PHOENIX HOUSE FOUNDATION ORAL HISTORY PROJECT

The Reminiscences of

Herbert Kleber

Columbia Center for Oral History

Columbia University

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PREFACE

The following oral history is the result of a recorded interview with Herbert Kleber conducted by Lance Thurner on January 23, 2015. This interview is part of the Phoenix House Foundation Oral History Project.

The reader is asked to bear in mind that s/he is reading a verbatim transcript of the spoken word, rather than written prose.

1PM	Session #1
Interviewee: Herbert Kleber	Location: New York City, NY
Interviewer: Lance Thurner	Date: January 23, 2015

Q: So this is Lance Thurner and I am in the offices at Columbia University's Psychiatric Institute to interview Herb Kleber as part of the Phoenix House Oral History Project. It is January 23rd, 2015, roughly one o'clock in the afternoon. As you know, Dr. Kleber, this interview is part of our effort to record the history of Phoenix House. Although I want to track your career and the way the field has changed over the last sixty years or so, I'd like to keep this with Phoenix House in mind and with the idea of the therapeutic community, and where it came from, and how it's changed. I would like to start with just a little bit about how you came into, first, psychiatry, and then addiction work, and what the state of the field was like when you began.

Kleber: I did my psychiatric residency at Yale [University] from '61 to '64. Then, they were drafting doctors, but if you volunteered, they would let you stay out until after you finished your residency. I volunteered for the Public Health Service. Because I was a researcher—I had done research in medical school—they agreed to send me to NIH [National Institutes of Health]. Then about three months before I was to go to NIH I get this letter saying, "We're looking forward to seeing you July 1st. You've been assigned to the Public Health Service Prison Hospital at Lexington, Kentucky."

Q: This is the famous, or infamous, narcotics farm.

Kleber: Right. So I said, "There must be some mistake guys. We had an agreement." [laughs] "Good luck!" I contacted the Public Health Service and they said, "Well, we're happy to send you to NIH if you can find someone to go to Lexington [Kentucky] in your place." [laughs] Needless to say, I landed at Lexington and spent two years there. That's how I first got involved with addiction.

Q: Your medical degree—did you specialize in psychiatry?

Kleber: You don't specialize in medical school. You specialize after medical school in residency.

Q: In residency. So what was your training like, then, in psychiatry?

Kleber: Yale was a superb department of psychiatry. In those days, it tended to be somewhat analytically oriented. This is the early '60s. The chairman was an analyst. A lot of the leading professors were analysts. You had some who flew in the face of that. [Thomas P.] Tom Detre, who left Yale and went to [University of] Pittsburgh [School of Medicine] and became chair of psychiatry there and then dean of the medical school. I remember one of my colleagues—Detre ran a ward at Yale and one of my colleagues went to see him and said, "Where's my office going to be when I come to your service?" He said, "We don't permit that kind of acting out. If you're foolish enough to want to see a patient alone, you can sign up for an interview room. Otherwise, you'll share an office with four other people." So his was the only one of the few parts of the department that was not analytically oriented. I was not analytically oriented. I had a couple

years of analysis while I was at medical school, which helped me learn that I was not cut out to be an analyst. The idea of seeing seven or eight patients day in, day out, month in, month out, and being relatively silent is not who I am. I'm a much more active kind of therapist.

Q: Then when you went to the narcotics farm, to Lexington, did your training and your knowledge of analysis shape your understanding of addiction?

Kleber: No. [laughs] Lexington had two parts to it. It was a prison hospital. Of the thousand people there, seven hundred were prisoners doing between one and ten years, and three hundred were volunteers. These were doctors, lawyers, pharmacists, people who had gotten into trouble with drugs, where their boards would say, "Go to Lexington. Stay there until they feel you're ready to leave and we'll let you keep your license." It was two very, very different groups. Most people didn't get therapy. Most people had work therapy. They'd be assigned to the kitchen. They'd be assigned to the farm. They'd be assigned to the woodshop, which made furniture. They'd be assigned to the laundry, whatever, whatever. It was also the only co-ed [co-educational] prison that I'm aware of. So the most popular prison industry was what? The laundry—

Q: The laundry. [laughs]

Kleber: —because what the guys working in the laundry would do is, they would take the grocery cart, which transported the towels and sheets into the women's quarters, and they would

hide below it, and then be wheeled into the women's quarters. [laughs] That was a very popular prison work assignment.

Q: What was treatment like at Lexington?

Kleber: I repeat. [laughs] A few people got individual therapy. Most got group therapy. In addition to that aspect of it, there was also the Addiction Research Institute, which was opened there in 1935. It did research on drug abuse and made a lot of discoveries. It was a forerunner of National Institute on Drug Abuse. It was eventually closed. Are you familiar with the Tuskegee Syphilis scandal?

Q: Yes.

Kleber: Well, when that hit the headlines, Congress held hearings. They decided that prisoners could not be involved in research because they could not give free consent. Since that's who made up most of the people taking part in the ARC's [Addiction Research Center] research, there was no point in it staying at Lexington. When that left, which would have been in the '70s, Lexington reverted to just being a prison. There was no point in having an Addiction Research Center there if you couldn't do research.

