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This Issue in Brief

The Future of Parole—In Rebuttal of S.1437.—While S.1437 appears to deal with the problems of uncertainty and disparity in criminal sentences, it actually would cause more harm than good, asserts Cecil C. McCall, chairman of the U.S. Parole Commission. Disparity would increase with the elimination of the parole release function and judicial discretion would be needlessly restricted, he adds. Congress should preserve the gains made in the 1976 Parole Reorganization Act, and retain the Parole Commission in its present role as the term-setter for prison sentences of more than 1 year, he concludes.

Criminal Diversion in the Federal System: A Congressional Examination.—Timothy Kevin McPike, deputy counsel to the Senate Subcommittee on Improvements in Judicial Machinery, examines the history of Federal involvement with the pretrial diversion concept, including a chronology, a brief description of the contents of past legislative attempts, and an indepth examination of the current legislative proposal. The hearings held by the Senate and the position taken by the Subcommittee are thoroughly discussed as they reflect the trend in current thinking on several important issues in the pretrial diversion area.

Methadone: Blessing or Curse.—The use of methadone in the detoxification and maintenance of narcotic addiction has been accepted as a viable treatment method. However, diversion and abuse of methadone are becoming serious problems. This article by Dr. George Gubar does not advocate one position or the other concerning the long-standing controversy about the use of methadone. Rather, there is an attempt to describe the historical background of methadone, its diversion, and some suggestions as to possible approaches to reduce its abuse.

Social Climate and Prison Violence.—Some explanations of prison violence center on the personal motives of chronically disruptive inmates, and assume that such persons are violence-prone in all sorts of settings, asserts author Hans Toch. Other explanations have centered on prison conditions, but have over-generalized prison impact, or (more frequently) they have highlighted deterrent features, such as security measures. This article examines and illustrates ways in which prison subenvironments may contribute to the

CONTENTS

Methadone: Blessing or Curse*

BY GEORGE GUBAR, PH.D.**

METHADONE was first developed as a substitute for morphine to be used as an analgesic by the Germans during World War II. The drug was uncovered by an intelligence team of the U.S. Department of Commerce during an investigation of the German pharmaceutical industry shortly after the war. Methadone has been referred to by a variety of names (the Germans first called it dolophine) but in 1947, the Council on Drugs of the American Medical Association established "methadone" as the generic term for this compound.

Early clinical trials established methadone as an excellent pain killer which had many of the pharmacologic actions of morphine. In 1949, studies by Drs. Isbell and Vogel at Lexington, Kentucky, revealed that methadone had a marked addiction liability and therefore, these researchers would not consider it for use in the treatment of opiate addiction. They noted that methadone "in sufficient doses produces a type of euphoria which is even more pleasant to some morphine addicts than is the euphoria produced by morphine."

At the present time, the approved uses of methadone are limited to analgesia in severe pain (terminal cancer) and detoxification and maintenance treatment for narcotic addiction. The use of methadone has been greatly restricted because of the increasing incidence of illicit use and abuse in recent years.

By far, the greatest interest in methadone has centered around its use in the chemotherapy of narcotics addiction. In this regard, methadone is viewed as potentially a beneficial tool for *detoxification* and *long-term maintenance* of individuals addicted to heroin and other opiates. Methadone has been used in a variety of different ways in both modalities. The methadone regulations issued by the Food and Drug Administration in December 1972 define detoxification treatment as follows:

> "Detoxification treatment" using methadone is the administering or dispensing of methadone as a substitute narcotic drug in decreasing doses to reach a drug-free state in a period not to exceed 21 days in order to withdraw an individual who is dependent on heroin or other morphine-like drugs from the use of these drugs.

Most researchers have grouped detoxification into two major categories: *inpatient withdrawal* and *ambulatory* (or outpatient) *detoxification*. Both of these techniques require certain basic adjustments to make the treatment appropriate to the patient including modifications that take into

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*** This article is not being presented to advocate one position or the other concerning the long-standing controversy about the use of methadone in the treatment of opiate addiction.**

Rather, it is hoped that the facts and suggestions will assist persons to understand the controversy, and to consider the possible means by which treatment programs may be made more viable for both the opiate addict and the community.

