The Planning and Organization of Programs for Persons
Addicted to Narcotics and related drugs
University of Harvard and School of Public Health
Class of Dr. Alonso
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PART I. PLANNING AND DEVELOPING A COMPREHENSIVE OF SERVICES FOR THE REHABILITATION AND PREVENTION OF ADDICTION

DEFINITION OF THE PROBLEM

Drug addiction has so many facets-- medical, sociological, legal, and moral, to name a few — that defining it becomes a taxing semantic exercise. To reach a cogent definition we must refer to the end result of all its different aspects as manifested in individual addicts. If we do this, we can talk of drug addiction as a “way of life".

Regardless of where any individual lives, he will relate to the people and events around him in certain expected ways, ways that are demanded by social, historical and psychological pressures. If he deviates widely from this general way of relating, (exhibiting excessive suspiciousness, manipulation, egocentricity, lack of responsibility, instability, etc.) he becomes an alien within his group. Symptoms patterns which are common in people who are leading this kind of existence are delinquency, alcoholism, drug addiction, eccentricity.

In examining thousands of addicts from this point of view, I and others have found that they conform to this kind of behavioral pattern. We have invented the term "psychopathic way of life" to define it. (For our .purposes;- the difference between the addict and others who engage in.-this way of life is that by virtue of his addiction, the addict becomes our direct problem.) To add another dimension to the personality of the psychopathically oriented individual, he is morally shallow or relatively amoral.

Thus he differs on three levels from the individual who has developed methods of handling harmoniously his inner, personal life his interpersonal social life, plus whatever elements of morality are related to his culture.
By defining the problem of addiction in this way, one polarizes the extreme of deviation from the norm, and at the safe time comes up with guideline for achievement.

DEVELOPMENT OF A CONCEPTUAL STRUCTURE TO RESPOND TO THE PROBLEM BASIC PRINCIPLES

According to our definition of drug addiction our job then becomes to help as many individuals as possible to travel from one extreme of the spectrum to the other, from the psychopathic way of life to the productive way of life. Several basic principles guide us in this task: l) People participating in our program must accept that such a transition from one point to the other is possible, that addicts can be rehabilitated until proven otherwise. A corollary to this is of course that the addicts themselves must approach their rehabilitation in the same way. This is difficult for the addict, (His instability, his distrust towards authority, his tendency to

continually test all human transactions with which he becomes involved makes it so. In the past, these attitudes have led the addict to believe that the helping professions — medical doctors, psychiatrists, social workers and the like — had nothing to offer him and that his condition was hopeless. This difficulty has to be overcome, beginning with demanding a positive attitude on the part of the treatment staff. 2) It must be understood *by* all that the transition from one way of life to another is really a transition room one subculture to another, from the subculture of the addict to the "square" subculture of the rest of society which lives within the limits of law, morality and personal achievement. A comprehensive program actually strives to bridge the gap between these two cultures so they can interact productively.

These cultures are at war with each other. The addict subculture has lived off the "square" culture, manipulating it, stealing from it and forming a parasitic relationship with it. 3)A comprehensive program is dependent upon an inherent dynamism and flexibility that will make it able to encompass the multiplicity of stress situations that can occur from day to day, and to change and grow without creating bottlenecks. Our scope in New York City is not only to apply ourselves to the 100,000 or so persons addicted to drugs, but also to those who are not addicted but who live in the addict subculture and who make up a population several times as large. 4) A comprehensive program is only possible to the extent that each patient takes upon himself maximum responsibility fox his own participation in the program at the level of his particular capacity. This is the only effective substitution for one—to one treatment which in a comprehensive program is logistically impossible. To my mind, it is the only way in which the patient will become consistently committed to and take pride in his gradual rehabilitation. In order for this principle to work, however, the program must be structured into a sequential series of settings, each with clearly defined levels or degrees of responsibility. We cannot expect the addict to adopt full responsibility on every level the minute he enters the program. This capacity is developed gradually and logically until, by the end of his rehabilitation, he will be able to assume responsibility for achieving a productive life in his community. 5) The step by step progression during the rehabilitation process must generate sufficient motivation to the addict to enable him to overcome his resistance to change and maturation. The rehabilitation process demands a state of becoming ^encompassing the psychological, moral, emotional, vocational, educational and civic aspects of the individual's life. The condition of "becoming" becomes a new way of life, and the individual becomes existentially free in the sense that he can now make his vital choices unrestricted by drugs or emotional limitations. Our definition of cure, becomes synonymous with a permanent state of becoming, it becomes synonymous with developing an existential attitude.