Q: It's hard to imagine how a place like that inspires one to go into addiction treatment.

Kleber: It doesn't. There was about a ninety percent relapse rate within the first ninety days. So when I came back to Yale in 1966 and joined the faculty, the last thing in the world I wanted to do was to treat addiction. But once you had been at Lexington, you were a marked man. That is, people sought you out who thought you might know something about treating addiction. PTAs [parent teacher associations] wanted you to speak at school meetings. People who had been at Lexington wanted to see me in terms of therapy and parents were very upset about their kids using drugs and they wanted to see me. Finally, after a year or so of that I said, "Well, maybe it's fate." I applied to NIH. There was not NIDA [National Institute on Drug Abuse] then. No point going into a lot of detail, but I sent in a small research grant and they said, "Why don't you think big? Devise a program that will have all the major treatment components that we feel might be successful." I did and they funded it.

Q: So what were the components?

Kleber: I had a methadone program. Methadone had begun in the early '60s at Rockefeller Center.

Q: Rockefeller Institute, yes.

Kleber: We were one of the first to do methadone maintenance outside of New York. I think we were the third or fourth oldest methadone program in the country. So we had a methadone program. We had a therapeutic community. The only one I was familiar with in New York was Daytop Village. I don't think Phoenix House was started then. I think they started a year or two

later. I met with the people from Daytop Village and they sent a group of about twelve people to New Haven [Connecticut] to open up a Daytop [Village] House there. So we had that, and maybe three or four months into that there was a big eruption in New York City [New York] between the board and David Deitch, who was running Daytop Village, and they fired David [Deitch]. When they fired him, hundreds of people left, both staff and patients, and guess where they came? New Haven. [laughs]

Q: They came up to New Haven?

Kleber: Because we were the only one around. We had a small house, which housed these twelve people that came up originally. So we scrambled to find housing. I had some living in my house. Other people had them living in their houses. Then we found other places for them. Some went to Philadelphia [Pennsylvania] and founded the Gaudenzia House. Some went to Chicago and founded a program there. Some went to Massachusetts and Rhode Island. That was Marathon House. Of course I got a call from reporters saying, "What's this we hear? There's all these New York addicts descending on New Haven?" [laughs] It was fun. So we had that. We had a therapeutic community. We had an adolescent program, which was primarily a day program. We had an outreach program in the community, which was staffed by some of my former patients from Lexington. We had a research component. We grew like Topsy.

Q: As you're beginning this large research and service project, what was the state of the understanding of addiction—and especially heroin addiction—in the academy at this point in time? What were you venturing into as a field?

Kleber: Two different schools of thought, and we embodied both. You had those who felt that—like [Vincent] Vince Dole—that this was not simply a psychological addiction, but that once you had gotten addicted, your brain had changed and you probably needed to be on it for years, if not decades. Then you had a therapeutic community model, which said, "No, it's a psychological disorder and we can treat it with behavioral kinds of approaches." We had probably a very unique thing. We had a committee made up of representatives from each of the components and anyone who wanted treatment was screened by that group and decided what kind of treatment you would go into. So some would be assigned to methadone. Some would be assigned to Daytop.

Q: When did you first encounter the idea of the therapeutic community? Where was it and what did you think of it? Do you remember?

Kleber: Well, it was the only non-pharmacologic model. So I had methadone. At that time that was all I had as a medical model. I needed a psychological—well, 'psychological model' may not be right term—an approach that looked more at behavior. We felt that our methadone program was going to be different than Vince Dole's.

Q: How is this?

Kleber: In that Vince basically felt that the treatment was methadone. I felt that we could put people on methadone, keep them on it, give intensive therapy, and then withdraw them from it.

We did that for a number of years. I remember we invited Vince [Dole] and Marie [Nyswander] up to give a talk, and I remember during his talk in the Q and A [questions and answers] afterwards there was one of our staff that really was questioning him very severely. Then after that was over we went out to dinner and Vince said, "Who is that guy asking all the questions? Is he on methadone?" I said, "No. He's one of our counselors. He had been on methadone and he wanted to come off it. So he's been off it for about three or four months." Vince said, "I thought so."

[laughs] Eventually Vince was proven right, but it took me five or six years to realize that—although some people can get on methadone, get their lives together and get off it—the majority, no matter how intensive our treatment, how skilled our staff, would relapse once we withdrew them. We tried everything. Then we started moving into antagonists. Our adolescents we started off at outpatient. When that wasn't enough, we started a day program. That wasn't enough and so we began to experiment with narcotic antagonists. Naloxone—we were using up the world's supply of naloxone. We were giving these people eight hundred milligrams a day. Just to give you some idea, the dose that they use to reverse overdose is maybe 0.01. So it was a huge amount, but orally it's not well absorbed, but it lasted 18 hours. So we would give it to the adolescents right when they left at four in the afternoon and it would hold them until the next morning.

