here on desolation row.'"

[13]Gardner, 18-20,42. Also see Smith and Luce, 325.

[14]"What's Happening on Haight Street," Haight Action,II,3 (June, 1972), 1.

[15]Gardner, 25.

[16]Gardner, 27.

[17]Smith and Luce, 139-41.

[18]Smith and Luce, 141.

[19]Gardner, 27.

[20]Gardner, 29.

[21]Gardner, 32.

[22]Gay et. al., for instance, in "Short Term Heroin Detoxification on an Outpatient Basis," point out that in the third week of October, 1969, sixty addicts sought treatment at the Haight

Clinic. During the first nine months of 1969, only two to four addicts were seen each week. In the International Journal of the Addictions, VI,2 (June, 1971), 241-64.

[23]Smith and Luce, Love Needs Care, 340.

[24]Smith and Luce, 363.

[25]Smith and Luce, 343-44, 358-60.

[26]Gay and Gay, "Haight Ashbury..." 82.

[27]Gardner, A Special Study...47.

[28]Gardner, 50.

[29]It might be pointed out that the clinic complex has not defined its structure "unconventionally" either. No structural provisions for patient-advocacy, community control, or worker control are built into this organization, as they are in some free clinics (see Health/Pac,34, Oct., 1971, for a report on free clinics and their organization).

[30]Gardner, 33.

[31]Charles W. Sheppard, George R. Gay, David E. Smith, "The Changing Face of Heroin Addiction in the Haight Ashbury," (unpublished paper, Haight Ashbury Medical Clinic, 1970).

[32]Sheppard, Gay, and Smith, "The Changing Face...."1. Also, Gay, Matzger, Bathurst, and Smith, "Short Term Heroin Detoxification..."242.

[33]Sheppard, Gay, and Smith, "The Changing Face..."11-12.

[34]For instance, Mandel mentions that the "mystique of the dope fiend" is used to "disenfranchise the medical establishment" in "The Sociology of a Multi-Modality Strategy in the Treatment of Narcotic Addicts," Journal of Psychedelic Drugs, IV,2 (Winter, 1971), 132-37.

Chapter Three: The Observer

[1]For a full explanation of projects for the doctoral education of nurses, the reader is referred to "Doctoral Education for Nurses in the United States," by Joseph D. Matarazza and Faye G. Abdellah in Nursing Research,XX,5 (Sept.-Oct., 1971)404-14.

[2]Susan D. Taylor, Alice J. Gifford, John Vian, "Nurses with Earned Doctoral Degrees: An Analysis of Information Collected for the American Nurses' Foundation's Directory of Nurses with Earned Doctoral Degrees," Nursing Research,XX,5 (Sept.-Oct., 1971)415-27.

[3]Howard S. Becker, Outsiders: Studies in the Sociology of Deviance (New York: the Free Press, 1963), 166.

[4]Ned Polsky, Hustlers, Beats and Others (Garden City, N.Y.:

Doubleday and Company, 1969), 119.

[5]Polsky, 121.

[6]Arthur J. Vidich, Joseph Bensman, and Maurice R. Stein(eds.) Reflections on Community Studies (New York: John Wiley and Sons, 1964), ix.

[7]Raymond L. Gold, "Roles in Sociological Field Observations," Issues in Participant Observation, eds. George J. McCall and J.L. Simmons (Menlo Park, California: Addison-Wesley Publishing Company, 1969),35.

[8]The Sociology of George Simmel, ed. Kurt Wolff(Glencoe: The Free Press, 1950),127. Cited in Gold, 35.

[9]Polsky, Hustlers, Beats and Others, 129.

[10]Polsky, 118.

[11]Hans O. Mauksch, "Becoming a Nurse: A Selective View," eds. James K. Skipper and Robert C. Leonard, Social Interaction and Patient Care (Philadelphia: J.B. Lippincott, 1965),331.

[12]The American College Dictionary (New York;Random House,1959), 393.

[13]Gold, "Roles in Sociological..." 31.

[14]Harold Garfinkel, Studies in Ethnomethodology (N.J.:Prentice Hall, 1967).

[15]Aaron V. Cicourel, The Social Organization of Juvenile Justice (New York: John Wiley and Sons, 1968), 1-21.

[16]Maurice Natanson, Introduction to Alfred Schutz, Collected Papers vol. ii (The Hague: Martinus Nijhoff, 1962), xxxi-xxiv.

