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This paper builds upon a helpful typology of free clinics that divides them into four major kinds - the street, neighborhood, youth, and sponsored.[1] While the typology tends to weave among characteristics of clientele, locale, and source of support in setting up its units, it nonetheless has the advantage of being based on an empirical assessment of the major forms of clinic operations through the country. Youth clinics - the type that particularly concerns us here - are defined as "generally organized by adults, service clubs, or official boards... because of their concern about drug use among high school students." Such clinics are distinctive from the other types in that "they generally offer drug care which is limited to education and counseling."[2]

Our examination of the youth clinic model attempts to determine its distinctive characteristics vis-a-vis the remaining types of programs. In this regard, we hope to move information and insights about free clinics beyond the head-counting, diagnosis-tabulating stage and the sometimes (and quite understandable) self-congratulatory observations that have surrounded the early, innovative period of the free clinic movement.

RATIONALE OF FREE CLINICS

Two major themes in regard to free clinics provide important ingredients in our comparison of the youth clinics with the other types. The first concerns the nonjudgmental ethics which is ubiquitous in the free clinic world, and the second concerns the absence of sophisticated research, which is equally characteristic. Combined, these two items have particular significance in pinpointing what we believe is a special vulnerability of the youth-type clinics which leads them to distort or, at least, to redefine common goals of free clinic work.

(1) Non-judgmental ethos. Certainly, the most pervasive operating stance of the free clinics has been their emphasis on the nonjudgmental character of the service they deliver. In contrast to establishment health care, clinics are marked by a self-imposed "simplicity and candor."[3] A writer describing a Los Angeles clinic program notes that "volunteers are

screened carefully to make sure that they have a nonjudgmental attitude toward people."[4] while another commentator observes: "We don't ask any questions and we don't make any judgments,"[5] and still another says: "We are there to provide a service to people of the community, not to make them fit our concepts."[6] The matter is summed up very well in the following quotation:

> We also said that we wouldn't treat amything that somebody himself didn't define as wrong with him. If he came in looking for a job, that's what we helped him with. If he came in saying he was strung out on speed and wanted to get off, that's what we helped him with. We did not try to impose a set of artificial diagnoses on the individual and say, this is your problem and this is what I'm going to help you with.[7]

(2) Absence of research. There are a number of reasons why there are virtually no outcome reports regarding the work of the free clinics. For one thing, service requirements take precedence over what is seen as cold-blooded and impersonal analysis, work which is defined as self-serving for the researcher and useless for the client. For another, it is seen as important that clients retain their anonymity, so that they are reassured that dossiers are not being compiled on them which might come to the attention of law enforcement authorities or might be divulged to persons, such as their parents, from whom they want their contact with the clinic to be kept secret. For a third matter, free clinics, like most social services, are not readily susceptible to evaluative investigations because they will not randomize their intake, on the ground that to deprive anyone seeking assistance because of research priorities is both inhumane and unethical. The following remarks, which were preceded by the observation that minority community people do not want to become "guinea pigs" sums up a number of the issues:

> The idea that research might be done at the clinic was also resented by several members of the board and was of real concern to them. Some feared invasion of privacy of medical records. Others had long standing grudges because of sociologic studies made...earlier that were considered to invade the privacy of people solely to reap rewards for the researchers. Almost all requests to review clinic utilization systematically met with such objections.[8]

YOUTH-TYPE CLINIC: OPERATING PRINCIPLES

The absence of research in free clinics necessitates reliance upon

anecdotal and intuitive indices of success in order to reinforce personnel in the necessary belief that they are accomplishing something worthwhile. This is a very easy matter when the intervention involves physical matters, such as treatment of veneral infections or the prescription of drugs for upper respiratory complaints. It is a much more difficult task when the service, as in youth clinics, is only of an educative and counseling nature. Similarly, the nonjudgmental ethic may be hard-pressed to survive when counseling processes are tied closely to matters such as the expectation of the funding agency that the clinic "rehabilitate" a "reasonable" number of persons in order to "prove" its value.

These conditions, among others, feed into the following items, which we derived from more than a year's participant-observation involvement with a Southern California youth-type free clinic. We will first state them as general principles, and then document them with excerpts from the "rap" sessions, which are the primary treatment vehicles at the clinic.

1) Faced with a highly intransigent problem - that of drug use - clinic personnel are inexorably pressed to redefine their client's problems judgmentally, that is, not as drug use but as personality and performance inadequacies of a subtle and generally nonmeasurable nature. This redefinition allows the question of intervention efficacy to be bypassed without undue intellectual embarrassment.

2) Lacking solid criteria of success (such as the elimination of "real" sickness), clinic personnel come to measure success not in terms of the number of clients who have completed treatment, but rather in terms of the number who continue to appear for therapy. Under such conditions, they tend to resist with more vehemence than that devoted to almost any other issue decisions by clients to stop participating in the clinic program.