INHERENT DIFFICULTIES IN A COMPREHENSIVE CONCEPT

A comprehensive program is one which applies a general philosophy to and provides services for every aspect of the addiction problem in a given geographic area, from prevention and community development to all levels of treatment and rehabilitation within a given period of time. This concept of comprehensiveness is inalterably related to structural difficulties. Some of these difficulties are inherent and certain are not. I will list those that are inherent first.

1. **Mobilization of fiscal resources**

It is an established assumption that large blocks of financial resources are not generally available for testing programs, and it is a fact that our program has never before been tested on a large scale in its entirety. The response to this problem must be an attempt to mobilize as large a section of the public as

possible behind the concepts and goals of our program, through, a persuasive, large scale, and civic campaign. This approach is a departure from the traditional sober, factual presentation presented to a specific funding source which is usually employed by public health or mental health programs in search of financing. It is doubly necessary in our case, homeward, not only because of the large amount of money needed but also because the goals of our program must be reached to a great extent at the end of three years. Within this time, we must provide a whole sequence of services each linked to and dependent upon the existence of the other.

At present, our major source for funding comes from New York State under its newly enacted narcotics control law. Already the City has signed a contract with the State under which the Office of the Coordinator of Addiction Programs (OCAP) will receive $8.5 million for the treatment and rehabilitation of up to 2,000 State committed addicts during the first year of the State program.

Up until the last couple of years, the Federal Government has participated in local community programs primarily on the research level. Funds available for research are of-certain interest to the OCAP program, as approximately 10% to *15%* of the available fiscal resources will be utilized for on-going research projects, but our main emphasis is of course on service programs.

There are two Federal programs which are now providing funds for services in the addiction field and we are making every effort to take full advantage of both of these. The first, the Office of Economic Opportunity Amendment Act of 1966, makes funds available for prevention and community development programs, and we now have assurances of a $.*5* million grant to cover the current fiscal year. The second, the Narcotic Addiction Rehabilitation Act of 1966, makes available a smaller sum for services in the treatment and rehabilitation field. As New York City has the largest concentration of drug addicts in the country, we hope to qualify for a large portion cf these funds also. Two or three million dollars are expected from this source.

2. **Mobilization of adequately trained personnel**

Apart from the unfortunate fact that there is an overall scarcity of properly trained personnel in the behavioral sciences field, our plans suffer because of the natural tendency of professionals to gravitate towards more rewarding, lucrative, and less exacting areas in the field. A successful mobilization of personnel in the large numberr needed must take the nature of a civic campaign with the use of such techniques as charismatic persuasion of potential employees, and a dramatic presentation of the .challenge involved.. Again, this is difficult because it is a departure from the usual tradition, and can give to our program a somewhat "kooky" character which we would like to discourage.

Another difficulty is the paucity of adequate training facilities for professional personnel. Training in the behavioral sciences field has usually followed a trend towards specialization rather than towards *a* professional sharing of labor. In our program, professional disciplines must be blended in effective teamwork. In the last few years, there has been an increased emphasis on teamwork in the training of psychiatrists, social workers, and psychologists, but there is still a long way to go. Our program itself has to become a training instrument as it develops until such time as adequate outside training resources are available.

