REPORT TO SUBCOMMITTEE NO. 4 ... 16
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

Narcotic Addiction Treatment And Rehabilitation Programs In New York City

B-166217

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

APRIL 11, 1973

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-166217

The Honorable Don Edwards
Chairman, Subcommittee No. 4
Committee on the Judiciary
House of Representatives

Dear Mr. Chairman:

In accordance with your October 15, 1971, request, the General Accounting Office has obtained information on narcotic addiction treatment and rehabilitation programs in New York City. This is the last of five reports issued pursuant to your request. The other reports covered the cities of Washington, D.C.; Los Angeles and San Francisco, California; and Chicago, Illinois.

We discussed this report with the appropriate Federal, State, and city officials, but we did not obtain their formal written comments. Oral comments received have been considered in preparing this report.

We do not plan to distribute this report further unless you agree or publicly announce its contents.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

Contents

ABBREVIATIONS

ARTC	Addiction Research and Treatment Corporation
ASA	Addiction Services Agency
GAO	General Accounting Office
HSA	Health Services Administration
NACC	Narcotic Addiction Control Commission
NIMH	National Institute of Mental Health
NYPD	New York City Police Department

COMPTROLLER GENERAL'S
REPORT TO SUBCOMMITTEE NO. 4
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D I G E S T

WHY THE REVIEW WAS MADE

This is the last of five reports requested by the Chairman of the Subcommittee on programs for treatment and rehabilitation of narcotic addicts in Chicago, Illinois; Los Angeles and San Francisco, California; New York, New York; and Washington, D.C.

The General Accounting Office (GAO) was asked to determine for each of the five cities

--how much money Government agencies were spending on narcotic treatment and rehabilitation,

--goals of the different programs,

--methods of treatment,

--number of patients in treatment,

--services available,

--cost of the different treatment methods,

--criteria used to select patients,

--extent of assessments of program performance, and

--what was learned from these assessments.

The Subcommittee's concern is that adequate provision be made for program assessments so that the Congress and the executive agencies will have a basis for improving the programs.

FINDINGS AND CONCLUSIONS

New York City does not need to be told it has a serious narcotics problem. Numbers addicted, property stolen, and deaths from overdose attest to it. Estimates of the number of addicts range from 115,000 to 300,000. It is estimated that addicts steal about a half billion dollars worth of property annually. About 1,400 deaths during 1972 were narcotics related. (See pp. 8 and 9.)

New York City's approach to the problem is focused for the most part around its Addiction Services Agency (ASA). ASA is responsible for city-wide planning, management, evaluation, and innovation of treatment and rehabilitation projects. In January 1973 ASA identified 274 facilities in the city treating about 53,000 narcotic addicts--32,000 in methadone programs and 21,000 in drug-free programs. The city was funding or operating 220 of these facilities. (See pp. 10 and 11.)

The State's Narcotic Addiction Control Commission (NACC) has responsibilities extending over the entire field of narcotic addiction, including prevention of drug abuse

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and narcotic addiction, treatment and rehabilitation of addicts, and investigation into the causes and effects of drug abuse. As of June 1972 the State was providing treatment for about 9,600 addicts under its civil and criminal commitment program. (See pp. 12 to 14.)

There are many approaches to rehabilitating addicts and differences in programs in terms of objectives, methods of treatment, and cost. For example, methadone maintenance programs cost from $1,200 to about $1,800 a year for each addict. Drug-free residential programs cost about $3,700 to $7,700 a year for each patient. Methadone detoxification costs about $100 per patient on an outpatient basis. (See chs. 3 through 11.)

Some methadone maintenance programs had substantial waiting lists. (See pp. 22 and 26.)

Both the city and State have recognized the need to evaluate the performance of their drug programs. In its 1971 annual report ASA said development of a sound, uniform system of evaluation is one of its toughest problems and listed development of such a system as its highest priority. In January 1973 an ASA Deputy Commissioner advised GAO that an evaluation system had been developed. (See p. 15.)

NACC reported the need for a method to compare treatment programs to determine which programs are successful in treating and controlling

Program	Date started	Treatment method	Number of patients	Costs
Beth Israel Methadone Maintenance Treatment Program (see p. 21)	February 1965	Methadone maintenance	From February 1965 through March 1972, 8,650 patients were served. As of March 31, 1972, 5,800 were in treatment.	Program costs for fiscal years 1971 and 1972 combined were estimated to be about $15 million.
Health Services Administration Methadone Maintenance (see p. 25)	November 1970	Methadone maintenance	As of June 30, 1972, 6,000 were in treatment.	Funds available for fiscal years 1972 amounted to $13.9 million.
Health Services Administration Ambulatory Detoxification (see p. 29)	July 1971	Outpatient detoxification by using methadone in decreasing doses over about 1 week.	From July 1971 through June 22, 1972, 11,611 were served, of which 1,956 were readmissions.	From July 1971 to September 1972 funding available totaled $2.1 million.
City Prison Detoxification (see p. 35)	1965	Male prisoners are detoxified in their cell blocks with aid of methadone immediately after entering the penal institution. Female prisoners are detoxified in a clinical setting.	Between March 22, 1971, and December 11, 1972, 45,147 male addicts were detoxified. An average of 800 male inmates are undergoing detoxification at any one time. From 1965 through December 1972, 22,029 women were detoxified.	About $1,261,000 in grant funds were available for a 2-year period.

narcotic addiction. In January 1973 the Director, Bureau of Management Information Systems for NACC, advised GAO that NACC's system had improved. He added, however, that it still has not reached the stage where rehabilitation programs can be compared to show which programs are more successful in treating addicts. A similar situation exists for programs financed by ASA. Also, neither system provides for the compilation of cost data for program evaluation purposes.