3) Youth clinic staff members are apt to mimic establishment tactics and pretensions instead of using their own strengths and talents in a straightforward manner. This results from the difficulty of providing short-term nonjudgmental help which will readily resolve a client's drug problem, and from the necessity to retain a respectable roster of clients to reassure the funding agency that worthwhile services are being offered.

ILLUSTRATION OF GENERAL POINTS

Each of the preceding items is documented below by material recorded during our participant-observation work:

1) Redefinition of clients' problems. Objective presenting problems

are redefined by the youth clinic counselors as symptomatic of deeper difficulties, enabling the counselors to lengthen the span of the clients' attachment to the clinic. This procedure is vital to the survival of the clinic, which serves about 100 persons a month, with perhaps four out of five of these persons representing part of the previous month's workload. Surface symptoms are translated into the necessity to discover where you "really are at." A newcomer to our clinic, for instance, was quickly informed by a group leader about what was expected of him:

> Counselor: How are you feeling tonight, Bill?
>
> Bill: I had a crappy week. My boss was on my tail from Monday to Friday. We're expected to put in a lot of overtime. This week I worked seventy-five hours. I'm just really burned out.
>
> Counselor: Yes, but how are you feeling?

On another occasion, a 25 year old graduate student (the participant-observer) recounted his efforts to get a job:

> Counselor: How are you feeling tonight, Charlie?
>
> Charlie: I'm feeling a little down. I've been trying to find a job for the past ten weeks. Every place I go I get the same line: "Don't call us; we'll call you."
>
> Susan: Why can't you find a job?
>
> Charlie: Because there aren't too many openings for an M.A. in sociology.
>
> Susan: What do you need?
>
> Charlie: A Ph.D.....
>
> Counselor: But is there something in your own head which is keeping you from getting a job?

Members who refuse to go along with this type of thinking, who insist that they want practical help not abstract analysis, will be chastised for their impatience and truculence. The following interchange took place, for instance, when a group member brought with him a written report detailing what had happened to him since the previous session:

Bob: First of all, I want to explain why I have this piece of paper. I recorded everything that happened last week. I did this because I wanted to get everything straight. (Reading.) On Monday, Dad and I got along fine. We went to a ballgame, the Dodgers versus the Phillies, and had a great time. On Tuesday, I was supposed to mow the lawn, but I forgot....

Counselor: Stop! Stop! I can't believe this. Bob, why are you doing this to us? All you're doing is storytelling. Why can't you get down to a feeling level. Stop giving us this bullshit! What's the worse thing that could happen if you told us what you really feel?

2) Response to client withdrawal. Counselors consume an enormous amount of time and ingenuity trying to keep members who want to leave the group from doing so. Problem solving is defined as a long-term, nonurgent process, a job that is never really completed. Dropping out seems to be regarded by the counselors as a personal affront to them:

1st Counselor: There's rumors that you might be quitting Group?

Ted: Yeah, I just might. I've been feeling awful comfortable.

1st Counselor: Let's sit on the floor and talk about it.

2nd Counselor: That's a good idea.

(The group forms a tight circle on the floor).

Ted: I feel I'm really comfortable. I'm happy with my job. Dad got so bad that I moved out. And last week I moved in with Betty (a former girl friend). Things have really been good between us. I'm no longer pressured to marry her (Betty had had an abortion). She has a job and can support me and....

1st Counselor: I disagree with your idea that everything is cool. I don't think it's really a positive thing to go from one dependency at your parents' house to another dependency at Betty's. I kind of question your motives.

2nd Counselor: I'm sorry, Ted. I don't mean to laugh,

but you're saying, "I really feel good, but I still have all these problems."

Ted: O.K. But when I was out of Group for ten weeks, while I missed the socializing, I didn't miss anything else.

2nd Counselor: Then there's nothing you get out of coming here?

Ted: Well, I enjoy coming and socializing, but....

Roberta: That's a fucked-up reason to come!

Ted: So what! What I need to do now is get more outside of here. I need to form new relationships.

2nd Counselor: It sounds like a cop-out to say you have to leave Group to build meaningful relations on the outside.

Ted: It's just that I don't think the pros of coming here every week offset the cons. It's a real sacrifice to come down here every week for three and a half hours. I have to walk; it's almost two miles; and it's cold at night.

2nd Counselor: I think that's bullshit. I want to know why you want to quit? If you had a deeper feeling about wanting to quit Group, what might that feeling be?

Ted: The fear of opening up, maybe?

2nd Counselor: Is there somthing to the fact that you might be on the edge of really relating to the group?

Ted: It could be. I have relaxed a lot.

2nd Counselor: I think you have an ambiguous attitude towards wanting to quit Group. I have an idea. Ted, you play me and I'll play you.

(The role playing lasted about ten minutes. During that time, Ted agreed that he was afraid to express his real feelings to his father and to the group.)

2nd Counselor: If you were really yourself, Ted, maybe it wouldn't matter what your Dad was doing.