We give a substantial role to the non-professional our professional staff. This situation again contains certain inherent difficulties. We must achieve a productive, peaceful coexistence between these two levels of manpower. The gap between them can and must be bridged at several levels.

Professionals and non-professionals must be trained to work in teams. Professionals must be encouraged to utilize non-professionals in certain of their less exacting duties thus freeing their own time to fulfill other pressing needs. On the other hand, non-professionals must be taught not to over-extend their involvement into professional fields for which they are not properly trained.

The necessity of achieving a feeling of teamwork between a variety of personnel has stimulated us in the development of new training techniques. One of the most exciting elements of our program is a process we call Attitudinal Confrontation Training (ACT) which, briefly stated, means the identification and reinforcement of a basic level of; functional parity so that individuals can work productively in groups irrespective of academic, social, and other differences. By functional peer level, we mean a substantially equal level of concern, responsibility and productivity towards vocational tasks and towards the concept of the program.

3. **Overcoming the natural resistance to change**

Our program has clear implications concerning the necessity for change; in broad conceptions, methods, techniques, and attitudes, professional and non-professional. Reform generates tremendous amounts of collective anxiety and resistance. A reformist comprehensive approach to drug addiction is no exception.

To cope with this situation, we must develop, and we are developing professional and non-professional community structures to absorb the heat generated by this collective resistance. Within the addict community, one way of challenging resistance is the adoption of a dare approach result of which the sceptical addict is invited and, if his curiosity is aroused, will come to the Community Orientation Center in his neighborhood. The Center, known as a C.O.C. is the first step in our rehabilitation program, and is manned by a trained, rehabilitated ex-addict. Our skeptical addict will go there not to be rehabilitated but to try to pull the Community Orienteer back into addiction. This part of the program depends on the strength of the Community Orienteer to withstand the tempting approach of the addict and to turn his energy into motivation towards his own rehabilitation.

The same approach can be applied successfully in the local communities. Two City-wide, locally-based organizations have been established where citizens can get together and, within a structured situation, gradually work towards changing hostility into productive action. One group called R.A. R. E. (Rehabilitation of Addicts by Relatives and Employers) is composed exclusively of relatives of addicts, while the other one, A.W.A.R.E. seeks to involve all concerned neighbors not directly related to the addict subculture.

Perhaps the most resistant group of all is the professional community. Its already highly structured character as well as a tendency to apply professional dogma in a rigid way may be reason for this. We have found that demonstration mechanisms developed within the less sophisticated communities, such as parents, addicts, and community groups can eventually become effective in overcoming negative resistance to change even among professionals, since professionals are also parents, neighbors, interested citizens, and sometimes even addicts.

4. **Maximizing effective participation of on-going programs**

Although many of the programs started in the past have done much to keep alive hope and energy in the field and in certain cases have had an encouraging degree of success, they have had the negative consequences of creating a tradition of fragmentation of services often causing professional and human .isolation on the one hand and direct conflict on the other. Under this tradition, there has been no possibility of the development of standard criteria by which programs, patients, staffing patterns and so on can be evaluated.

This fragmentation has been confused many times with the entirely defensible concept of diversity of approaches. But have found through experience, that many programs which may have been effective for small numbers of people, when placed in the context of the over-all epidemic-logical approach to the problem, actually appear to be of a conflicting nature, and it is the role of a coordinating agency such as ours to make the sometimes very difficult decision of discarding those which within the over-all context, do more harm than good.

THE POLITICAL FRAMEWORK

When translated to everyday reality, the demands of political reality expediency often serve to postpone the pursuit of generally lofty purposes by the party in power. To the extent that political factions respond to collective irrational pressures in a community, and to the extent that these are generated by the anxiety towards change, an inherent difficulty is created. By applying the principles of our prevention program to sectors of the community where these irrational pressures exist, we often succeed in diminishing them to a harmless level.