Each year we added new things. We had the vocational programs. We had our own medical programs. We did a lot of research trying different drugs. Naltrexone came along; much better than naloxone, longer acting, developed by Endo [Laboratories]. Endo was bought by DuPont

Pharma. DuPont decided there was no money in it and they decided they were going to stop it. We were finding it useful. Having worked with addicts and even more so with academia—as I tell my young people, "Academia is a blood sport." I had made friends with the *New York Times* people and *Washington Post*, and we scheduled a press conference. I called DuPont and said, "In three weeks we're having a press conference where you're going to be labeled a war profiteer. We have our brave soldiers coming home from Vietnam addicted to narcotics and here's a very promising method of treating them and you're discontinuing it because of money." They caved. Naltrexone was continued. We did research on it and showed it could be a very useful technique for treating narcotic addiction.

Q: You were at Yale during these years. Were you concentrated solely on heroin and opioids?

Kleber: Everything. Opioids were mainly what our adults were on, but our adolescents were into you name it. A lot of them were into narcotics. That's why we were interested in naltrexone, but others were—remember what the '60s and '70s were. There was marijuana—even though the marijuana then was very weak. When John Lennon said marijuana was a harmless giggle, it was about two percent. Now marijuana is anywhere between fifteen and thirty percent. But there were the psychedelics. Then of course in the '70s you also had that drug Quaalude—

Q: Quaaludes, yes.

Kleber: —which got very popular. Each year, we had a wonderful group of people doing research. Cocaine came along in the late '70s, early '80s. We did some of the earliest research on

developing medications for cocaine. We kept innovating and innovating. I had wonderful people on faculty. A lot of them are still there at Yale. A few have moved on to other places. [Thomas] Tom Kosten, who was very important there, went to Baylor [College of Medicine]. Frank Gavin went to UCLA [University of California Los Angeles]. But most of the staff stayed there and they're still there.

Q: Can we talk a little bit about the therapeutic community model? So when you're beginning this program at Yale, did that model have any academic legitimacy? The lore, of course, is that it begins with Synanon and comes out of that model.

Kleber: And that's where David [Deitch] had been.

Q: Right, and comes out of, more or less, the life experience of addiction. What was the perception within the medical establishment of this idea?

Kleber: It was really the only thing we had that was not pharmacologic. Psychotherapy is a nice idea, but it doesn't tend to work very much with addicts. Marie Nyswander, after all, was an analyst before she joined with Vincent Dole. So traditional psychotherapy did not seem to have a role. That's where the TC [therapeutic community] came in. It seemed like it was the only viable model, other than our medications.

Q: Now does it somehow reflect the wider change in the field of academic psychology towards behavioral psychology?

Kleber: Possibly, but a different kind of behavioral philosophy than you see today. Again, the model being of addicts helping addicts, strict models, haircuts. Not physical haircuts, but emotional haircuts. Group therapy where the first rule was you're not permitted to get out of your seat, [laughs] but you can say whatever it is you please as long as you don't get out of your seat because that becomes a threatening kind of behavior.

Q: We've then discussed a good bit about developing use of methadone and antagonists, and eventually agonists. While you're at the drug dependence unit, do you do research on the therapeutic community and try to change the model, adapt it, improve upon it?

Kleber: I don't think so. I think my faculty was much more biologically oriented. The therapeutic community was an entity unto itself. We did not really try to change it, but they kept trying to change. They evolved, perhaps not as fast in retrospect as one might like, but they did evolve. They did evolve.

Q: What were the major changes you think—how the practice of therapeutic communities changed?

Kleber: The coffin disappeared. The coffin was that, if you planned on leaving, they would hold a mock funeral for you. You would lie in a coffin and they would hold a funeral service for you, and they would say, "If you leave, we're either coming to your funeral or visiting you in prison." That was a very dramatic way of doing it, but there was adverse publicity about that and that

eventually got stopped. I'm trying to think what other practices. I have to say I didn't get terribly involved with what was going on in the TCs. I was much more involved with the pharmacologic approaches. We didn't have buprenorphine yet. So basically we had methadone, but we also developed other medications through treating cocaine. We found that some of the anti-depressants could be useful to treat cocaine, desipramine especially. We did some other kinds of psychological approaches. I think Bruce [J.] Rounsaville carried out a lot of those. He was less biologically oriented, more psychologically oriented. Unfortunately he died a year or two ago. He had atrial fibrillation. They put in a pacemaker. They thought he was cured and that he could go back to exercising. He was a swimmer, did laps, came out of the pool, fell back in dead. So that will teach you to do exercise!

Q: So it was during these years that you got to know Mitch [S. Rosenthal] in Phoenix House. Can you explain a little bit about getting to know Mitch?

Kleber: I don't think I got involved with Phoenix House until after I had left New Haven because we had our own Daytop model. There was no point in interacting with New York program. In '89 I left Yale.

Q: To go to the White House.

Kleber: To go to the White House under the President George H.W. Bush. I was the Deputy for Demand Reduction under [William John] Bill Bennett. I was there for about two and a half

years. They were wonderful years. I think we did some good. We changed the percentage of money going to supply versus demand.

Q: To reducing supply.

Kleber: And increasing the funds for demand. We got a number of other changes. I got Bill Bennett to visit a therapeutic community. I'm trying to think which one he visited. Was it Phoenix House that he visited?

Q: I don't know.