Much of the material in this article regarding the background and therapeutic use of methadone was taken directly from an article titled *"Methadone: The Drug and Its Therapeutic Uses in the Treatment Of Addiction,"* National Clearing House for Drug Information, Series 31, No. 1, July 1974.

The material concerning the Monsignor Wall Social Service Center was prepared by Mr. Hubert Moran, September 1977.

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consideration (1) The amount of heroin habitually used; (2) the existence of multiple dependency involving hypnotics, alcohol or minor tranquilizers; and (3) the patient's overall physical and psychiatric condition.

The goal of inpatient withdrawal is to help the individual reach a drug-free state in a supportive and closely supervised environment which for a limited time at least, protects him from the adverse pressures of the street. During this process, it is hoped that the program will be able to provide adequate ancillary services, and that once drug-free, the patient will be more likely to become a productive member of society. Further, if the long-range goal of detoxification is referral to a long-term residential rehabilitation program, the patient is easier to motivate after inpatient detoxification. During the inpatient treatment process, a great deal of stress is placed upon helping the addict to learn new, or re-establish old, productive behavioral patterns.

The ambulatory methadone detoxification technique, more than any other, requires that the patient assume the largest share of responsibility for treatment and rehabilitation, but unfortunately the addicts do not have the strengths or reserve to accept this responsibility. The physician's role is a great deal more passive in ambulatory detoxification than in inpatient detoxification, in that he can administer medication and provide supportive services *only if* the addict patient decides to come to the clinic.

The success of either process has not been too promising. The experience of most programs in detoxification is that approximately 70 percent of the patients drop out of therapy against medical advice, and of those 30 percent who complete medical withdrawal only 9.5 percent remain drug-free at the end of 6 months (of 100 patients entering programs, 3 are drug-free for at least 6 months = 3 percent).

To continue with the FDA definitions of December 1972, they state the following concerning *methadone maintenance:*

> "Maintenance treatment" using methadone is the continued administering or dispensing of methadone, in conjunction with provisions of appropriate social and medical services, at relatively stable dosage levels for a period in excess of 21 days as an oral substitute for heroin or other morphine-like drugs, for an individual dependent on heroin. An eventual drug-free state is the treatment goal for patients, but it is recognized that for some patients, the drug may be needed for long periods of time.

While detoxification subscribes to the goal that total immediate abstinence is the starting point of all rehabilitation, methadone maintenance attempts to emphasize social and vocational rehabilitation over time. The historical precedent for maintenance which supports the shift away from total abstinence as a goal of treatment is to be found in the clinics established in 1912-13 in Florida and Tennessee to dispense narcotics legally to addicts. Following the passage of the Harrison Narcotic Act in 1914, approximately 44 clinics throughout the country were opened by 1921 to supply addicts with legal heroin at low cost, or no cost.

The origin of the use of methadone in the maintenance of narcotics addicts is generally attributed to Drs. Vincent Dole and Marie Nyswander in 1965. The modality which they developed was based on the assumption, that during the development of addiction to heroin, certain metabolic changes took place. The justification for the use of this drug by these researchers was predicated on the diabetic model employing insulin. They assumed that once methadone relieved the metabolic deficiency, the person could function normally.

Another concept basic to the original Dole-Nyswander methadone model is that of "narcotic blockade." It is supposed that if high enough doses of methadone (80 to 120 mg. per day) are given to patients, they will develop a physiological state of "blockade" in which all of the opiate receptor sites in the body are occupied by methadone. In this state, the methadone maintained persons will be "immune" to any effects from all but extraordinarily large subsequent doses of other narcotics.

The original Dole-Nyswander program accepted addicts for treatment *only* if they met the following criteria: (1) they volunteer for the program; (2) they were between 20 and 40 years of age: (3) they have a history of at least 4 years of "mainline" heroin use with repeated relapses following detoxification; and (4) they have no concurrent dependencies on nonnarcotic drugs such as alcohol, barbiturates, or minor tranquilizers. Following admission, patients were hospitalized for a period of 6 weeks during which time they received thorough medical and psychiatric examinations, and were gradually stabilized on a "blockading" dose of 80 to 120 mg. per day of methadone. At the end of the 6-week inpatient period, patients were given their high dose methadone daily on an outpatient basis. Urine specimens were taken regularly to monitor any relapses into illicit drug use.