The specific difficulties involved in the political framework of an apolitical comprehensive program can be broken down into several areas. One of these is connected with the source and degree of authority required by a program such as ours. The Mayor and City Council have given the OCAP program as much authority as the City Charter makers possible under certain restrictions from State and Federal law. The question is, is this local authority given to such a coordinating agency enough to achieve a fully effective program?

My experience in the last year has shown me that it is, although there are certain areas of difficulty arising from the complexity of OCAP's official operational status. OCAP must preserve its Agency status under the direction of a Commissioner and not become identified as a Department so that it can remain flexible enough to cross lines of authority and become active in different areas of concern which properly belong under the jurisdiction of several governmental departments. The price to be paid for such flexibility and agency access is that many of the departments and agencies involved have to play an important and sometimes lengthy part in the decision-making process. The criterion for maintaining this complex structure is simply whether the production of the OCAP program and the achievement of coordination remains ahead of the difficulties and the delays involved in this procedure.

We have found that a very positive result often evolves out of the almost forced relationship that different agencies must maintain with each other, and that is a very definite trend towards institutional change with these agencies. One very happy example of this has happened within the Corrections Department of the City. As a

result of this Department's co- operation with OCAP, it has incorporated into its own rehabilitation program a special rehabilitation program for drug addicts. Under the City's contract with New York State, under which $8.5 million has been made available by the State to the City for the treatment and rehabilitation of 2,000 drug addicts according to the OCAP concept, OCAP has sub-contracted with Corrections and other departments to provide services.

Another specific difficulty involving political reality and one that is part and parcel of the checks and balances of our democratic society, is the risk of undue political strength developing in the hands of the people in charge of such a comprehensive program regardless of their own integrity, by virtue of the broad powers given by the City administration and its deep roots into public and private institutions and into community life. The proper reaction to this phenomenon is to parcel out as soon as possible to public and private voluntary agencies, those programs and services which, if concentrated within one single agency, could lead to such *a* risk. Therefore, the programs that our office operates are and will continue to be those which fill gaps in the areas of rehabilitation, prevention, education, and so forth, where no voluntary programs exist. It will also be our responsibility to transfer the operation of these programs to public and private groups as soon as they are developed so that the aspect of control is diminished without at the same time diminishing the functional effectiveness of the programs themselves.

Community Orienteer, who work in their communities during the afternoon and early evening and serve as staff members at the DECC during the morning hours. The DECC will reproduce, as far as possible, an environment which resembles a hospital. By remaining in this intermediate setting from approximately 9:00 a.m. to 10:00 p.m., the addict is isolated from his endemic environment most of the time, and will, in an ever increasing percentage of the cases, complete his physical detoxification before admission to the hospital. If no such hospital is available to complete his Induction, some cases can be referred to non-hospital treatment settings.

The DECC provides a more formal atmosphere than the C.O.C., but a less formal one than the following hospital environment. It offers the addict the opportunity to mix with three different social groups; his fellow addicts, the rehabilitated, trained ex-addicts, and, for the first time, professional members of the staff. The DECC also provides a community setting for professionals who work in surrounding hospitals and other treatment institutions to link their services, and links its own services with other community mental health programs, public health district centers, welfare centers, and so forth. In addition, the DECC provides a field training facility for professional and non-professional personnel, and a place where interested citizens can view an operating program on a day-to-day basis.

The Inductee who is referred from the DECC to a Mental and Physical Detoxification Ward (MPDW) will find a regular closed, medical facility set aside especially for the service of addicts with a capacity for about twenty-five persons at any one time.

The Detoxification phase comprises recognition of the necessity for institutionalization of most addicts for a short period of time with an emphasis on the medical aspects of treatment. Detoxification provides the possibility of bringing into a more relevant role City and private hospitals which already operate or could be encouraged to operate this kind of service, since the program requirements are simple.

Detoxification services, like those of the C.O.C.'s and DECC's, are linked to the needs of particular communities and as such, serve these communities through the gathering of statistical and clinical information as a result of the flow of patients through the detoxification programs. These statistics also provide an indication of the effectiveness of previous services, through a tabulation of the numbers of patients who go through the detoxification phase as well as the number of individuals who repeat this phase.

