June 13, 1971

Dr. Jerome Jaffe
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Dear Jerry,

The preliminary announcement of your appointment by the President to lead the national effort against drug abuse was most welcome here. I hope the appointment is made, and I wish you all success. The undertaking is a great one and I am confident the nation will follow your leadership willingly.

Since the reports in the New York Times last month of the high rate of opiate use in our troops in Southeast Asia, I have become additionally concerned about this horrendous aspect of this tragic war. In considering the alternatives, I concluded that our clinical experience with the antagonists (much of it unpublished) warranted some suggestions which I shared with those authorities I could reach in Washington. I write now in the hope that our experience may complement and re-enforce your suggestions and recommendations.

I consulting with the V.A. leaders in Washington, I became aware that plans were being entertained to rapidly return large numbers of addicted servicemen to their home communities, particularly to the V.A. ceneters, for treatment programs focussed on methadone maintenance. Such a rapid dispersion of the addicted drug users would be a tragic error, for the V.A. centers are ill-equipped at present to care for these men, and the users would provide multiple foci for local drug use and experimentation as well as connections to enhance a drug traffic. Such a course, based on dispersion, is the worst possible solution, for it will return men who are unprepared for community life, to homes without jobs and with inadequate counselling, and encourage the spread of addiction.

Every effort should be made to identify, detoxify and treat the men in Asia, before they return home. One interesting suggestion is to return the men to the States in slow ships, thus providing at least 3-4 weeks of isolation, group therapy, counselling, and medication.

While I know every effort will be made to restrict the drug traffic, educate the men, and identify users by urine and nalorphine tests, we would encourage some specific applications of our esperience with the antagonists. It now seems possible to provide prophylactic programs, similar to the use of atabrine for malaria in an earlier war. Opiate sependence has many of the characteristics of a contagious disease, and I believe the daily administration of cyclazocine would serve the same purpose today. Surely, if drug use is as widespread as the Times has reported, then an experiment in a small segment of the 330,000 man army would be warranted.

Your experience with cyclazocine led to widespread secondary effects, and in our early studies we confirmed your data. The effects were exaggerated by the dosage schedules we then used. Since January, 1970, we have inducted all our patients to 4 mg. cyclazocine in 4 days with minimal discomfort, surely no greater than our patients experience who begin treatment with imipramine. For prophylaxis, 1-2 mg each day (0.5-1.0 mg b.i.d.) should serve as an adequate deterrant. The administration of a tablet twice a day at mealtime should serve our purposes.

We have also discharged 6 patients from all care after 1.5 to 4 years on cyclazocine. These men remain drug-free, without 'craving' after 3-9 months on no medication. Such a limited experience is interesting and not decisive, but sufficient to encourage further trials. Surely, some military patients could be randomly assigned to the antagonists, and were this experiment done carefully, an adequate sample could be provided in a very short time. The men would have similar histories of drug use, conditions of treatment and living, etc. to those assigned to other regimens. Such an experiment would answer many questions not only for the military, but for the nation as well.

In our discussions, and in the press, you have repeatedly suggested that with the limited funds at your disposal in Illinois, methadone was the treatment of choice. I agreed then, and I agree today, that methadone provides the best answer for today. With the crisin in Viet-Nam and the availability of funds from the military, the V.A., and the P.H.S., surely the extensive clinical trials we discussed should be undertaken as a logical back-up to the other programs which you will encourage.

For more than two years, I have supported and encoyraged expanded studies of the antagonists. As a national leader, I know you will accept the repponsibility of leading the effort without the parochialism so sadly evinced during the past few years by all of us. I am delighted with your appointment, and I am encouraged that now I can again turn my attentions to my laboratory studies.

With all best wishes for your personal success, I remain,

Most sincerely yours,

Max Fink, M.D.
Professor of Psychiatry