The most significant modifications of this program to date have involved the lowering of the requirements concerning age and years of use for clients accepted to methadone programs; carrying out the stabilization procedure on an outpatient basis; and the use of lower doses of methadone for maintenance purposes.

Many clinicians believe that they are seeing large numbers of addicts who appear not to need either high doses of methadone or prolonged maintenance. For example, one researcher reported that in a Philadelphia program, drug-craving for several patients could be suppressed at low-dose levels up to 40 mg. of methadone per day. This researcher postulated that these patients utilized methadone in a different manner than the high-dose patients of the Dole-Nyswander program: the drug seemed to serve as a kind of tranquilizer or antidepressant which enabled patients to achieve a somewhat calm state while attempting to reconstruct their lives.

When low-dose maintenance is employed strictly on an outpatient basis, numerous advantages accrue. The addict is allowed to remain in his community, and is not required to sever his employment or constructive relationships for 6 weeks. Also, from a simple cost-effectiveness basis, the ambulatory methadone maintenance modality is far less expensive to operate than one which requires institutionalization and scarce hospital beds. This is not to say that inpatient "build-up" or stabilization does not have its advantages. In fact, there are many patients who require this kind of a controlled environment in the initial phases of treatment.

When low-dose ambulatory methadone maintenance patients were compared with the regular Dole-Nyswander type of patients, it was found that in selected cases, outcomes of both types were not significantly different. It was concluded that "the dosage per se was less important than other factors such as typology of patients, ancillary services and attitude of the program staff."

A Description of an Ongoing Program: Monsignor Wall Social Service Center, Hackensack, New Jersey

The Monsignor Wall Center is located in two converted house-trailers which are parked adjacent to the Bergen County Jail Annex on East Broadway in Hackensack, New Jersey.

The "typical" methadone maintenance patient at this center during 1976 was approximately 26 years old, white Catholic, Italian with 11½ years of formal education and had abused heroin for about 6½ years. Of the 150 patients treated on a daily basis, 22 percent were veterans and contrary to popular belief, only 6.7 of the total population were on public assistance (welfare). During 1976, 82 percent of the patients were engaged in socially acceptable activities[1] which left 18 percent as unemployed.

The detoxification patients during this same period were generally younger, better educated and had shorter histories of heroin abuse than those in the original Dole-Nyswander Program. There were approximately five times more applications for detoxification than methadone maintenance.

There were approximately 4 males treated for every female—which mirrors the standards for abuse and treatment. The average length of treatment for all methadone maintenance patients treated in 1976 was 19 months. Of the total number of patients on the Methadone Maintenance Treatment Program at Monsignor Wall in 1976, only 9 were arrested while on the program.

In spite of statements to the effect that the "heroin problem is disappearing," this center showed a 15 percent increase in the number of prospective patients screened for treatment services in 1976 vs. 1975 (1,210 vs. 999).

One topic which is usually *not* discussed by methadone maintenance programs concerns the submission of unacceptable (positive) urine specimens. Briefly, the procedure at Monsignor Wall is as follows:

The patient is first confronted by his or her respective social worker and is warned, referred to a physician or an administrator, or is presented at a staff conference for disciplinary action.

In the last quarter of 1976, 8 patients were responsible for 42 percent of the 142 unacceptable urines submitted. Their disposition was as follows:

2 were administratively detoxified
4 were transferred to another program
1 was pending transfer (at time of report)
1 had an increase in methadone dosage

During the first quarter of 1977, 31 of 148 patients serviced, submitted unacceptable urines. Their disposition was as follows:

[1] Acceptable activities are defined as employed, mothers of small children, pregnant, or attending academic or vocational schools.

9 (who had submitted only *one* positive urine) were warned

6 were transferred to another methadone maintenance treatment program

2 were transferred to a residential program

1 was transferred to a hospital

4 were administratively detoxified

2 eloped (split) from treatment

7 were being evaluated at the end of the quarter

These statistics indicate that the staff at the Monsignor Wall Program is interested in their patients, and do not (as has been suggested) merely "dispense methadone."

If Monsignor Wall is *typical* of all methadone maintenance programs, why are there so many problems inherent in this approach to the treatment of opiate addiction?