Kleber: I remember one thing that came out of his visit. One of the residents had on their wall a cartoon from the Simpsons. It said something like, "Bad and proud of it," or something like that, or mischievous or something like that. Bennett said, "I hope you don't take that as your role model." Of course there were reporters trailing after us all the time. What was the headline? Not that Bennett visited a TC—that he gave a press conference afterwards praising the work they were doing—it was, "Drugs czar bashes cartoon character." [laughs] Bill said, "You are not going to get me to another one of these programs."

Q: Now what did you think about joining the White House, the politics of it? What was involved in your decision to go that route, of going into the political realm?

Kleber: I felt that I could do more good with a national purview to work on, rather than just one program in one city. My hope was that I could change things on a national scale, both in terms of funding, and in terms of approaches. I remember under President [Ronald] Reagan, he held a conference for a drug free America, where they bashed using any kind of a medical approach, such as methadone. That was simply perpetuating addiction. So they wanted to take money away from NIDA because they were funding methadone programs and methadone research. So one of the first things we did was issue a white paper on treatment, which said that treating addiction is difficult. We need all the modalities that we can have available, and that medical modalities like methadone—we didn't have buprenorphine yet—can be very helpful in doing this. That sort of put an end to it, although that group had tried to keep me from getting the job. They sent nasty letters to the White House.

Q: Because you were pro-methadone?

Kleber: Yes. What they said is, "Dr. [Herb] Kleber is soft on drugs." We got five thousand school superintendents to write positive letters. Eventually the White House decided they would nominate me for the position. A hearing was held by [Edward Moore] Ted Kennedy. He chaired it, and it was a grilling hearing; that is, it was a Democratic committee and I was a Republican. Finally at the end, Senator Kennedy said to me, "Well, Dr. Kleber, it must have been difficult keeping your optimism up after all these decades treating addicts. What keeps you going?" No one had asked me that. I thought for a moment and what popped into my mind was a quote from the Talmud: "The day is short. The task is difficult. It is not our duty to finish it, but we are forbidden not to try." That ended it. How do you bash a guy after he says that? So my group at

Yale asked what they could give me as a going away present. I said I would love to have that framed so I could put it on a wall of my office in the White House. My staff there, being good scholars, went back to the Talmud and said, "We can't do it." I said, "Why?" They said, "Because you left out a line. You left out the third line. The day is short. The task is difficult. The workers are lazy." [laughs]

Q: That's what the—

Kleber: That's the original quote. [laughs] I said, "No, I wasn't about to say that." So we compromised. You see at the bottom of that it says, "The Talmud, as misquoted by Herb Kleber." So that ended the hearing and I got approved and joined the staff. Some habits die hard. I'm never on time for anything, as you saw in terms of your appointment today. Bennett had executive staff at 8:00. I would show up at 8:20. Finally he said, "Herb, the meeting begins at eight. Why are you always late?" I said, "Traffic is dreadful." He said, "You told me you walk to work." I said, "Yes, the streets were crowded with pedestrians." [laughs] And being the gentlemen he was, he changed the committee until 9:00 and I had no longer an excuse for being late. Go ahead. Sorry for the diversion.

Q: That's quite all right. I'm wondering a little bit leading up to your joining the White House—up until then and since then—Republicans had been known for a far more tough on crime and tough on drugs sort of approach, from [Richard Milhous] Nixon's war on drugs, to the Rockefeller Drug Laws, and since to people like George [Elmer] Pataki and [Rudolph William

Louis] Giuliani. To what degree was there partisanship at that point in time regarding drug treatment?

Kleber: President Nixon was against using methadone. He was convinced by [Jerome] Jerry Jaffe, as well as some of his other staff—I think [Harry Robbins] Haldeman was also involved—that if he wanted to be seen as a law and order president, he couldn't afford to end methadone because again, you had all these veterans coming out of Vietnam addicted to narcotics. You might see a crime wave. So it was important to let methadone continue. Not only did it continue, but it expanded. We used the same argument on Mayor Giuliani. Giuliani was annoyed because the methadone programs, at that point—and at this point I'm in New York City—methadone programs in New York had a relatively poor employment rate. Only about twenty percent of their clients were employed—but probably more than that because a lot of them were paid under the table. Giuliani said he was going to cut out city support of methadone programs unless they improved their employment rate. His staff met with the meeting of the programs and told them that. They said, "Well, if you want us to do it, you have to give us more money." That infuriated Giuliani. So when he came to his talk, he was going to say that he would hope that they would do more in a way of getting people off welfare and all that. Instead he said he was going to end methadone programs in six months.

We met with Giuliani using the same argument that had been used on Nixon. "You want to be known as a law and order mayor. If you end methadone in New York City, you're going to have a marked increase in crime. You don't want that." So he not only announced—on a Saturday, when it was a very poor press conference—that he was ending that, but that he was giving five

million dollars to the programs to improve their psychosocial work. I was given the task of monitoring how that money was spent. During my whole career—first methadone and then later buprenorphine—always there's people who feel you should not be using drugs to treat drug addiction.

Q: But it's not partisan in any way, you don't think?