The city and State have taken action to expand their evaluation efforts. (See p. 15.) GAO agrees that their program evaluations need to be expanded considering that:

--The estimated number of addicts in the city far exceeds the number in treatment indicating a need to provide additional services.

--Each treatment approach probably provides some benefits but the variety of approaches have differences in performance criteria, types of services offered, and cost per patient.

To provide an overview of programs in New York City, GAO obtained information on several programs funded by Federal, State, and local government agencies and private sources. Information on the programs, discussed in detail in the report, is summarized in the following table.

Evaluation criteria	Pertinent results
Freedom from narcotic "hunger" as measured by urinalyses. Decrease in antisocial behavior as measured by arrests and incarcerations. Increase in social productivity as measured by homemaking, employment, schooling, and vocational training.	Columbia University evaluations showed that, although many patients use heroin during first few months of treatment, fewer than 1 percent return to regular heroin use while under methadone maintenance treatment. The first 1,000 patients in treatment accumulated 2,314 arrests and incarcerations during 4 years prior to admission to the program. During the 4 years after admission, the group had only 180 such events, a 92-percent decrease in antisocial behavior. Sixty percent of the group remained in treatment after 4 years. The employment rate for the first 1,000 males was 26 percent at admission. After 2 years this rose to 67 percent. Those remaining in treatment totaled 673. A later study also showed an increase in the social productivity for those patients remaining in treatment.
Admissions (the program's position is that success can be measured by the number of people who voluntarily apply for treatment). Rate of retention over time. Patient functioning while in treatment. (Arrests, employment, education, dependence on public assistance, and opinions of the staff.)	As of December 31, 1971: --Of the 3,802 patients admitted during 1971, 3,270, or 86 percent, remained in treatment. --Of the 118 patients admitted during 1970, 90, or 76 percent, remained in treatment. Of the first 500 persons admitted to treatment 22 percent were employed or homemakers. Of the 350 remaining for 1 year, 175, or 50 percent, were employed or homemakers.
Patients admitted to treatment. Patients completing treatment. Progress of patients after leaving treatment.	An evaluation of the program by the Center for Social Research of the City University of New York showed that: --Almost half of the patients treated had not received treatment before. --Treatment costs averaged $60 for each patient who began treatment and about $100 for each patient who completed treatment. --Use of heroin by patients dropped while undergoing detoxification and during subsequent followup periods. --Data collected on a followup study of patients does not conclusively demonstrate the program's effect upon addict criminal behavior but does suggest that addicts who reduce their heroin use also reduce their criminal activity.
Objectives are to get an addict through withdrawal with a minimum of suffering. Program officials believe that the suffering which accompanies withdrawal has resulted in attempted and actual suicides.	No suicides or attempted suicides occurred among detoxified addicts between March 1971 and February 16, 1973.

Tear Sheet

Program	Date started	Treatment method	Number of patients	Costs
Addiction Research and Treatment Corporation (see p. 38)	October 1969	Methadone maintenance without attempting withdrawal. Methadone maintenance followed by withdrawal at a gradual rate in the second year of treatment. Ambulatory methadone detoxification over several months.	October 1969 through June 1972--1,800 persons treated. As of June 30, 1972, 1,375 in treatment.	From November 1, 1971, to October 31, 1972--about $3.3 million was spent.
Phoenix House (see p. 43)	May 1967	Residential drug-free therapeutic community.	May 1967 through May 1972, 4,677 addicts were served. May 1972 population was 1,158 residents.	Fiscal year 1972 costs were $5.6 million.
Daytop Village (see p. 47)	Began in 1963 as demonstration project. Incorporated in 1965 under present name.	Drug-free, self-help, therapeutic community. Ambulatory (nonresidential) treatment program.	Between January 1969 and December 1972, 1,880 individuals entered the residential facilities. Between January 1970 and December 1972, 1,669 individuals entered the ambulatory units. As of December 31, 1972, 459 were in residential treatment and 94 were in ambulatory program.	Received about $2.3 million for 1972 operations
Horizon (see p. 51)	May 1969	Therapeutic residential community. Ambulatory treatment. Community education and relations program. Yoga program.	From May 1969 to December 1972, 3,131 persons were served. As of December 31, 1972, 230 were in treatment.	Available funds for the year ending April 30, 1973, totaled $2.5 million.
Odyssey House (see p. 54)	January 1966	Psychiatrically oriented therapeutic community. Outpatient induction and posttreatment reentry programs.	During 1972 about 426 inpatients were served--average daily census was 320. From May 1967 to December 1972, about 15,000 outpatients and 4,235 inpatients were served.	For the 6 months ended June 30, 1972, available funds totaled about $760,000.
New York State Addict Commitment Program (see pp. 12 and 58)	April 1967	State civil and criminal commitment program. Institutional and ambulatory treatment combining drug-free therapy and methadone maintenance.	As of June 30, 1972, 2,155 were in residential facilities and 7,494 were in aftercare.	For the fiscal year beginning April 1, 1972, about $48 million was appropriated for the commitment program.

