

September 29, 1970

MEMORANDUM FOR BUD KROGH

FROM: Jeff Donfeld

You asked me to prepare a plan for a task force study of a national drug rehabilitation program. I would like to propose the following approach for devising a nation-wide drug rehabilitation program:

Convene in Washington a group of experts to discuss the composition of an effective nationwide drug rehabilitation and prevention program. Such a group might be composed of the following:

1. NIMH -- one representative
2. OEO -- one representative
3. Veterans Administration -- one representative
4. BNDD -- one representative
5. Jerry Jaffe (State Programming)
6. Bryce Brooks (Suburban Programming)
7. Mitch Rosenberg (Therapeutic Community)
8. Vincent Dole (Methadone Maintenance)
9. Henry Brill (Hospital Administration)
10. Sidney Cohen (Research)
11. Bob DuPont (City Programming)
12. Alan Cohen (Prevention)

I believe it would be necessary to structure an agenda around the following topics:

1. What is the problem? Who do we want to rehabilitate?
  - a. Hard-core heroin addict
  - b. Soft-drug abuser
  - c. Experimenter

Jaffe feels that it is only appropriate to discuss the rehabilitation of the heroin addict because he inflicts the greatest toll on society and too little is known about psychedelic drug abuse at this time to institute any treatment programs.



Question #1 can be eliminated and the announced purpose of the meeting can be to develop a program for just a. or just b. or just c. I believe that if we are purporting to develop a comprehensive package that we should not ignore the growing problem of psychedelic drug abuse - that is the problem plaguing the homes of middle-America and their problem should not be ignored, on political and ethical grounds. And we should try to stem the ~~flow~~ by treating the experimenter before he becomes an abuser. Let's not have another piecemeal federal program.

2. Once a decision is made on who the target population(s) will be, a consensus should be reached on the modality or modalities which are ~~most~~ effective for the target population(s).

Is there consensus that the most successful approach is the multi-modality consisting of short and long term therapeutic communities, outpatient group therapy, methadone, confinement and a youth dynamic?

The programs should be billed as experimental both because we do not have any answers and in order not to build the expectations of the country. Experimentation should be mandatory so that we get some answers on how to treat the non-hard core abuser as well as the heroin mainliner.

The group should discuss the proper mix between treatment and experimental components of a program. It should discuss the areas in which the most experimentation is needed.

3. Once a parameter is established in question #1, the manpower needs of the program should be discussed.

What kinds of clinicians are required for the program, how, by whom and where are they trained? Many feel that the clinical psychiatrist is not suited for this type of program. Do all agree? This should be a phased training system so that those trained will find employment in one of the programs.

4. Because so little is known about how to rehabilitate even the heroin addict, strict evaluation systems must be built into all of the programs so that only the empirically, rather than rhetorically, successful modalities receive heavy funding.

The group should discuss the kind of evaluation systems which would



provide the most useful data which can be uniformly collated so that it can be collected and evaluated.

The feasibility of a central computer should be explored so that costs are reduced and so that each program unit does not evaluate its own successes or failures and so that each program unit does not take the time to do what a computer can do quickly.

This data system should be looked upon as a tool for greater management effectiveness and not as bureaucratic demands of Washington for statistics. Should the central authority in Washington spot check programs in order to insure that accurate data is coming to Washington?

5. What will be the likely cost of such a program? If multi-modality units are decided upon, is Jaffe correct in asserting that \$100 million will take care of 60% of the hard-core heroin addicts and that it costs \$900,000 to take care of the first 300 patients, including start-up costs and that the incremental cost per 100 patients is \$165,000? Should the federal government pay the costs of starting-up programs, staff, urine analysis, evaluation and medication?

6. Should the program be administered in Washington by an existing federal agency or would a new entity best achieve desired results?

7. What should the delivery system be? How can the federal funds best be funnelled to the individual program units?

Should there be block grants to states? Should a federal agency contract with individual program units? Should a corporate authority (like proposed postal system) be created to hand out money and program criteria? What should be the criteria for continued funding?

8. How do you determine where program units will be located around the United States and within cities? How do you balance macro-political considerations, the reluctance of communities to have program units within their confines and programmatic needs?

9. Should drug prevention be a component of a nation-wide drug rehabilitation program? If yes, what would it consist of?

10. Assuming that methadone will be an important aspect of drug rehabilitation, how can treatment, research and law enforcement interests best be accommodated?



What are the long term consequences of a methadone maintained addict population? Is it a drug skid row? What are the politically sensitive issues involved in methadone and how does one address them?

11. Does legislative authority exist to implement the optimum program? If not, should statutes be amended or is new legislation required?