After successfully completing detoxification, the addict is ready to enter the second phase, treatment, which lasts for an average of ten to twelve months. Treatment is carried out in a residence - this can be a psychiatric hospital, brownstone house, a self-help residence, or a variety of other facilities - which has the capacity for about 40 persons at a time, and provides the type of communal living situation which we call a "therapeutic community". If the therapeutic environment is sufficiently intensive, an average of one patient a week will be evaluated as treated and discharged to the next phase. In New York City, we estimate that about one-fifth of the total number of addicts being treated under our program at any given time will make up the Treatment Phase, Phases I and III splitting the remaining four-fifths about evenly. The Treatment stage provides an opportunity for professionals (and non-professionals to develop effective team ^relationships *end* to participate in the life of the community in an on-going, non-detached way. Like the *DECC,* it provides a training experience for personnel to be hired by the OCAP program as well as for those attached to cooperating agencies, and a place for concerned citizens to view an aspect of the program 1m operation.

By the time the patients reach Re-Entry, Phase III of the program, their basic treatment is defined as completed. However, they will face the difficulties in adjustment from an isolated, supervised environment to resumption of everyday life in their communities. In order to facilitate their return, the ex-addicts transfer to a Re-Entry House which provides (a supervised residential situation, but one in which they will perform most of the operational matters and inner disciplines themselves aided by professionals and trained ex-addicts. In certain cases, they will be able to live at home while still partaking in the program to be undertaken in the Re-Entry phase.

The Re-Entry program has five levels of functional progress consisting of increased work responsibility with addicts in previous stages of the plan. In level one, the ex-addicts are assigned to four, six-hour, work shifts a day, *seven days* a *week as clinical aides* in the detoxification ward. In level two, the ex-addicts will work about seven hours a day as clinical assistants to the staff of the day-evening care centers (the DECC's), and in **level three**, they will work as full-time therapeutic aides in the Therapeutic Community *and participate and in some cases lead the thrice-weekly intensive treatment group sessions. By level* four, the ex-addicts are ready for community work. B*egin as apprentices in the Community Orientation Centers.*

Re entry provides two new kinds of services for the ex-addicts; traditional psychiatric therapy if needed, and, most importantly, vocational and educational training. In addition, the practi%2 of gradually increased participation by the ex-addicts in the government of the Re-Entry House, and in handling their own affairs, provides them with citizenship training which eventually will be an important factor in the effectiveness of the trained, rehabilitated ex-addict as a community prevention agent.

At the Re-Entry phase, data is gradually accumulated which establishes criteria for the standard certification of ex-addicts which will provide proof of their rehabilitation and help them in finding employment. This data also provides excellent material for a follow-up and evaluation of the previous treatment programs. This evaluation includes specifically a comparison of different approaches, the end results of each phase of the OCAP program, a justification for the expansion of the program, budgeting procedures and so on.

After the Re-entry phase is completed, the ex-addict is certified as rehabilitated. Certification affords a kind of guarantee to the future employer or anyone else who may form a relationship with an ex-addict that they are dealing with a person able to accept the responsibilities requested of him.

In addition to these treatment environments, there are several other environments, which serve to identify deviant behavior in young people who have not yet become addicted to drugs. These form basic components of our community development and prevention programs. One such envisages the establishment of 30 Juvenile Evaluation and Prevention Units (J.E.P.U.'s) equipped to provide attitudinal training as well as occupational and recreational programs for such youths. Another, the Volunteers in Service to New York City (V.I.S.N.Y.C.), will comprise an organization of young people serving in their own neighborhoods in community development and self-help projects.