Evaluation criteria	Pertinent results
Abstinence from use of drugs other than methadone. Employment, schooling, and homemaking. Stable family life. Social adjustment in the community. Decline in criminal behavior.	A May 1972 report by Columbia University covering 428 patients concluded that: --Patients over age 35 at time of admission are most likely to remain in treatment. --Early addiction and a low degree of participation in conventional social activities were strong indications of those most likely to drop out of treatment. --Because of an increasingly younger addict population, programs will have increasing difficulties retaining patients.
Full rehabilitation and socialization of the addict which includes being drug free and employed or in school.	A February 1972 research paper indicated: --About 70 percent of Phoenix residents did not complete the program. --Only 40 percent remained more than 12 months. --About half of 254 dropouts studied had been arrested during the year before entering the program. After leaving the program the arrest rate dropped to about one-third. As of March 1972: --150 former residents had received high school equivalency diplomas and 250 residents were working toward high school diplomas. --261 persons had graduated from the program and were drug free for 24 months and employed or in training.
Abstinent from drugs. Employed or in school.	A Daytop study showed that, of 454 people entering the residential program in 1971, 234 dropped out and 5 were expelled. A December 1971 study of persons out of the program at least 6 months showed that: --Of 66 graduates interviewed, 61 had not returned to drug use. --Of 24 dropouts interviewed, 12 had not returned to drug use. --None of the graduates had been arrested. --Four dropouts had been arrested. --Of the graduates, 55 were employed. --One-fourth of the graduates and dropouts were going to school.
No formal criteria to measure program performance. A person is considered a success if he is going to school or working and is not on drugs.	Through 1972 104 people finished the program.
Patients meeting the following criteria are considered successes: --completion of the inpatient phase which averages 14 months, --drug-free over this time based upon daily urine testing, --having at least 6 months in reentry living and working outside the program while being drug free.	For a 4-year period about 45 percent of 2,500 new admissions left against medical advice or were expelled within a week after entering due to poor motivation. Of the initial 41 graduates, 39, or 96 percent, were found to be leading drug-free lives. Of those who dropped out of the program, about 50 percent became readdicted, 20 percent remained drug free, and 30 percent could not be located.
Treatment program is considered successful if it can accomplish any of the following: --restore the addict to his maximum level of functioning in society, --reduce the threat of danger that each addict represents, --relieve the pressures and disabilities that contribute to addiction, --prolong the addict's period of abstinence.	A February 1971 study by the Criminal Justice Coordinating Council indicated that about 44 percent of those entering aftercare were continuing successfully in this phase of treatment. The remainder had absconded or returned to drug use. However, of 526 persons discharged from the program between April and September 1970, only 97, or 18 percent, completed treatment through the aftercare phase without absconding or relapsing to drug use at least once.

CHAPTER 1

INTRODUCTION

The Chairman of Subcommittee No. 4 of the House Committee on the Judiciary asked us to obtain data on programs concerned with the treatment and rehabilitation of narcotic[1] addicts. The Chairman asked for information on programs receiving Federal, State, or local funds in Chicago, Los Angeles, San Francisco, New York, and Washington, D.C., and that separate reports be prepared for each city.

For each city we were asked to obtain information on the amount of money being spent by governmental agencies on narcotic treatment and rehabilitation, program goals, methods of treatment, number of patients in treatment, services available, costs of different treatment methods, criteria used to select patients, extent of assessments of program performance, and what was learned from assessments. The Subcommittee's interest was that, in developing legislation concerned with programs for treating and rehabilitating narcotic addicts, adequate provision be made for program assessment efforts so that the Congress and executive agencies would have a basis for improving the programs.

This report, the last of the series, concerns narcotic addiction treatment and rehabilitation in New York City. It is a compilation of data supplied by city and State officials and by officials of the various programs we contacted during our review. We did not verify the accuracy or reliability of the data.

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[1]Throughout this report the term "narcotic" refers to drugs which are derived from opium, such as heroin, morphine, and codeine.

CHAPTER 2

NARCOTIC ADDICTION PROBLEMS AND REHABILITATION PROGRAMS IN NEW YORK CITY

HOW SERIOUS IS NEW YORK CITY'S NARCOTIC ADDICTION PROBLEM?