Kleber: No. I think in my experience—well, I take that back. People who are tough on crime would be more likely to support a therapeutic community as a point of view as being tough on addicts, as opposed to medications like methadone or buprenorphine.

Q: During these same years then—your final years at Yale, joining the White House and then coming to New York—during this same period, the general perception of addiction changes in the U.S. [United States] from being an inner-city kind of problem to being more of a trans-class problem, or nationwide problem. How did that change, and how did that change the field?

Kleber: I'm not sure it has. I think you have still different points of view. You have Phoenix House, which has evolved from the original Daytop model, partly because it was run by psychiatrists, whereas Daytop was not. Daytop was run by people like David Deitch, who was a recovering addict himself. So I think having a psychiatrist there as a founder of Phoenix House gave it a more comprehensive picture than the original Daytop had been, involving more psychological techniques, et cetera. But I think there's still—not antipathy—but there's still a marked difference between those who espouse a TC model and those who espouse a medication

model. That especially changed with the onset of buprenorphine, because with methadone you had to go to a clinic. You had to earn take outs. It may take you years before you got a take out of four or five days. Buprenorphine came about because of DATA, the Drug Abuse Treatment Act of 1999. Then buprenorphine was scheduled by the FDA in 2002 as a schedule three drug. DATA had said that you didn't need to have the safeguards of the methadone program if it's a schedule three drug as opposed to a schedule two. DEA [Drug Enforcement Administration] fought that all the way to Switzerland, where there was a meeting of one of the international governing bodies. DEA wanted to go there to say that buprenorphine should be a two, not a three, which would have meant you couldn't prescribe it in an office setting. Unfortunately for them, some congressmen got hold of that and forbid DEA from sending anyone to that meeting. I don't know how that happened! But it happened because I was at that meeting in Switzerland and DEA wasn't there. So they decided not to recommend that buprenorphine be changed to a two rather than a three.

Q: To a two. That's exaggerated the difference between the pro-medication side and the—

Kleber: Yes, because now you can give buprenorphine in an office setting. What's hitting the therapeutic communities these days is the financing. I think that Daytop—in my days with the TC the stays were twelve to eighteen months. I think Phoenix House and all the other TCs are having trouble now getting funding for that kind of duration of stay. I don't think that's a function of buprenorphine. I think that's a function of funding of medical care. It has a big effect on the therapeutic communities.

Q: Yes. Can you explain a little bit about your relationship with Mitch and the TC? One thing, as you get to know Mitch, you guys are on opposite sides of the methadone debate. Is that right?

Kleber: No. I think Mitch is a psychiatrist and I think he realizes that you need a variety of approaches. I've not heard him give any anti-buprenorphine talks.

Q: No, but back in the '70s he spoke—

Kleber: Back in the '70s.

Q: —quite a bit against methadone.

Kleber: Yes, but that was methadone. It was a different model. Buprenorphine is a different model than methadone. I've never heard him speak against buprenorphine, even though there are problems with bup [buprenorphine]. There's diversion, especially in places where bup is scarce, where there aren't enough doctors who prescribe. This is not a big issue in New York City, but you go to Kentucky and West Virginia where you may not have a doctor who prescribes for a hundred miles and there aren't many of them. Originally you can only have thirty patients. Now after one year you can have a hundred patients. There's legislation being proposed to increase that number to two hundred, which I have trouble with because I don't see how you can treat a hundred patients, let alone two hundred. My own feeling is—as it was with methadone—these are drugs, not treatment. They need to be given in the therapeutic context.

When we ran the methadone program in New Haven, patients were required to attend therapy programs, which could be either group or individual. That was required if you were going to receive methadone. On the other hand, we used certain behavioral techniques also; for example, you had to be very careful about people loitering outside the program because that would get the community upset. Often these would be people who were selling drugs, selling stolen goods. So I laid down a rule that you had five minutes after you left the program to not be available by sight, either up the street or down the street. If you are, then you get a warning. Second warning you're taken off methadone. That ended the loitering problem. We had a couple computers that were lost—not lost—that were stolen. So I stopped all methadone take out until those computers were returned. They were returned in twenty-four or thirty-six hours. Then of course the ACLU [American Civil Liberties Union] tried to sue us on the loitering thing, saying that sidewalks are public property and that people have a right to be on the sidewalk. I simply said, "You're absolutely right. They have a choice. They can either be on the sidewalk or they can be on the methadone program. They can't do both." They withdrew the case. I guess somehow I've learned the techniques of the therapeutic community in terms of shaping behavior. On the other hand, I think that it's in many cases necessary to do it in the context of medications.

Q: Do you think that what drug a patient is using impacts whether or not the therapeutic community model is going to work for them? To put it another way, how do you decide—I've seen you've written a number of different types of treatment or we need to have options so that we can put with what fits them best. So who is right for a therapeutic community and who needs to be on methadone or bup?

Kleber: Well, first there are many times you have no choice. For example, some of the probation officers or some of the judges who run the drug courts don't approve of maintenance medication. So you don't have an option in those cases. I have a patient—I've got to be careful here so I don't give away an identity—I have a patient who was convicted of a felony because he set fire to some motorcycles and cars. He was sentenced to either four months in prison or fifty-two weeks of coming in on weekends, but he's now on bup. So we worked out a schedule where he could survive being on weekends by taking a double dose Friday before he went in and that would hold him on Saturday, and then taking it right away when he got out. So you have to be able to devise techniques as you go along. You have to be flexible and have to deal with the prejudices that exist in society while trying to change the ones where you feel there's not a good rationale for it.