You could change how you react to him.

Ted: And how do I do that? Just what should I do?

2nd Counselor: Well, for one thing, you don't quit Group. (The other members begin to laugh.) Have we convinced you, Ted, that you're still sick? But seriously, Ted, underneath that anger towards your father is a hell of a lot of hurt, and it's important to get at it.

1st Counselor: So will you be here next week, Ted?

Ted: Yeah, I'll probably come.

Roberta: Probably?

Ted: I'll be back.

3) Imitation of establishment psychiatrist role. The role of "junior psychiatrist", one requiring little training and no credentialing, is common among members of the counseling staff at the youth-type clinic. Since everyone is equally unqualified and the role itself is quite unassailable, once its basic ploys have been mastered, its assumption is difficult to resist. Nurses, physicians treating burns, technicians doing lab tests - be they professional, paraprofessional, or amateur - will not be able to maintain their position for long without showing some sure signs of adequacy. Junior psychiatrists, however, need fear no such reckoning.

The youth clinic counselors' conceptions of themselves are illustrated by their book-lined offices with large sofas, the attache case they carry, and the signs on office doors: "In Session, Do Not Disturb." The following interplay indicates how both treators and those being worked upon fall into the role chosen by and for them:

Joe: I feel that I've been shit on by Kathy (his girl friend).

Counselor: How does that make you feel?

Joe: It makes me feel like the world is really a strange place. Honesty is really important to me.

Counselor: Has anybody who has been close to you, besides Kathy, like people in your family, been dishonest or used you?

Joe: No.

Counselor: O.K. So it's not like a transference thing you're putting on other people. Like you're not over-reacting to the dishonesty you see in other people?

Joe: No. I feel pretty submissive. It's an introspective thing with me.

CONCLUDING NOTES

This paper has attempted to illustrate a number of ideas which suggest that the structure of youth-type clinics forces them toward redefining parts of the fundamental philosophy of the free clinic movement. Most notably, youth-type clinics are apt to abandon a nonjudgmental approach, because they do not offer services whose value is readily demonstrable. They also are apt to redefine their clients' problems from immediate things to things more amorphous and less susceptible to apparent resolution. This is largely because they cannot quickly and cleanly deal with drug use (which usually is their mandate from the community), but nonetheless must convey the impression of making strenuous and satisfactory efforts in this direction.

This is not to say that the procedures of the youth-type clinic are without merit or that they are not of help to some people. The question is more basic: Are they as much help to as many people needing help as they might be with different structural arrangements and different program stresses?

Currently, we are involved in a followup study trying to assess the impact of one youth-type clinic on its clients. There is a need for many more such studies, and particularly for comparative studies, done with sensitivity and with respect for the rights of clients, which assess outcomes in terms of client characteristics and other important variables. Our bias, for the moment at least, is toward clinics which combine health treatment with counseling functions. It has been noted elsewhere that sometimes in such multi-service facilities "drug treatment wants to do 'its own thing', independent of the needs of other parts of the clinic."[9] This tendency can be fought in the multi-service meeting, but when drug counseling becomes isolated, we believe that it is apt to succumb to the kinds of pressures and definitions that we have outlined in this paper.

We might note in conclusion that the term "para", as in "para-professional", means not only "besides" but also can be part of a combining form meaning "guard against." We think this double-edge definition is worth final stress. It is our belief that free clinic personnel, be they professionals or not, ought to guard against the absorption of unfiltered

establishment practices, adopting only those which meet the needs of their clients, persons who have so callously been overlooked by traditional services in the past. To these they ought to add new values, such as a stress on candor and the acceptance of people as they are. We have been suggesting that this blend of the decent old and the invigorating new might be best achieved in clinics whose structure is broader and whose mission is more encompassing then that of the youth-type free clinics.

FOOTNOTES

1. J. L. Schwartz, "Preliminary Observations of Free Clinics." In D. E. Smith, D. Bentel, & J. L. Schwartz (eds.), The Free Clinic: A Community Approach to Health Care and Drug Abuse. Beloit, Wisconsin: STASH Press, 1971, pp. 144-151.

2. Schwartz, op. cit., p. 151.

3. B. Meyers. In Smith, Bentel, & Schwartz, op. cit., p. 7.

4. E. Dunbar, & H. Jackson, "Free Clinics for Young People," Social Work, (September, 1972), p. 29.

5. G. H. Lawrence & B. Schonfeld, "Washington Free Clinic: Community, Programs, & Problems," in Smith, Bentel, & Schwartz, op. cit., p. 113.

6. H. J. Freudenberger, "The Professional in the Free Clinic: New Problems, New Views, New Goals," in Smith, Bentel & Schwartz, op. cit., p. 75.

7. L. Kirschner, in Smith, Bentel, & Schwartz, op. cit., p. 25.

8. Quoted in Schwartz, op. cit., p. 196.

9. In Smith, Bentel, & Schwartz, op. cit., p. xv.