The city does not need to be told it has a serious narcotic problem. The estimated number of persons addicted, property stolen, and deaths due to overdoses attest to it.

In its study, "An Assessment of Drug Use in the General Population," the State's Narcotic Addiction Control Commission (NACC) in 1971 established the dimensions of drug use in New York State. NACC's estimate for New York City was 38,000 addicts. But since it believed, because of assessment methods used, that only one-third of the regular heroin users had been identified, NACC increased its estimate to 115,000 addicts.

On the other hand the city's Addiction Services Agency (ASA) estimated in January 1972 that there were about 150,000 narcotic addicts in the city based on the Narcotics Register. The Narcotics Register, a list of all known narcotic addicts in the city, is compiled from records of the New York City Police Department (NYPD), treatment facilities, private physicians, and other organizations which deal with addicts.

The Bureau of Narcotics and Dangerous Drugs, Department of Justice, estimated that the city's narcotic addict population amounted to about 300,000 as of December 31, 1971.

Number of deaths due to narcotics

The city's Medical Examiner reported that 1,414 deaths in the city were attributed to narcotics use during 1972. Of these, 927 were due to narcotism, a term that refers mainly to deaths caused by heroin overdoses (but also overdoses from morphine, methadone, and codeine) and deaths from diseases, such as hepatitis, in cases that are directly related to narcotics abuse. Another 487 deaths were attributed to narcotic-related accidents, suicides, homicides,

and other diseases. Of 1,259 deaths in 1971, 888 were due to narcotism and 342 were narcotics related. No classification was given to 29 deaths.

Number of arrests on narcotics charges

NYPD reports as narcotics arrests those involving charges for possession of dangerous drugs; possession of hypodermic syringe and needle; and intent to sell, or sale of, dangerous drugs. NYPD reported 41,266 narcotics arrests during 1971. In 1972 arrests decreased to 25,157[1]. These figures include juvenile offenders under 16.

Damage caused by addicts

Data on the damage caused by addicts is scarce. NYPD reported that it does not have a feasible way to gather such data.

A study published in July 1970 by the Hudson Institute, a policy research organization under contract to the State of New York, stated that addicts steal over $500 million worth of property each year in the city. Burglary and shoplifting were the prime types of thefts.

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[1]An NYPD official informed us that the reduction of narcotics arrests in 1972 was due to a shift in law enforcement emphasis from drug users to dealers. Drug users are more numerous and more vulnerable to arrest than dealers.

WHAT IS BEING DONE TO HELP THE ADDICTS?

The city's effort

The city's effort has centered around ASA which is responsible for citywide planning, management, and evaluation of drug treatment and rehabilitation programs. ASA's stated goal is to reduce the number of drug abusers in the city. In January 1973 ASA identified 274 facilities in the city which were treating about 53,000 narcotic addicts. The city was funding or operating 220 of them. Others are federally, State, and/or privately supported.

Treatment modalities or methods

Methadone

Methadone, a synthetic narcotic, is used to treat and rehabilitate narcotic addicts through either detoxification or maintenance.

Detoxification, the gradual withdrawal from narcotic addiction, is done either in an inpatient or outpatient setting. In both cases detoxification is brought about by decreasing methadone dosages until all dependence on drugs has ceased. Medication is used to minimize withdrawal pains and is administered only as long as it is needed to detoxify.

Under the methadone maintenance treatment approach, the addict is given a daily oral dose of methadone to block the need for narcotics. Methadone maintenance treatment should help an addict (1) function in a more socially acceptable manner, (2) decrease his criminal activity, and (3) increase his employment potential. Also it should enhance an addict's acceptance of accompanying psychotherapeutic or counseling services. In November 1971 the Mayor of New York City stated that methadone maintenance is a proven form of treatment and announced that the city was committed to insure that every addict seeking such treatment would be able to enter a program. As of January 1973 methadone treatment (maintenance or detoxification) was being provided to about 32,000 addicts in the city.

Drug free

Successful completion of this treatment requires the addict to become entirely free of dependence on drugs. Treatment is given in either an inpatient or outpatient setting.

Inpatient treatment follows a structured program designed to change addict behavior. Treatment includes discipline, group encounters, and a rigidly tiered system of progressive levels of job responsibility during an average residential stay of 12 to 18 months. A variation from this approach includes a shorter residential stay coupled with educational and job training programs.

Outpatient treatment is delivered through:

--Ambulatory therapeutic communities. These are very similar to the inpatient program except that addicts are not residents but attend the program 5 days a week from 10 to 12 hours each day. The average length of treatment is 8 months to 1 year. If treatment is successful, time in the program is reduced.

--Youth center programs. These are for the younger addicts who have not been using drugs for a long time. Counseling, education, and recreational programs are employed to develop discipline and skills required for school or job success. Clinical support is frequently given through encounters and group counseling.

--Crisis intervention and counseling programs. These are somewhat informal approaches to help addicts resolve practical problems in such matters as housing and jobs. It also offers clinical support, such as group counseling and encounter sessions.