Q: What kind of patients do you think don't fit for the therapeutic community?

Kleber: In other words, if we could just pick, we can send them to either a—for example, someone who's unemployed may do better in a methadone program where they have to come than in the bup program where they simply get a prescription for two weeks or four weeks supply of bup. That's one way of distinguishing, for example, between methadone and bup. Some people need the structure of a methadone program. Likewise, you need people who need a structured kind of psychological approach. I think those people do well in a therapeutic community. I think that they don't do terribly well in traditional therapy. They need some of the behavioral kind of approaches that are used in a program like Phoenix House. I think that's why I

was willing, for a period of time, to join the Phoenix [House] board. Don't ask me when because I've been on so many boards, off, on, whatever.

Q: Well, while you were on that board, were you involved in any major changes in the institution?

Kleber: I don't recall any major changes that I was part of or involved with. The one that I felt most strongly about, I lost.

Q: What was this?

Kleber: I opposed Howard Meitiner [phonetic] being made—

Q: So you were—

Kleber: Head. I had a very good candidate who was willing to do the job and I thought would be superb for it. I think the board felt that that person might be too powerful.

Q: Coming from outside, too, yes.

Kleber: Yes. Maybe they wanted someone like Howard who knew nothing about addiction, therapeutic communities, or whatever. And of course, as you know, he was just laid off.

Q: Right. So maybe you were right. You must feel a little vindicated.

Kleber: [laughs] Well, unfortunately. I would rather have been proven wrong.

Q: So it was after that that you left the board?

Kleber: Yes.

Q: I'm wondering a little bit about, what's the vision of how treatment might change in the next ten years, in the next twenty years?

Kleber: It's money and funding. I have a patient who has fractured vertebrae in the neck and has—I'm not going to tell you his occupation.

Q: That's fine.

Kleber: But he was rear-ended a couple times and damaged the neck vertebrae. He's going to be operated on for that. The surgeon wants him to stay in a hospital three days. The insurance company says, "We see no reason why he can't go home the same night." [laughs] He's fighting it and maybe he'll get one day. In a sense, that's the story of Phoenix House and the therapeutic communities. It's not just what's going to be good for the patient. It's going to be who's paying for it and what are they willing to pay for. Are they going to seek the lowest common denominator? What they're going to be more interested in is saving money than they are saving

lives. I have a small private practice. I'll submit a bill—let's say, for $350 for a session. Then I'll get a fax from the insurance company, which says, "If you're willing to accept two hundred or two and a quarter, we'll pay you now. If you're not willing to accept it, you'll get paid, but we don't know when." [laughs] It doesn't affect me because I don't accept insurance. I'm happy to fill out forms, but the patient is responsible for the bill. So the patient will already have paid for that bill. That's the shape of what's happening and that's why most psychiatrists in New York do not accept insurance. They can get away with it because New York is a relatively prosperous city. A program like Phoenix House, which is dependent on outside funding—so when you say what's going to happen in five years, ten years, I think what's going to happen depends on what happens with the funding structure.

Q: What about on the research front? Are there any silver bullets coming down the research line? Are there any new paradigms coming?

Kleber: One of the paradigms that's coming on the medication side is duration. Methadone or bup you have to take daily. There's now a form of bup that I think you can take weekly. There's a number of research projects on bup lasting thirty days. That will change the nature of the beast to some extent. Likewise with naltrexone, which is a narcotic antagonist and therefore more acceptable to certain treatment approaches, like if you go to an AA [Alcoholics Anonymous] meeting and say you're on bup or methadone, what will happen?

Q: Well, you'll get shamed out.

Kleber: What they say is, "Shut up. Sit down. You're welcome to stay, but you can't speak until you get off those drugs." What happens is, some people go to those meetings and they don't tell, which sort of defeats some of the purpose of the AA or NA [Narcotics Anonymous] meetings. But now we have Vivitrol. Vivitrol is a one month naltrexone implant and there are people working on a six month implant. As those get perfected, you're going to see important changes in how treatment is carried out.

Q: I'd like to ask you a bit about how the idea of methadone, and bup, and the others, becoming more and more of, not something that you take for six months, or a year, or two years, but a ten year trajectory or more. Was that something that developed in the '70s, this idea? Or was the idea then that one would take methadone for a year and then quit?

Kleber: Like our original model in New Haven?

Q: Right.

Kleber: Nineteen-fifty, at the addiction research center—my god, I'm blocking out his name. One of the things that happens when you hit eighty is the memory for names tends to go quickly. In 1950, Bill Martin, the leading scientist there, discovered something he called PAS, Protracted Abstinence Syndrome. I don't know if you've heard of that before.

Q: I have.