In addition we are establishing a establishing a city wide operation organized, in local chapters called R.A.R.E. (Rehabilitation of Addicts by Relatives and Employers) which is composed exclusively of parents and close relatives of addicts. This organization will orient, train and educate these people so that they will become better able to assume responsibility in their families and in their communities. In particular, R.A.R.E. members will help to set up and support their local Community Orientation Center, refer addicts that they know to this center for future treatment, and, when that addict has completed the treatment program, help him to adapt himself productively to life in his community.

PROJECTIONS BASED ON ON-GOING EVALUATION

The development of projections is fundamentally an attempt to extrapolate from on-going evaluation and data a realistic determination of the product of the over-all program and match this product with the stated goals. We can think of projections in two specific areas: the development of the actual program structure ? and the impact and effectiveness of the program in terms of rehabilitation, prevention, treatment, legislation, public opinion and attitudes, and institutional change. The original design as we have seen, called for six structural levels of program development: (l) prevention, (2) the network of storefront centers (3) out-patient induction facilities, (4) detoxification, (5) intensive treatment, and (6) Re-Entry. In actuality after the past year's work, four structural levels are becoming apparent:

1. Community support programs. This program area encompasses the identification and organization of community program supports in specific areas outside and inside of the psychopathic matrix. Examples of such programs are RARE, AWARE, blockworkers programs, VISTA (Volunteers in Service to America) and certain early identification programs for youngsters such as VISNYC and

JEPU.

The end result of the interaction of these components is the development of a City-wide structure or network of services providing local community coordination of standard social service institutions such as welfare agencies, public health programs, private and public school systems and so forth, with new services which tend to neutralize adverse community attitudes towards addiction programs and, at the same time, to provide adequate settings for early diagnosis and engagement of affected individuals in treatment programs.

2. Out-patient induction. This is actually an intermediary phase between prevention programs and the medical and psychiatric treatment programs that follow. It includes the output; function of the C.O.C., the input function of the out-patient DECC, the partial integration of the addict into a treatment environment, and finally the referral of this partial patient into in-patient medical facilities. The C.O.C., output is becoming identifiable in three directions: (a) as prevention program support which reverts back into the community through the activities of the Community Orienter in helping such groups as RARE and_AWARE (b) the patient out-put of the G.O.C. in referral to the DECC, and (c) the program support provided by the Orienter in his part-time involvement with the G.O.C.

The DECC, in engaging C.O.C. referred patients and in incorporating the Community Orienters in its staff, provides program continuity and supervision and smoothes the transition between patient intake at a street level and patient admission at a hospital level.

3. Institutional treatment. This includes the final stage of induction which is medical detoxification, and post detoxification stabilization. Detoxification services link immediately with a separate facility for intensive treatment for the underlying personality disorders of the addict. A diversity of settings provide this second part of institutionalized treatment psychiatric hospital wards, partial or complete self-help residences and structured out-patient treatment programs, or a combination of the above.

4. The effectiveness of the OCAP program in terms of the actual re-habilitation of addicts is yet to be seen. The stated goal is couched in terms of engagement that is the number of addicts who are significantly involved in any aspect of the entire program. Significant in this sense implies on-going involvement with measurable individual progress in behavioral improvement, attitudinal change, and emotional, social, vocational and educational maturation. The presumption is that if the program structure as it develops provides a consistent opportunity for significant involvement, actual long-term rehabilitation rates could at least equal and perhaps surpass the cure rates in, let us say, neurotic conditions.

The effectiveness of prevention will be by definition very difficult to assess except perhaps in *a* long-range demonstrable decrease in the incidence of addiction. At this point in our program development, this criterion would seem remote and indirect. Other criteria should be more immediately utilized such as polls measuring public opinions and attitudes, institutional change, and the concomitant decrease in other

manifestations of related social pathology such as juvenile delinquency, prostitution, numbers rackets, and inter-racial friction.

Obviously, long-range projections a^ to the over-all effectiveness of a program of this nature will have to be evaluated within the context of social change in complex urban communities'. The challenge that this presents to research methodology and design can only be surpassed perhaps by the enormity and complexity of our actual operation.