As of January 1973 treatment was being provided to about 21,000 addicts in the city.

ASA estimated that, for the year ending June 30, 1973, money committed to drug programs in the city, exclusive of the State's commitment program, was about $120.2 million.

Source of funds	Total	City-administered	Other
	(millions)		
City	$ 21.8	$19.6	$ 2.2
State	66.3	48.7	17.6
Federal:			
Office of Economic Opportunity	4.7	4.7	-
National Institute of Mental Health	12.4	1.5	10.9
Law Enforcement Assistance Administration	2.0	2.0	-
Office of Education	0.8	0.8	-
Model Cities	3.6	3.4	0.2
Medicaid (note a)	8.6	3.6	5.0
Total	$120.2	$84.3	$35.9

[a]Medicaid is a cooperative Federal, State, and city program which pays for medical services provided to persons unable to pay their medical bills.

The above amounts are applicable to treatment and rehabilitation; research, education, and prevention efforts; and program management and planning.

The State's effort

New York State began addressing its narcotic addiction problem in 1952. In 1966 its activity was expanded with the establishment of NACC and a civil and criminal commitment program for the treatment and rehabilitation of narcotic addicts. The commitment program began in April 1967 and is a comprehensive rehabilitation effort combining drug-free therapy and methadone maintenance in residential and outpatient settings.

NACC has responsibility extending over the entire field of narcotic addiction, including the prevention of drug abuse and narcotic addiction, treatment and rehabilitation of addicts, and the investigation into the causes and effects of drug abuse. NACC also provides guidance and fiscal assistance to counties and municipalities under the State's Youthful Drug Abuser Act of 1970.

NACC supports several approaches for the treatment and rehabilitation of addicts including methadone maintenance and exaddict and professionally led drug-free communities. Through experience NACC is convinced that an approach tailored to the needs of each addict, rather than a single-treatment approach, is the only rational way to proceed.

NACC has stated that (1) all narcotic addicts cannot be treated uniformly, (2) many may not need prior institutionalization, and (3) it may be counterproductive to remove addicts from the community for treatment if they have such things going for them as a job or family ties. Consequently, under NACC programs the length of residential stays has been reduced, methadone maintenance has been expanded, and treatment in community facilities has been provided.

NACC was operating 18 rehabilitation centers, primarily in the greater New York City area, in its commitment program. For the fiscal year beginning April 1, 1972, about $48 million was appropriated for these facilities. As of June 30, 1972, about 9,200 narcotic addicts were receiving treatment at these facilities. Another 400 were being treated in facilities not run by NACC.

Within the New York City area NACC also provided about $54 million for a year's operation of 101 youth drug abuse programs, 9 methadone maintenance programs, 13 demonstration grant programs, 10 narcotic guidance council programs, and 3 research programs. Youth drug abuse programs are designed to provide treatment, education, and prevention services primarily to adolescents aged 16 and under. Services include residential treatment centers, day-care facilities, counseling clinics, vocational training, and crisis centers. Demonstration grant programs are voluntary programs, which offer residential, day-care, and community-based services including counseling, education, vocational rehabilitation, and recreation. Narcotic guidance councils are administrative bodies which attempt to encourage local citizens to serve on five subcommittees--school education programs, adult education programs, counseling youth activities, and publicity.

NACC was also funding three major programs offering services on a citywide basis:

--ASA Adolescent Treatment Centers. This is a network of 23 centers administered directly by ASA and funded for 1 year at about $2.4 million which provide counseling and recreational and vocational guidance to persons who have used drugs for only a short time.

--Central Board of Education Programs. This provides education and prevention services in 93 high schools, including 16 specialized intervention and rehabilitation centers which attempt to influence and motivate potential drug users not to begin the use of drugs. Funding for 1 year is about $4.7 million.

--Hart Island Residential Treatment Center. This drug-free, comprehensive, intensive, residential treatment program is for both legally committed and voluntary addicts and is divided into three phases--induction, treatment, and reentry into the community. Funding for 1 year of this program is $1.7 million.

DATA GATHERING AND EVALUATION

Both the city and State have recognized the need to evaluate the performance of drug programs. In its 1971 annual report, ASA stated that the development of a sound, uniform system of evaluation is one of its toughest problems and listed the development of such a system as its highest priority. In February 1972 the Chairman of NACC informed the National Commission on Marijuana and Drug Abuse that further research and rigorous comprehensive evaluations of the various programs now underway are needed to gain additional knowledge for the placement of an addict into the type of treatment program where the predictability of his successful rehabilitation will be the greatest. He indicated that some progress has been made in this area, but research efforts are continuing and evaluations of existing programs are underway.

In January 1973 an ASA Deputy Commissioner advised us that an evaluation system had been developed. Steps being taken by both the city and State to expand their evaluation efforts are discussed below.

The city's efforts

Prior to March 1971 ASA had no one responsible for program evaluation. In March 1971 ASA designated a Deputy Commissioner for planning, evaluation, and innovation. In July 1971 a director for evaluation was hired, and, as of December 31, 1971, the evaluation staff consisted of seven persons.