[17]Geoge J. McCall and J.L. Simmons, Issues in Participant Observation,2.

[18]Marcello Truzzi,(ed.) Sociology and Everyday Life (Englewood Cliffs, N.J.: Prentice Hall, 1968),3.

[19]Gold, "Roles in Sociological..." 35.

[20]William Caudill, The Psychiatric Hospital As A Small Society (Cambridge Mass.: The Harvard University Press, 1958).

[21]Cicourel, The Social Organization...viii.

[22]Kurt H. Wolff, "Surrender and Community Study: the Study of Loma," Reflections on Community studies, eds. Vidich, Bensman, and Stein, 234.

[23]Robert Redfield, The Little Community/Peasant Society and Culture (Chicago: University of Chicago Press, 1960),1-179.

[24]Redfield, 4.

[25]Redfield, 4.

[26]Redfield, 4.

[27]Redfield, 4.

[28]Redfield, 5.

[29]Gold, "Roles in Sociological..." 35.

[30]Arthur J. Vidich, "Participant Observation and the Interpretation of Data," Simmons and McCall, 78-87.

[31]S.M. Miller, "The Participant Observer and 'Over-Rapport,'" McCall and Simmons, 87-89.

[32]Vidich, "Participant Observation and the Interpretation..." 81.

[33]Max Weber On Charisma and Institution Building, ed. S.N. Eisenstadt (Chicago: University of Chicago Press, 1968).

[34]Redfield, The Little Community, 85.

[35]Redfield, 84.

Chapter Four: The Observed

[1]Louis C. Schaw, The Bonds of Work (San Francisco: Jossey-Bass, 1968)173-74.

Chapter Five: The Culture

[1]Howard S. Becker, Outsiders: Studies in the Sociology of Deviance (New York: The Press, 1963), 80.

[2]Becker cites Robert Redfield in discussing the abstracted nature of the term "culture," and its referrents in actions, artifacts, etc., in Outsiders, 80.

[3]Elizabeth Finn and Larry Littlejohn,(eds.) "Drugs in the Tenderloin," The Drug Abuse Papers, ed. David E. Smith (Berkeley: David E. Smith and the Regents of the University of California, Continuing Education in Criminology, UC Berkeley, 1969), 4.

[4]George R. Gay and Ann C. Gay, "Haight Ashbury: Evolution of a Drug Culture in a Decade of Mendacity," Journal of Psychedelic Drugs, IV, 2 (Fall, 1971), 82.

[5]David K. Wellisch and George R. Gay, "The Walking Wounded: Emergency Psychiatric Intervention in a Heroin Addict Population," (unpublished paper, Haight Ashbury Medical Clinic, 1971).

[6]Finn and Littlejohn, "Drugs in the Tenderloin," 4.

[7]Nellie Jo Lee, "The Genocidal Fix," Smack, eds. the editors of Ramparts and Frank Browning (New York: Harrow Books, 1972),90-1.

[8]See Chapter One, references 80-83.

[9]for instance, The San Francisco Chronicle, in an article on the Haight Ashbury clinic, reports that it is a part of "a growing set of alternative institutions in America built around communes, collectives, self-conscious minorities, and the generally anti-establishment counter culture..."(Jan. 10, 1972), 4.

[10]For example, the Health Liberation News reports that the "largely professional, all male and all white" board of the National Free Clinics Council negotiated a one million dollar contract with Nixon's Special Office on Drug Abuse. Issue 4 (Feb., 1972).

[11]William Burroughs, Naked Lunch (New York: Grove Press, 1959), vii.

[12]Nalline is a narcotic antagonist formerly used to detect opiate use in known drug users in "Nalline clinics" in San Francisco.

[13]Sol Yorick, "The Political Economy of Junk," eds. of Ramparts and Browning, 135.

[14]The Rolling Stones

[15]Richard A. Cloward and Lloyd Ohlin, Delinquency and Opportunity (The Free Press of Glencoe, 1960), 179-84.

[16]Even these programs show flaws. For example, in the Health Rights News of June, 1972, it is reported that methadone overdose deaths in New York City and Washington D.C. were higher in the first two months of 1972 than in all of 1971.