Kleber: What he postulated was that being on drugs for a period of time changes your brain. Even when you stop, even when you taper, the brain changes are still there and it may take six to nine months for the brain to heal. Some people say it never heals, that part of it remains changed. But in any event, we're relearning that. People forgot about that. I'm a true believer in it. I experienced it when I gave up smoking. For six months after I gave up smoking I had trouble concentrating. I had trouble writing papers. Then it gradually went away. I see it all the time with people who are addicted to narcotics, that you have this protracted abstinence. I think that's why when I'm taking people off of bup, when they feel, "I'm ready to get off it, Doc. Life's going good. I don't think I need it." I say, "Well, I'm quite willing to withdraw you, but only if you agree to go on Vivitrol for at least six months, because otherwise you're going to go through this protracted abstinence and you're going to relapse. After all the hard work you've put in, it would be a shame to see you throw all that away." They almost always agree to do it. I always try and get them to extend it beyond the six months and I'm usually not successful. So I can't give you much in a way of follow-up as far as whether they're able then to stay off.

Q: But some people, of course, stay on methadone for much longer.

Kleber: Decades.

Q: Decades. So what I'm trying to lead to here—what I want to ask you about—is how the understanding of the ability to actually solve addiction is changing. Are the dreams of the therapeutic community, that the goal is to be drug free, is that something that is still a reachable goal?

Kleber: Remember the old [Henry] Henny Youngman joke? Two guys walking down the street and one says to the other, "So, how's your wife?" The guy says, "Compared to who?" [laughs] Is it possible that some people can get on, get off and do fine? The answer is not—can they? Of course they can. I see patients who have been able to get off. They're the minority.

Q: They're the minority.

Kleber: They're the minority. So it's not that they don't exist, but how successful is AA?

Q: I have no idea.

Kleber: Guess.

Q: Twenty-five percent?

Kleber: Using their own numbers, a hundred people enter AA January 1st. December 31st, ten people still on it, still attending AA meetings, of whom nine are doing well. So AA is either ninety percent successful, nine out of ten, [laughs] or it's nine percent successful. That's unfair, because some people come in and out and then eventually stay steady and go to regular meetings and all that, maybe the second year or whatever. So there's probably a gradual accretion that makes it higher than nine percent. I think it may get as high as twenty percent, but I don't think it

gets much higher. It's tough to do. I have one patient now who has been attending AA for nine years and attributes his being able to stay clean from his attending AA meetings.

Q: But so from the field—from a field-wide perspective of drug treatment—the idea of curing addiction has very much gone by the wayside.

Kleber: No, we're not there yet.

Q: We're just not there yet.

Kleber: If you believe the PAS thing, about the protracted abstinence and it's due to brain changes, there's a lot of active research going on about how do you change the brain back? What technique can we use? Can it be transcranial magnetics sort of thing? Is it other ways of altering the brain? Of course, I'm an optimist. How else do I get here? [laughs] How else do I work with addicts for forty years? I'm a perpetual optimist. I believe we're going to find out better ways of altering the brain than we currently have. They will be able to work and they won't have to stay on a medication. But, I'm not sure how many people that's going to apply to.

Some things don't change. I have a quirk in my brain that I've known since the age of five. I have no sense of direction. My wife—when we come out of the subway, when we come out of the theater—she knows which way to turn by asking me and going the opposite way. I'm always right or always wrong, depending on how you want to look at it. I'm invariably wrong, no matter how many times I've gone to that theater, no matter how many times I've gone out of that

subway. I still guess the wrong way. I saw an article in the paper, in the *[New York] Times* maybe three or four months ago, that they've now discovered that there's a subspecies of mice; same thing. They don't have that sense of direction and they get lost. I asked Eric Kandel, our resident Nobel Prize winner here at Columbia—and I'm a friend of Eric's. So I said, "Eric, I'm willing to offer my brain for research. We should be doing brain scans and all this to see where that's located in the brain." He said, "No. We already know where it's located. It's located in the hippocampus." So he didn't take me up on my offer. My three kids—my oldest daughter has the exact same thing. My son does not.

Q: I'd like to talk a little bit now about—and this is our last topic for the day—about the social understanding of drugs in America in the last few decades, especially as we now see with the surprising rise of the legalization of marijuana in the last year or two.

Kleber: That will change.

Q: What? That will change?

Kleber: That will change, yes. Why? Why is it going to change?

Q: I'm wondering where you think—why has it been so successful recently? Is that indicative of a larger change of understanding of—

Kleber: Money. For example, Alaska was just one of the states that legalized marijuana. I think the money was ten to one. For every one dollar the anti-legalization had, there was ten dollars going in. Millions were spent. Same is true with some other states. There was five billionaires that are helping fund the marijuana legalization thing: George Soros; Peter [B.] Lewis, who just died, from Progressive Insurance Company; the guy who owns Virgin Airlines and all that.

Q: Yes, [Richard] Branson.

Kleber: Yes. Guy who owns Men's Warehouse.

Q: I don't know his name.