ASA evaluations are process and outcome oriented. Process evaluations are descriptions (profiles) of program operations. Outcome evaluations are concerned with relative effectiveness. Measurement indexes used in the latter include arrest and employment data.

The State's efforts

NACC has stated that a treatment program is successful if any of the following can be accomplished.

--The addict is restored to his maximum level of functioning in society.

--The threat of danger that each addict represents is reduced.

--The pressures and disabilities that contribute to addiction are relieved.

--The addict's periods of abstinence are prolonged.

NACC does not believe that abstinence should be the main goal of all programs. It believes that, while abstinence may be the eventual goal, it may not be attainable within any predictable timetable for many addicts.

The Legislative Commission on Expenditure Review stated in an April 7, 1971, audit report on Narcotic Drug Control in New York State that:

> The principal problem encountered in trying to evaluate both the private agencies and the facilities operated or funded by NACC is the singular lack of hard data except for the Beth Israel methadone program. Most of the programs have been able to generate some basic demographic statistics which are highly descriptive but are not evaluative in nature.
>
> The statistics from private agencies are probably less reliable and more subject to question than those generated by NACC. However, even NACC follow-up data have been limited. NACC directors do not know how their programs compare to other facilities, or whether individuals who participated in their programs are still abstaining from drug use or have become re-addicted to narcotics.
>
> In most cases, the private agencies have not had either the resources or the inclination to gather even the most basic evaluative data. Instead, they have relied on their service orientation to justify their operations. The statistics that have been issued are often highly colored and in many cases cannot be verified.
>
> Private and public agencies have not done the kinds of follow-up studies that are necessary for program evaluation. The private agencies, even those funded on a long-term demonstration basis, with exception of the Beth Israel methadone program

have not been evaluated on any sort of rational basis by NACC, but have been allowed to increase the size of their programs. Therefore, at the present time, there is no way in which treatment programs can be compared in any meaningful attempt to determine which, if any, are more successful in the treatment and control of narcotics addiction.

More attention should be directed to acquiring follow-up information about all known addicts over a given period of time. This information has been restricted for the most part to these persons who have been discharged from programs as drug-free. It must be expanded to include those who have absconded and are now dismissed as simply 'lost-to-contact,' or who have left treatment programs for other reasons. Records of these 'missing' addicts are essential to the orderly analysis and development of an overall State treatment program.

To assess its commitment program, NACC devised a data collection system that it believes will produce more than typical demographic output. The system has the following four interrelated components: (1) personal history obtained at intake, (2) the intramural, involvement, adjustment history which deals with an addict's stay in the facility, (3) the aftercare adjustment history which deals with an addict's activities after he leaves the residential facility but is still in the commitment program, and (4) the followup history of his subsequent activities and social status. NACC believes these four components will permit it to describe its program participants, the treatment and rehabilitation methods used, and the results of its efforts in considerable detail.

NACC has also devised a data collection system for other programs which it has supported financially. (See p. 13). The system provides standard demographic data (age, sex, race, etc.), and provides in some depth drug and treatment history and criminal involvement. When a patient leaves or completes the program, the treatment agency prepares a form showing the various types and extent of services provided. NACC believes that these two data inputs provide a basis for the statistical evaluation of program performance.

At the time of our fieldwork, the products of these systems had not been outcome oriented. They had been basically demographic as best evidenced by NACC's annual statistical reports which contain numerous tables, graphs, and charts showing such information as the number of persons in treatment, race, age, and educational levels. NACC believes that the system design changes implemented during the past year will allow for more outcome-oriented statistical and narrative descriptions, such as patient behavior changes indicated by reduction in crime, reduction or elimination of drug use, and a reestablishment of family relationships.

Program evaluations are also being performed for NACC under contracts. Since October 1965 the Columbia University School of Public Health and Administrative Medicine has been following the work of the major methadone maintenance programs in New York City. (See chs. 3 and 4.)

In January 1973 the Director, Bureau of Management Information Systems for NACC, advised us that, even though NACC's management information system has become greatly improved, it has not reached the stage where rehabilitation programs can be compared to show which programs are more successful in treating addicts. A similar situation exists for the programs financed by ASA. Also, neither system provides for the compilation of cost data for program evaluation purposes.

We agree with the city and State that their program evaluations need to be expanded considering that:

--The estimated number of addicts in the city far exceeds the number in treatment indicating a need to provide additional services.

--Each treatment approach probably provides some benefits but the variety of approaches brings with it differences in performance criteria, types of services offered, and cost per patient.

COORDINATION BETWEEN THE CRIMINAL JUSTICE SYSTEM AND THE ADDICT REHABILITATION PROGRAMS

In 1966 the State passed a law to provide for the identification of narcotic addicts in the criminal process and their commitment to NACC for rehabilitation. (See ch. 12.) This appeared to be a natural link between the criminal justice system and the treatment of addicts. The arresting officer became the focal point in identifying the addicts.