Although methadone is not the drug of choice among American narcotic addicts, its illegal use has been increasing. With the widespread proliferation of methadone maintenance and detoxification programs in the past 5 years, the issue of "drug program abuse" and the consequent increased availability of methadone on the illicit market has taken on greater importance.

In one survey (which is apparently typical) conducted at Dismas House in Paterson, New Jersey, 5 years ago, opiate addicts entering this residential program were polled as to whether they had *ever* used methadone (legally or illegally). Approximately 50 percent admitted using methadone at least one time. A very recent replication of this study at the same facility indicated that 100 percent of the opiate abusers applying for admission had experienced the use of legally dispensed or illicit (diverted) methadone.

The Administrators of most methadone programs feel that as a patient begins to respond to the medication and to the ancillary services (i.e. he gets "better" and is more cooperative and productive) he should *not* be required to come to the clinic as frequently. Placing more responsibility on the patient is regarded as having therapeutic value. Additionally, the clinic staff and space are freed for less routine matters. This is accomplished by granting patients more doses of "take-home" methadone.

The problem of illicit "street" methadone apparently stems from the ambulatory client who is receiving "take-home" methadone. A minute (infinitesimal) amount of methadone may be diverted by retaining medication in the mouth and carrying it out of a clinic, or by emptying the medication surpetitiously into a container rather than drinking it, but obviously the problem is take-homes.

If we consider these facts, it becomes apparent that a pattern is emerging. Apparently, we may be drifting into the same circumstances which occurred approximately 70 years ago when heroin was being used in the treatment of morphine addiction: *the blessing is becoming a curse.*

It is obvious that the addicts in New Jersey are purchasing methadone that has been illegally diverted from a methadone program. Intuitively, it may be assumed that a portion of this illicit methadone comes from local programs. However, most authorities agree that in the Northern and Central areas of New Jersey most of the illegal methadone is being diverted from the New York City[2] programs *or* from membership in multiple programs.

There is a possibility (and probability) that an individual may be "legitimately" registered in one program in New Jersey and simultaneously registered in another New Jersey program. However, it is much more likely that dual or (multiple) program membership would encompass a New Jersey program and New York City program. This individual could receive methadone in both programs using different identifications (which many addicts do), and consequently all of the take-home medication could be diverted into the illicit market. This can be done very easily and profitably considering how frequently and how many take-home doses a patient gets shortly after he enrolls in a New York City program. Should the addict consume the double doses, he is using the medication for its euphoric effect, rather than for treatment.

The addict who sells his take-home methadone usually purchases other drugs (such as heroin and barbiturates) with the profits so that he might achieve a *better* state of euphoria.

Another means of diversion can come from take-home medication, whereby the patient "splits" the dose because he is receiving a larger amount of medication than he requires. In this manner, he may consume a portion of the medication and dilute the remainder and sell it.[3]

[2] One factor which leads to this conclusion concerns the information that most of the illegally purchased "street" methadone is in the form of discets or is diluted with orange juice. In New Jersey, the drug used is methadose which is premixed and red (cherry) in color.

[3] Unfortunately, the addict can knowingly falsify his subjective reaction to a dose of methadone by complaining that the medication is "not holding" him (i.e., he is suffering from discomfort or sleeplessness). The physician might then increase the amount of methadone dispensed to the patient who would receive more medication than necessary.

Some Possible Means of Dealing With Methadone Diversion

(1) The clinic physician (who is responsible for the determination of dose-size) should be more attuned and knowledgeable to the physiological effects of methadone and attempt to stabilize patient at the lowest comfortable level of medication. (The patient should be "encouraged" toward low-dose maintenance where possible.)

(2) There must be some methods devised to cross-check multiple program membership. For example, in New Jersey there is presently no attempt to cross-check *interstate* clinic membership on a regular basis, including the addict who uses his own name in more than one program.[4] Certainly in Northern and Central New Jersey, there should be some means of identifying Jersey addicts who enroll in New York City programs and similarly in Southern New Jersey, those who register in Philadelphia programs.

(3) There must be more frequent and better controlled urine monitoring and surveillance to determine the use of illicit drugs. Positive tests would indicate to some measure the ineffectiveness of current treatment and adjustments in treatment methodology could be made.