[17]For example, in an abstract of Mainline to Nowhere: The Making of a Heroin Addict, the addict is referred to as a male: "an absentee or inadaquate father generally prevents his identification as a male, a phenomenon which is tragically present as a major characteristic of deprived minority group role in the United States. (New York: The World Publishing Company, 1967),by Yves J. Kron and Edward M. Brown.

[18]See the reference above: Kron and Brown link inadaquate masculine identification to "ghetto" upbringing.

[19]Congressman Morgan Murphy and Robert Steele, "The World Heroin Problem," eds. of Ramparts and Browning, 206.

[20]Burroughs, Naked Lunch, viii.

[21]David E. Smith, George R. Gay, editor's note, Journal of Psychedelic Drugs, IV,2 (Fall, 1971), 12.

[22]Steven E. Lerner, Ronald L. Linder, and Irving Klompus, "The Cost of Heroin Addiction to the Addict and the Community," *Journal of Psychedelic Drugs*, IV,2 (Fall, 1971), 103.

[23]Vincent P. Dole, "Biochemistry of Addiction, *Annual Review of Biochemistry*,XXIX (1970), 103.

[24]Arnold J. Mandel, "The Sociology of a Multi-Modality Strategy in the Treatment of Narcotic Addicts," *Journal of Psychedelic Drugs*, IV,2 (Winter, 1971), 136.

[25]Charles H. Keating, founder of the Citizen's League for Decent Literature. Quoted by Clive Barnes in a "Special Introduction" to *The Report of the Presedential Commission on Obscenity and Pornography* (New York: Bantam Books, 1970),ix.

[26]Morse Peckham, *Art and Pornography: An Experiment in Explanation* (New York: Harper and Row, 1971)1-50.

[27]*Report of the Presedential Commission*.... 5.

[28]*Report of the Presedential Commission*...3

[29]*Ned Polsky, Hustlers, Beats and Others* (Garden City, N.Y.: Doubleday and Company, 1967), 189.

[30]Barnes, "Special Introduction," xv.

[31]Peckham, 11.

[32]Geoffrey Gorer, "The Pornography of Death," *Death, Greif, and Mourning in Contemporary Britain* (London: Cresset Press, 1965), 169-75.

[33]"The Interns," CBS Television (Sept.13, 1971).

[34]Philip Slater, *The Pursuit of Loneliness: American Culture At the Breaking Point* (Boston: Beacon Press, 1972),2.

[35]Interview with Germaine Greer in *Playboy* XIX, 1 (Jan., 1972), 80.

[36]Jan Howard and Philip Borges, "Needle Sharing in the Haight: Some Social and Psychological Functions," *Journal of Psychedelic Drugs*, IV,2 (Fall, 1971), 71-80.

[37]David Raskin, "The U.S. Army: Amnesty Unlimited," *Smack* eds. the editors of *Ramparts* and Frank Browning, 53-61.

[38]Yorick, "The Political Economy of Junk," eds. of *Ramparts* and Browning, 123-4.

[39]Gay and Gay, "Haight Ashbury: Evolution of...." 81.

[40]"Miss Heroin," reprinted from the McGuire Air Force Base Air Tides, by "an anonymous addict."

Chapter Six: Conclusions

[1]David E. Smith and John Luce, Love Needs Care (Boston: Little, Brown and Company, 1971), 120.

[2]Smith and Luce, 123.

[3]Ned Polsky, Hustlers, Beats and Others (Garden City, N.Y.: Doubleday and Company, 1967), 123-4.

[4]Philip Slater, The Pursuit of Loneliness: American Culture at the Breaking Point (Boston: Beacon Press, 1971), 13.

[5]See "Sick heroin Careers", Chapter One. Also, as reported in"This World"(Sunday San Francisco Examiner and Chronicle) on July 30, 1972: a Senate subcommittee is examining material presented in a book by Alfred W. McCoy of Yale University which implicates the CIA and the State Department in international drug traffic. McCoy's book, to be published by Harper and Row, reports on provision of military and political support by CIA and State Department officials for America's Indochinese allies involved in heroin traffic.

[6]Slater, The Pursuit of Loneliness...17.

[7]Slater, 2.

[8]Slater, 24.

[9]Saul Bellow, Herzog (New York: The Viking Press, 1964), 228-9.

[10]Sol Yorick, "The Political Economy of Junk," Smack, eds. the editors of Ramparts and Frank Browning (New York: Harrow Books, 1972), 140.