Two things happened which broke this link. According to a Bronx County District Attorney, the police stopped filing commitment forms for addicts because of NACC complaints that it did not have sufficient facilities to accept all addicts recommended for commitment and NACC delays in processing commitment recommendations which made proving narcotic addiction more difficult. Secondly, for budgetary reasons, NACC stopped accepting criminal commitments in April 1971. According to ASA the effect of the curtailment was a sharp increase of addicts in the city's jails. On June 12, 1972, NACC resumed the intake of criminal commitments.

In January 1972 ASA began a project in the Brooklyn court system designed to divert addicts arrested for misdemeanors and certain felonies into nonprison treatment programs. The project provides addict-inmates the opportunity to receive outside treatment. If ASA believes the addict is motivated and if he is accepted into a treatment program, ASA will try to persuade the court to release the addict to the treatment program. The Criminal Justice Coordinating Council of the Office of the Mayor believes that, in the absence of a systematic means of linking the criminal justice system to treatment, this project can possibly serve as a model.

Further, the Council stated in the City's Criminal Justice Plan for 1971 that there was an enormous need for coordination between the criminal justice system and narcotic treatment and rehabilitation programs.

A diversion project begun at the Manhattan House of Detention with the consent of the Department of Correction on November 1, 1971, is similar to ASA's court project.

Here, emphasis has been on placing detoxified addicts in methadone maintenance programs after release. In both projects success in treatment may mean dismissal of the criminal charge.

Other attempts at diverting addicts from the criminal justice system to treatment are made by some of the voluntary treatment organizations such as Daytop Village. (See ch. 9.)

To furnish the information requested by the Chairman of the Subcommittee, we contacted the following:

--Public and private methadone maintenance programs.

--City-operated detoxification programs.

--Experimental outpatient program for methadone treatment.

--Drug-free therapeutic communities.

--State addict commitment program.

We obtained information on selected programs of the types identified above to provide an overview of the different programs operating in the city. The selected programs involve different treatment modalities and financing sources.

CHAPTER 3

BETH ISRAEL METHADONE MAINTENANCE

The Methadone Maintenance Treatment Program of Beth Israel Medical Center, a private institution, was started in February 1965 to rehabilitate confirmed addicts.

THE PROGRAM, ITS MODALITY, AND ITS GOAL

The program is specifically for the addict who has been using heroin for at least 2 years. It combines methadone maintenance with supporting vocational, psychiatric, social, and legal services. The program justifies drug maintenance on the basis that it enables the patient to become a normal functioning member of society--its ultimate goal. The treatment program has three phases.

Phase I usually lasts 6 weeks and is accomplished either in an outpatient or an inpatient setting, but predominantly on an outpatient basis. After a thorough physical examination, the patient is started on methadone. During phase I the methadone dosage is brought up to maintenance level--an amount sufficient to block the euphoric effects and to remove the craving for heroin. The patient visits the clinic every day, takes his methadone in the presence of a nurse, and leaves a urine specimen to be tested for evidence of narcotics, amphetamines, quinine, barbiturates, or methadone.

Phase II is accomplished on an outpatient basis with intensive services and lasts at least 9 months. These services include vocational guidance, legal services, and counseling on personal problems. The patient at first attends the clinic on weekdays only. Gradually, the frequency of visits is reduced to three times each week, then twice, and finally once.

Phase III, which essentially involves dispensing methadone, begins after the staff is convinced of the patient's progress--namely, that he had no alcohol or drug problem, attended school, worked, or managed a household for 1 year. Visits are weekly. Also, there is little need for counseling because of the patient's improvement. The patient continues to use methadone indefinitely.

Because of its limited capacity,[1] the program established a holding project in June 1970 which provides methadone maintenance treatment to patients but does not provide any supporting services.

HOW A PROGRAM PARTICIPANT IS SELECTED

Admission to the program is voluntary. Applicants are interviewed by program staff to determine eligibility. Control checks are made through the Methadone Data Office at Rockefeller University--a central registry of methadone maintenance patients in the city--to determine whether applicants are already enrolled in another program affiliated with the data office. To be admitted applicants must be at least 18 years old, be residents of the city, have been mainlining (intravenous injection) heroin a minimum of 2 years, and be addicted only to opiates. Other addicted household members must also apply, and the applicant must meet established intelligence standards. Ineligible applicants are referred to other programs.

HOW MANY PEOPLE DOES THE PROGRAM SERVE AND IS THERE A WAITING LIST?

Since its inception in February 1965 through the end of March 1972, the program had served about 8,650 patients. As of March 31, 1972, it was serving about 5,800 patients, 94 of whom were in the holding unit. As of March 31, 1972, about 3,000 persons were on the waiting list, of which 300 had already been interviewed for phase I.

WHAT DOES THE PROGRAM COST AND WHO SUPPLIES THE MONEY?

The program will cost almost $15 million for fiscal years 1971 and 1972. In fiscal year 1971 the program received $6 million from NACC and $600,000 from Medicaid. For fiscal year 1972 NACC provided $7 million and Medicaid reimbursed the program about $100,000 a month. The program administrator informed us that the annual program cost is about $1,800 per patient.