(4) There must be more stringent requirements developed for granting take-homes, and more direct (punitive where necessary) procedures for dealing with abuses of the take-home privilege.

The Monsignor Wall Social Service Center developed a policy including eligibility requirements for take-homes as follows:

(1) Eighteen consecutive months of methadone maintenance at this clinic.

(2) Socially acceptable behavior for the past year.

(3) No criminal involvement for the past year.

(4) No drug usage as documented by urine results for the past year.

(5) A cooperative attitude.

Having met these initial requirements, each case is presented for action at a weekly staff meeting. If the request is approved, the client is granted take-home medication for Sundays. To continue receiving the take-home privilege for one day per week (Sunday) the client must:

(1) Submit a supervised urine every Monday without fail. Failure to submit a urine is considered as positive or "dirty" for a controlled dangerous substance and results in the revocation of the take-home privilege for up to 6 months, and continued weekly supervised urines.

(2) Abstinence from the use of a CDS as documented by the urine results. Positive testing results incur the same penalty as in Number 1.

(3) Must keep scheduled counseling appointments every 3 weeks. If an appointment is missed or cancelled, it must be rescheduled within 7 days. If the rescheduled appointment is not kept, the take-home privilege may be removed for a period up to 3 months, during which time, appointments are scheduled and must be kept before the take-home privilege is reinstated.

(4) Engage in continuing socially acceptable activities, maintain a cooperative attitude and not have any criminal involvement. Failure to comply in these areas will result in an indeterminate suspension of privileges.

After 6 months of continued acceptable participation as outlined above the client may be evaluated by the staff for the second take-home privilege of Saturday. The *maximum* take-home privilege is two times per week.

Future Directions of the Methadone Maintenance Treatment Programs

(1) The introduction of LAAM (Levo-alpho-acetyl methadone) holds promise for the elimination of take-homes medication. Following is a description of the use of LAAM as quoted from the TRIPS bi-monthly publication (Field Report March/April 1977):

> Two proponents of methadone (Jaffe et al., 1970; Blackly et al., 1971) realized in the late 1960's that significant problems related to pharmacology of methadone existed. Methadone did not suppress the narcotic craving for a full 24 hours in many addicts. Very large doses of methadone were necessary to provide sustained relief of abstinence symptoms for 24 hours for these patients. These doses often produced unwanted sedation causing the patient to "nod" for the first several hours after consumption. Because of these kinds of inherent difficulties with methadone as a form of maintenance, L-Alpha-Acetyl-Methadol (LAAM, 1-methadyl-acetate) and its clinical usefulness was explored. Due to its high oral effectiveness, long duration of action and low toxicity, LAAM is now currently being used by over 68 treatment clinics throughout the United States.
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> Researchers (Jaffe et al., 1971, Blackly et al., 1972, Senay et al., 1974) found that LAAM offers the patient, clinician, and treatment program several advantages over methadone. Due to LAAM's long duration of action (72-96 hours), the frequency of visits to clinics can be reduced from daily to three times weekly even for pa-

[4] Approximately 2 years ago, there was a three state (New Jersey, New York and Connecticut) check made. Of the approximately 3,000 addicts registered in the New Jersey programs, about 16 had dual membership. These were attributed to record keeping errors (i.e., nonrecorded transfers from New York programs to New Jersey programs, etc.). That check did not in any way account for the use of aliases or false identification. In most cases, a valid driver's license is the only identification required.

tients entering treatment. Patients find participation more acceptable and return more regularly, especially those engaged in work, education, or rehabilitation activities outside of the clinic atmosphere since time and travel is greatly reduced.

Some investigations found that LAAM offers the patient a smoother sustained drug effect. The patient appears more alert and more emotionally level. Researchers also report that LAAM is less likely to be a reinforcer of daily drug taking behavior than is methadone. The three times weekly dosage schedule frees the patient from the daily necessity of engaging in drug-seeking and drug-taking behavior which is a very important therapeutic step forward.

As with every other form of chemotherapy, only longitudinal studies will be able to determine whether there will be any negative effects in the use of LAAM for the treatment of opiate addiction. One of the most important considerations prior to general accepted use of this substance must be a determination of its potential for abuse. Historically, opiate abusers have been notorious in inventing means by which chemicals used for treatment can be abused for their euphoric effect. Presently however, LAAM is one of the better possibilities for the future.