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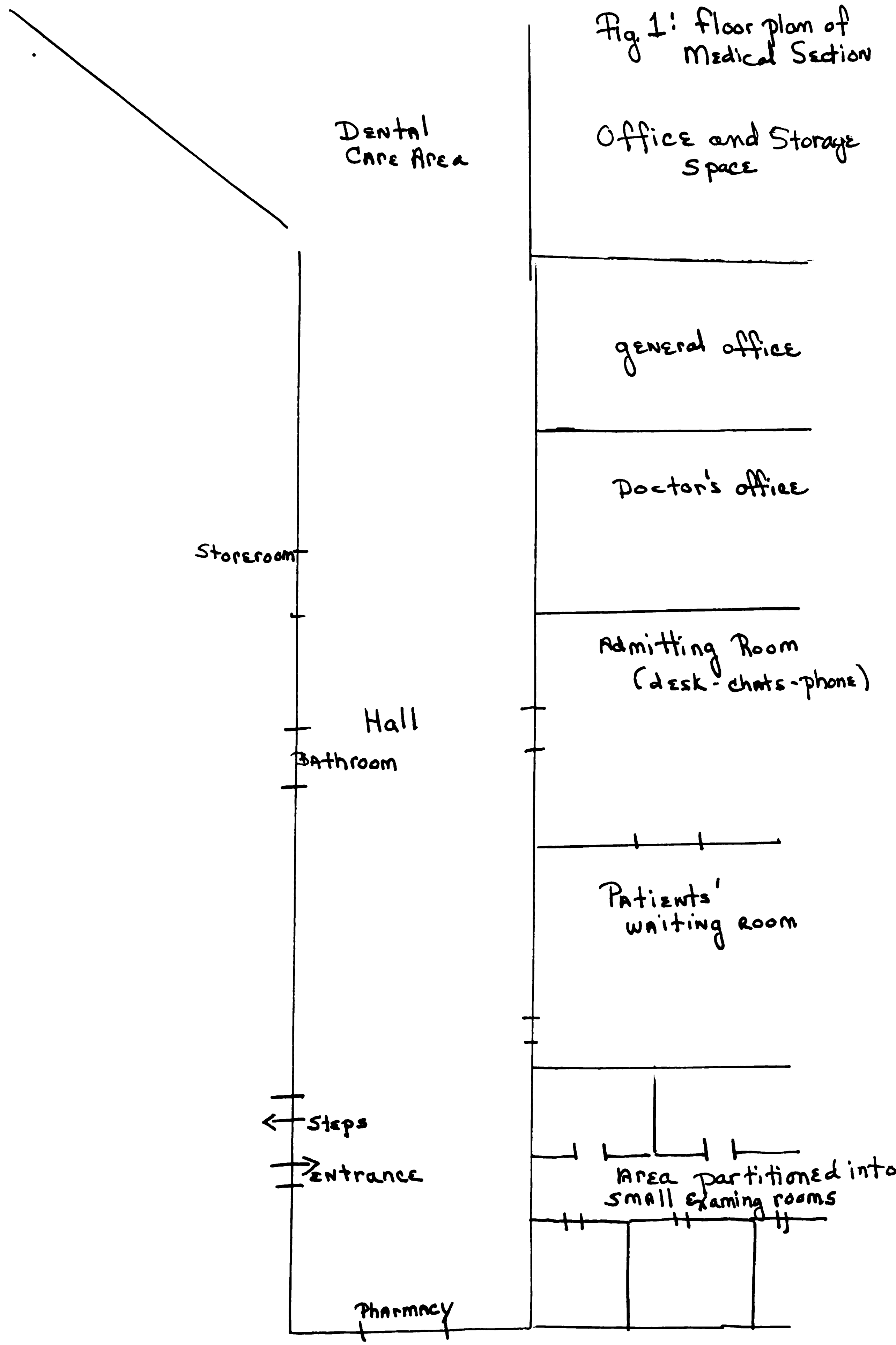
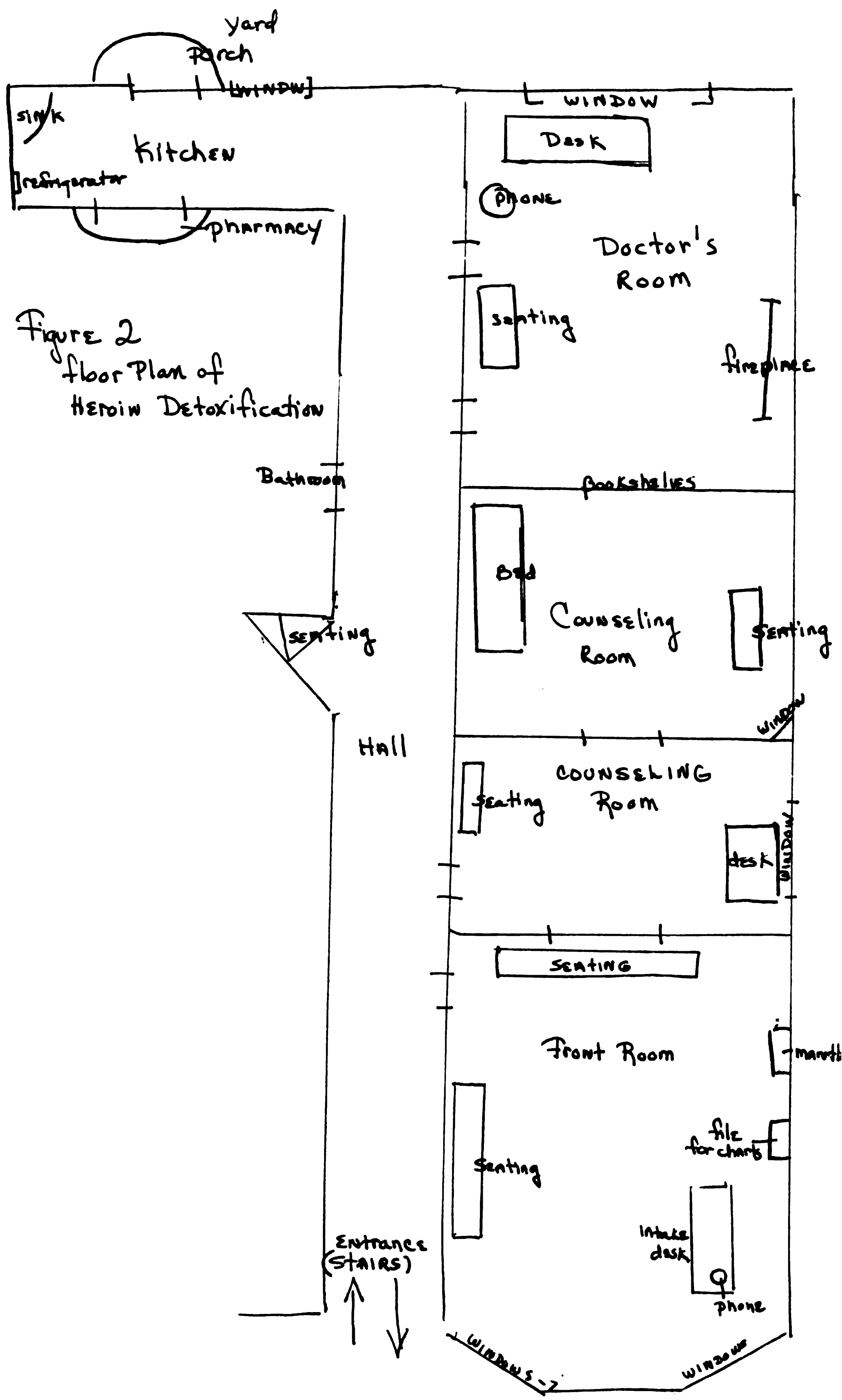