Kleber: And there's a fifth person. These are all billionaires. *New York Times* printed one of my sayings when they did a book review of [George] Soros's book a number of years ago. He talked about his views on legalization and then the *New York Times* asked me for a quote. I said, "Well, Mr. Soros reminds me of the old British school boy story, that school boys throw rocks at frogs in play, but the frogs die in earnest. Mr. Soros is playing with the idea of legalization and people will die because of it," which I'm sure went over well. I've never met him and that quote doesn't endear him to want to meet me. But there's a lot more money going into the pro marijuana group than going into the anti-. Billions of dollars are being made with the legalization of marijuana by the dispensaries and all that. What we're beginning to see is a change in people's attitudes towards marijuana—slowly. The problem is it's still—a majority of people who use it don't get into trouble with it. But a significant minority does, especially if you start young. There's

increasing evidence that if you take marijuana before the age of fifteen, you alter your brain in a deleterious way. That persists at least into your mid-twenties. There's more and more research on that and as you see, Colorado is a disaster with the increased automobile accidents. In California the councilmen—the fourteen members of council—voted unanimously to close all the marijuana dispensaries. In four months they had it rescinded. So much money went into the legal things. So much economic pressure was put on that they rescinded that.

Q: Of course one of the arguments of the pro-legalization side is always that marijuana is less dangerous than alcohol.

Kleber: They're right, [laughs] but was alcohol prohibition successful? Wrong. Imminently successful. Depends on your metric. During Prohibition, automobile accidents decreased, violence decreased. A number of the side effects of alcohol markedly diminished. Domestic violence markedly decreased. Why was Prohibition repealed? Not because it wasn't successful, but because—using today's numbers—in America today we have about 100 million people who drink. Eighty-five percent of them have no problems. Fifteen percent are either problem drinkers or alcoholics. The equivalent numbers back in '34 said, "I'll be damned if I'm going to give up my alcohol because you can't hold yours." That's why Prohibition was repealed. People say a state takes in all of these tax dollars on alcohol. For every dollar that a state or the federal government gets in alcohol taxes, they spend nine dollars. Are you aware of that?

Q: For emergency room visits and stuff like that.

Kleber: Everything. But it comes out of a different pocket. The one dollar goes into the general fund. The nine dollars comes out of criminal justice, automobile, hospitals. It's not that states or the federal government makes money on alcohol taxes. They're not going to make it on marijuana either. There will be enough problems with marijuana that—and this is a book that you must get ahold of, but it's not out yet. [laughs]

Q: I'll look for it once it's—

Kleber: It will be out in April.

Q: Two months, three months.

Kleber: I wrote the foreword for it.

Q: Did you?

Kleber: Basically what I said is—

Q: Let me just read for the tape. The book is called *Marijuana: The Unbiased Truth about the World's Most Popular Weed* by Kevin P. Hill.

Kleber: If you read I think it's the third paragraph there, sort of sums up—or maybe it's the second. I don't remember—where I say the pro-marijuana people will find much that they agree

with and much they disagree with. The same is true for the anti-marijuana group. Both will find things to agree with and to disagree with.

Q: So is the issue that there's simply not enough research?

Kleber: No. The problem is that it's that eighty-five percent that ended Prohibition. [laughs] So as long as you're part of the eighty-five percent, or eighty percent, or whatever, that isn't paying a price for the marijuana—either in automobile accidents or your youngster starting at—I mean most youngsters now are not starting marijuana at the age of twenty-one. They're starting marijuana at what?

Q: Eleven.

Kleber: Fourteen, fifteen, yes. What we're finding is, in their twenties they tend not to do well in school. They've dropped out. They have less energy, et cetera. At some point enough of that will happen. Now we have four states that have legalized it. What we're missing is a good detection of marijuana of recent use because the data on marijuana, as far as driving accidents, is it lasts too long in the blood and the urine too. The fact that you test positive for marijuana doesn't mean that the accident had anything to do with marijuana.

Q: It could have been three days ago or something.

Kleber: We need a technique—which will probably have to be something like saliva—that will tell you what your marijuana level is now, not what it was a week ago when you were smoking heavy. What is it when you were driving? Hell, people are texting and driving. I think a recent young woman was arrested for eating while driving. [laughs]

Q: Well, it makes you glad to be living in New York and not needing to drive. I just realized as we wind up this tape that we haven't really talked much about Mitch. Is there anything you'd like to say about your relationship with Mitch?

Kleber: I think Mitch is a wonderful human being. He's bright as hell. He's compassionate. He has a lot of insights into human behavior. I enjoy him as a human being. We try to have breakfast with each other once every couple months. I treasure those breakfasts. I think that they're interesting. I enjoy his company. I think Phoenix House is fortunate that he's been around all these years to advise it. I just think he's a wonderful human being.

Q: Did you ever have any—besides being on the board—any professional relationship with Mitch as far as when you were in the White House, perhaps consulting?

Kleber: No. I didn't know Mitch.

Q: You didn't know Mitch.

Kleber: Remember I had very little to do with New York City, although I was offered the drug czar job in New York City under [John Vliet] Lindsay. I asked what the drug czar would do and I said, "You don't want a drug czar. You want a public relations expert. [laughs] That's not who I am." I'm just as ready to insult newspapers as I am to insult my colleagues.

Q: Well, I thank you for a wonderful interview, Dr. Kleber.

Kleber: Thank you for taking the time and effort to do it.

[END OF INTERVIEW]