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Riverside Hospital: The Birth of Adolescent Treatment

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An earlier article in this column on the history of adolescent treatment and its current renaissance (White, Dennis, & Tims, 2002) noted that adolescents have been admitted to adult treatment programs since the opening of the inebriate homes and asylums in the mid-nineteenth century. This practice eventually led to calls for specialized adolescent treatment programs. This article explores the history of the first such program. The story of Riverside Hospital is a fascinating one that contains many lessons with contemporary import.

The Story of Riverside Hospital

In the early 1950s, the citizens of New York City became alarmed by a surge in adolescent heroin addiction. Adolescents were admitted to the addiction units of Bellevue Hospital and Kings County Hospital, but there was universal agreement on the need for a resource designed specifically to treat the problem of narcotic addiction among the very young. This recognition led to the opening of Riverside Hospital on July 1, 1952.

Riverside Hospital's 141-bed facility was divided into four wards: three for adolescent males and one for adolescent females. There were also separate recreation and educational buildings, a chapel, and housing for staff who worked at the facility. The grounds contained tennis and handball courts, basketball courts, and a baseball diamond. The facility was staffed by 300 employees organized within multidisciplinary teams that sought to integrate the technical knowledge of all team members in the treatment planning process (Gamso & Mason, 1958). The program was initially designed on the assumption that clients would be voluntary and motivated to become drug-free, but adolescent addicts admitted to Riverside Hospital were almost always admitted under duress. Most of the adolescents treated at the hospital came from a small number of census tracts that were among the poorest and most crowded in New York City (Wakefield, 1992).

Riverside should have worked. It had strong community support. It utilized a state-of-the-art theoretical framework to treat addiction. Patients were medically detoxified and offered the opportunity to remain for a six-month individualized rehabilitation program consisting of psychological therapy, educational classes, and structured leisure. The program was staffed by a multidisciplinary team of physicians, psychiatrists, psychologists, social workers, nurses, welfare caseworkers, teachers, clergy, and lay volunteers. Every effort was made to work with the families of the adolescents in treatment, and efforts were made to follow adolescents after treatment through a community clinic located in Manhattan. Riverside's program appeared to be the ideal model of treatment. It should have worked, but in the eyes of local leaders, it did not. Riverside Hospital was closed in 1961; when a follow-up study of 247 former patients revealed that 97% of those treated had continued their addiction following treatment (Maddux, 1978) (This section abstracted from White, 1998, pp. 235-236).

The Lessons of Riverside

The story of Riverside contains many of the promises and pitfalls of today's adolescent treatment. Here are nine important lessons that can be mined from this story.

1. There is a reservoir of community concern and compassion that can be tapped to create resources for the treatment of adolescent substance use disorders. For nearly a decade, Riverside Hospital shone as a symbol of community recognition and response to the problem of adolescent opiate addiction. The Hospital was birthed via the mobilization of key sources of power and influence—parents; schools; the medical, legal and social service communities; private philanthropists; and the media. Since the opening of Riverside Hospital, that reservoir of concern and those sources of support have been tapped in hundreds of communities across the U.S. While the Riverside experience confirms that communities will respond to salvage their children if assured there are methods to achieve that goal, it also confirms that the processes required to sustain community support for adolescent treatment institutions are qualitatively different than those required to birth such institutions.

2. Addiction disrupts all aspects of an adolescent's life, and that impairment is best addressed within multidimensional assessment processes and multidisciplinary models of intervention. Riverside Hospital was ahead of its time in the use of such procedures. The youth entering today's

addiction programs are again teaching us that multiple problems require integrated strategies and solutions.

3. *Medically-facilitated detoxification does not by itself constitute a treatment for addiction.* Detoxification, unconnected to other levels of care and support, is best viewed as a recurring addiction career milestone rather than a port of entry into long-term recovery. The follow-up data on Riverside patients painfully revealed that brief detoxification and psychological stabilization are not a sufficient foundation for sustained recovery. The same is true today.

4. *Coerced entry into treatment and superficial compliance with institutional rituals of treatment should not be mistaken as a foundation for post-treatment recovery.* The criminal justice system continues to be the primary source of referral for adolescents entering treatment. Coercion can bring adolescents to treatment, but only special interventions to engage and enhance motivation for change can shift resistance or superficial compliance into sustainable recovery.

5. *Recovery initiation in an institutional setting is rarely sustainable for adolescents without continued recovery support services in the adolescent's natural environment.* Riverside Hospital tried to offer post-treatment support via a single community clinic but it placed the responsibility for initiating clinic contact with adolescents who had little motivation to do so once back in their natural environments. While such passive aftercare programs have continued into the present era, there are recent calls for models of assertive continuing care that provide a high level of post-treatment, professionally directed monitoring and recovery support services (White & Godley, 2003).

6. *The treatment of adolescent substance use disorders must be based on an understanding of the ecology of adolescent addiction and recovery.* The staff of Riverside Hospital, in attributing the sources and solutions of addiction as residing within the adolescent, failed to address the family, social, cultural and economic contexts within which addiction flourishes. While family models of treatment have since become an important element in modern adolescent treatment, there remain few models that actively shape the adolescent's post-treatment social environment. Such models would mediate peer sources of recovery support and sabotage and would enhance youth-oriented supports within local communities of recovery.

7. *Short-term treatment outcomes are not necessarily predictive of long-term outcomes.* The documentation of high, short-term relapse rates and the failure to conduct more time-sustained outcome studies leave unanswered the true effects of treatment at Riverside Hospital. Such short-

term outcomes fail to measure delayed effects of treatment (e.g., recovery following post-treatment relapse, clinical deterioration following initial recovery experiments, cycles of recovery initiation and relapse) and the potential cumulative effects of two or more treatment episodes. Such effects are of great interest to those currently conducted adolescent treatment outcome studies.

8. Short term strategies that generate support for treatment may not work in the long run. Treatment institutions that promise a permanent reversal of severe and persistent addiction through a brief, single episode of institutional treatment sow the seeds of subsequent therapeutic pessimism and a backlash against the institution. Attributing responsibility for treatment failure on the intractability of addiction or the characterological foibles of clients provides a temporary reprieve from institutional accountability for the design and execution of its clinical protocol, but this fuels changing views of addiction (which becomes seen as untreatable), addicts (who are no longer seen as worthy of care) and treatment institutions (who are no longer seen as culturally viable or valuable). The high relapse rates at Riverside were viewed not as a unique failure of this institution, but as confirmation of the “once an addict, always an addict” adage. That view contributed to Riverside’s closure and added ideological support for passage of draconian drug laws that transferred large numbers of young addicts into state and federal prisons. In the eyes of the community, Riverside’s closure seemed to confirm the correctness of this strategy. It is with an understanding of these longer-term cultural processes that poorly designed, poorly delivered, and over-sold treatments harm substance-involved adolescents, their families and their communities.

9. Pioneer programs often experience threats to their existence from both within and without. The demise of Riverside Hospital was preceded by the fall of other pioneer institutions (e.g., The New York State Inebriate Asylum) (Crowley & White, in press), and the void it left was filled by other institutions (e.g., Synanon, Janzen, 2001) that experienced a similar fate.

Adolescent treatment institutions have risen and fallen in the past. It is not enough to rebuild a network of youth-oriented addiction treatment programs. We must find a way to increase the effectiveness of such programs and realistically define their value and niche within local communities across the country. We must create effective programs to sustain adolescent recovery in the community and find ways to sustain support for such programs during periods that community and cultural attention is drawn to other issues.

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