Fig. 1: floor plan of Medical Section
Dental Care Area
Office and Storage Space
general office
Doctor's office
Storeroom
Admitting Room (desk - chairs - phone)
Hall
Bathroom
Patients' waiting room
Steps
Entrance
Area partitioned into small examing rooms
Pharmacy



Yard
Porch
WINDOW
SINK
Kitchen
refrigerator
pharmacy
Figure 2
floor Plan of
Heroin Detoxification
WINDOW
Desk
PHONE
Doctor's
Room
seating
fireplace
Bathroom
bookshelves
Bed
Counseling
Room
Seating
seating
WINDOW
Hall
COUNSELING
Room
Seating
desk
WINDOW
SEATING
Front Room
mantl
file
for charts
Seating
intake
desk
phone
Entrance
(STAIRS)
WINDOWS
WINDOW

Figure 3 (taken from Sheppard, Gay, and Smith, "The Changing Face of Heroin Addiction in the Haight Ashbury", p. 11)

Size of Habits (Dollars/Day)

	less than$50	$50-$90	$100-$200	$200+	Total
NJ	275(63.5%)	113(26.1%)	41(9.5%)	4(0.9%)	433(100%)
TJ	80(53.6%)	38(25.6%)	28(18.8%)	3(2.0%)	149(100%)
OSJ	85(44.5%)	61(31.9%)	41(21.5%)	4(2.1%)	191(100%)

Race

	White	Black	Mex.-Amer.	Oriental	Indian	Mixed
NJ	352(81.2%)	61(14.1%)	16(3.7%)	2(0.5%)	2(0.5%)	0
TJ	108(72.5%)	29(19.5%)	9(6.0%)	2(1.3%)	0	1(0.7%)
OSJ	128(67.0%)	42(22.0%)	17(8.9%)	3(1.6%)	0	1(0.5%)

Number of Withdrawals

	0	1	2	3	4	5or more
NJ	180(41.6%)	110(25.4%)	64(14.8%)	25(5.8%)	9(2.1%)	45(10.3%)
TJ	25(16.8%)	26(17.5%)	30(20.1%)	26(17.4%)	9(5.4%)	34(22.8%)
OSJ	14(7.3%)	24(12.6%)	29(15.2%)	21(11.0%)	26(13.6%)	77(40.3%)

Method Used to Withdraw

	Cold	Methadone	Self-Rx'd	MD-Rx'd	total	withdrwls /addict
NJ	311(52.0%)	132(22.1%)	102(17.1%)	53(8.8%)	598(100%)	1.38
TJ	183(49.5%)	65(17.7%)	98(26.8%)	22(6.0%)	368(100%)	2.47
OSJ	347(57.0%)	131(20%)	89(13.5%)	62 (9.5%)	656(100%)	3.43

Figure 4 (from "The Changing Face..."p.12)

Drugs Used Heavily Prior to Heroin

	Mari-juana	LSD	Amphetamine	Barbi-turates	Alc.	Co-caine	Opium
NJ	271(62.5%)	175(40.5%)	201(46.4%)	106(24.5%)	92(21.2%)	2(.5%)	2
TJ	94(63.0%)	61(41.0%)	81(54.4%)	39(26.2%)	41(27.5%)	3(2%)	0
OSJ	89(46.5%)	33(17.3%)	62(32.4%)	45(23.6%)	36(18.8%)	2(1%)	0

Family Status

	Single	Married	Cohabi-ting	Divorced	Widowed	Separ-ated
NJ	215(49.7%)	125(28.9%)	57(13.1%)	18(4.2%)	1(0.2%)	17(3.9%)
TJ	78(52.4%)	39(26.2%)	16(10.7%)	12(8.0%)	0	4(2.7%)
OSJ	69(36.2%)	55(28.8%)	15(7.8%)	29(15.2%)	6(3.1%)	17(8.9%)