(2) Many researchers believe that the only effective "safe" means for dispensing methadone is to do so on an inpatient (or residential) basis. In many respects, the goals would be the same as those of a drug-free therapeutic program in that the addict would be accepted into a drug-free program while being maintained on methadone. Prior to discharge, however, the client would be completely detoxified. Theoretically, the patient would be exposed to the benefits of both modalities; a residential, therapeutic community and methadone maintenance.

In many instances, an opiate addict would be resistant to this type of program. Addicts traditionally resist entry into any residential program. There would have to be second party (courts, probation, significant others, etc.) persuasion! Benefits of this approach would, in all probability, accrue in that it would reduce the "split" (elopement) rate of residential programs, which has always been a concern.

Another possibility in utilizing this approach would be to compel all patients who wish to detoxify from opiate use or to be induced (built-up) in a methadone program to do so on an inpatient basis.

(3) The concept of temporary methadone support is gaining the interest and philosophical approval of many researchers in the field of maintenance. This method would make fixed, low-dose (30—50 mgs. per day), short-term maintenance available to ambulatory addicts who might not be interested in long-term maintenance, nor amenable for short-term detoxification. Slow withdrawal would be accomplished within 6 months or 1 year of intensive treatment. During this period, the patient would be exposed to therapeutic contact with medical, psychiatric, and social rehabilitation. Completion of the methadone maintenance period would not be open to negotiation, but would be fixed prior to the initiation of the treatment program. The maximum program length could not extend beyond 16 months.

Dr. Peter G. Bourne in his article entitled "Methadone: Benefits and Shortcomings" of May, 1976 states:

> It is clear the methadone maintenance used nationwide has failed to live up to the expectations generated by Dole and Nyswander's early experience, or to the inflated hopes created by the intense initial publicity, *Methadone is no Panacea!* However, its usefulness should not be judged against those original unfulfilled hopes, but rather against the realistic alternatives which the addict faces (the use of heroin) . . . .

There are presently approximately 60,000 to 80,000 persons in treatment throughout the country with an estimated heroin-addicted population of 600,000 to 750,000 persons. Mathematically, only 10 percent of the opiate-addicted population is being treated. Therefore, even if we assume that all methadone maintenance programs have failed (which they haven't) and all methadone clinics were to be closed (which they shouldn't) this would *not* significantly affect the status of almost *all* of the opiate addicts in the United States.

It is imperative that methadone clinics that are interested in treatment and rehabilitation, and *not self-perpetuation,* should voluntarily adopt a much more stringent selection process for methadone maintenance clients; a much more stringent regimen for those clients who are enrolled in their programs; a realistic set of rules, regulations and requirements for determining eligibility for a take-home privilege; a decisive procedure for dealing with major infractions with the rules and regulations of a methadone dispensing clinic; and better staff selection process.

For those individuals and agencies that are responsible for accountability of the methadone dispensed, there must be methods developed to prevent diversion through the use of computers to reduce the number of individuals enrolled in multiple programs; and swift action taken when illegality is uncovered.

And for those researchers who are involved through the private business sector or through governmental agencies, methadone is *not* a panacea, nor is heroin maintenance. There *must* be some manner of dealing initially with opiate addiction whether chemotherapeutically, psychotherapeutically or a combination of both, so that we can then deal with the addict psychologically, socially, economically, and morally.

We cannot sit idly by and watch methadone turn from a blessing to a curse. We must continue to utilize all modalities of treatment and rehabilitation until we arrive at a viable alternative. To suggest *negatively* that the solution to the problem is to completely eliminate methadone maintenance treatment programs without a *positive* alternative is indefensible.

I personally agree that the use of methadone for 60 percent of the clients so treated may merely be substituting one addiction for another. But these are exactly the same percentage of patients who fail in therapeutic communities.

The answer in both cases, is more effort and less complacency, and perhaps a combination of both forms of treatment. I know of no therapeutic drug community which is being fully utilized and has a waiting list. Our goal should not be to determine what will not work, but rather to determine what will work, and to make it work better.

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