Sex

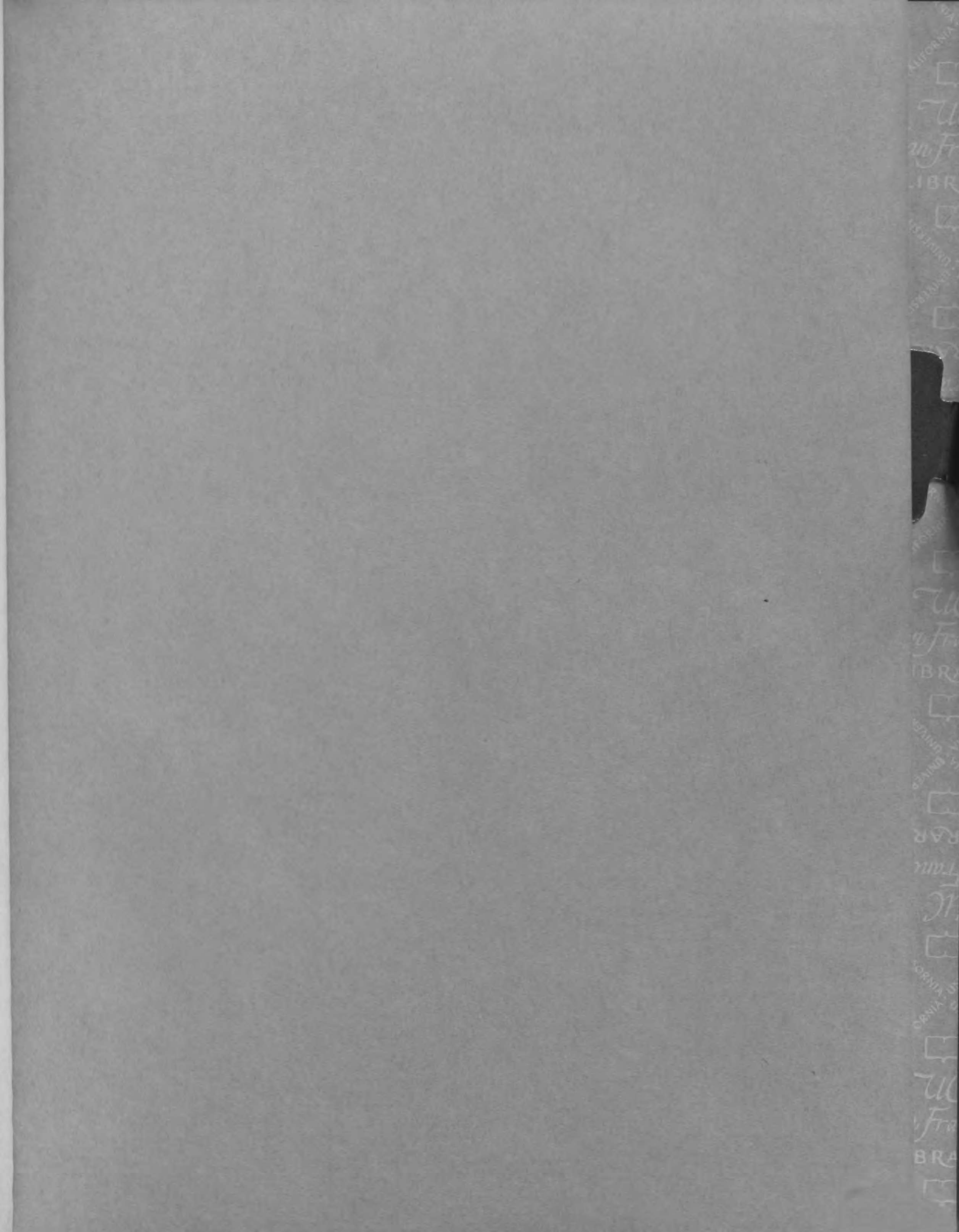
	Male	Female
NJ	290(67%)	143(33%)
TJ	120(80.5%)	29(19.5%)
OSJ	156(81.7%)	35(18.3%)

Number of Dependent Children

	0	1	2	3	4 or more
NJ	310(71.6%)	69(16.0%)	30(6.9%)	13(3.0%)	11(2.5%)
TJ	102(68.4%)	32(21.5%)	6(4.0%)	5(3.4%)	4(2.7%)
OSJ	103(54.0%)	47(24.5%)	17(9.0%)	13(6.8%)	11(5.7%0

ABSTRACT

This is a field study of a group of health care workers who treat heroin addicts. The investigator, a psychiatric nurse, spent eleven moths at a heroin detoxification service, in the role of participant/observer. The study examines the social and historical conditions which serve as preludes to "sick heroin careers"(addict careers) and "therapeutic heroin careers"(health care worker careers). The setting of this study is conceived of as an institutional juncture where both types of "heroin careers" are pursued. The staff group in this setting has many of the properties of "community." Members of this staff community are categorized in terms of the types of rewards they seek in their work with addicts. It is suggested that the constant source of conflict at the treatment service derives from differences in the "personal reward systems" of group members. In spite of conflicts, the group appears cohesive and homogeneous. It is proposed that this cohesion is due to a community culture which the worker group shares. This culture is manifest in shared "addict like" beliefs and behaviors. The unifying concept which underlies staff behaviors and beliefs appears to be an attitude toward life, a community ethic. This ethic is based on the concepts of awareness and choice, freedom and responsibility. It is suggested that the therapeutic heroin career affords the health care worker the opportunity to share in the existential ethic associated with addiction, without risking the hazards of the heroin dependent life.



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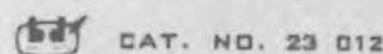

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