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[1]Program capacity is determined by the number of clinics in operation and the staff-to-patient ratio. The program tries to limit the size of phase II clinics to 150 patients.

HOW IS PROGRAM PERFORMANCE MEASURED AND WHAT DO THE LATEST RESULTS SHOW?

Since the program's inception Columbia University's School of Public Health and Administrative Medicine under a NACC contract has independently evaluated all patients entering the program. Columbia has adopted the following success criteria for the treatment and rehabilitation of narcotic addicts.

--Freedom from narcotic "hunger" as measured by repeated, periodic "clean" (i.e., no illicit drug use) urine specimens.

--Decrease in antisocial behavior as measured by arrest and/or incarceration.

--Increase in social productivity as measured by homemaking, employment, and/or schooling or vocational training.

Selected information from Columbia's reports follows.

--Although many of the patients test the methadone blockade of heroin by using heroin one or more times during the first few months, less than one percent have returned to regular heroin use while under methadone maintenance treatment. (Reported in November 1970.)

--The first 1,000 patients in treatment had accumulated 2,314 arrests and incarcerations during the 4 years before admission to the program. During the 4 years following admission, the group, 60 percent of whom were still in the program, had only 180 such events, a decrease of 92 percent in antisocial behavior. Columbia assumed that there could be a reasonable degree of underreporting of arrests among patients but nevertheless believed that the marked decrease in antisocial behavior as measured by recorded arrests and incarcerations was impressive. (Reported March 31, 1971.)

--A study of 466 women who, as of March 31, 1970, had been in treatment from 3 months up to 3 years, showed that about 8 percent were employed upon entrance into the

program. Of the 466 women, 109 had been in the program for 2 years; at least 35 percent of these were employed.

--The employment rate for the first 1,000 male patients was 26 percent at the time of entrance into the program. After 2 years the employment rate for 673 patients still in treatment was 67 percent.

In November 1970 Columbia concluded that program successes far outweighed the failures--most of the patients had completed their schooling, increased their skills, or become self-supporting. In a progress report for the 5-year period ended March 31, 1971, Columbia reported that the results of the program continued to demonstrate that it had been successful in rehabilitation of most of the patients treated.

In a followup study of the first 1,230 patients[1] admitted between January 1964 and December 1968, over 90 percent of whom were from Beth Israel or Harlem Hospital, Columbia, reported (data applies through March 31, 1972):

--810 patients, or 66 percent, were still in treatment while 420, or 34 percent, left the program (356 alive, 64 died while in the program).

--92 percent, or 309 out of 334 of those classified as socially productive (employed, in training, or a homemaker) on admission, remained in that category.

--75 percent, or 355 out of 476 of those classified as unemployed upon admission, became socially productive.

--Of the 356 patients who left the program (1) 144, or 41 percent, were arrested or imprisoned at least once, (2) 95, or 27 percent, had been hospitalized for detoxification 1 or more times, (3) 54, or 15 percent, were participating in abstinence programs, (4) 15, or 4 percent, were known to be dead, (5) 10, or 3 percent, were under treatment by private physicians, (6) 8, or 2 percent, left the area, and (7) 30, or 8 percent, no information.

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[1]Included in the study were patients in an experimental program which preceded the Beth Israel program.

CHAPTER 4

HEALTH SERVICES ADMINISTRATION

METHADONE MAINTENANCE

The New York City Health Services Administration (HSA) Methadone Maintenance Treatment Program (HSA-Methadone) is a voluntary outpatient program using a combination of methadone maintenance and supportive medical and social services to help the addict achieve a productive role in society.

THE PROGRAM, ITS MODALITY, AND ITS GOAL

Since its inception in November 1970, the HSA-Methadone has been administering methadone using a technique which gradually brings patients to maintenance level under medical supervision. The program offers medical and psychiatric services, social and vocational counseling, and uses urinalysis to detect the use of illicit drugs. In cooperation with the city's Department of Probation, the program also treats probationers who voluntarily seek methadone maintenance.

The program has general, pharmacological/medical, and social objectives. Its general objective is to provide prompt methadone maintenance treatment to all eligible addicts who request it. The pharmacological/medical objective is to eliminate heroin hunger, establish a narcotic blockade, and provide comprehensive medical services. The social objective is to provide the assistance needed to help the patient function normally and achieve a productive role in society.

As of June 30, 1972, the program had 37 facilities operating throughout the city. Most units are operated under contracts with hospitals. The HSA-Methadone staff includes doctors, nurses, counselors, research assistants, and secretaries.

HOW A PROGRAM PARTICIPANT IS SELECTED

To be eligible the addict must live in New York City, must have mainlined heroin for at least 2 years, and must be at least 18 years old. Applicants with a primary addiction to drugs other than narcotics are not accepted. Applications are screened for compliance with eligibility requirements. Eligible addicts are interviewed at intake by a counselor and receive a medical examination prior to admission.

HOW MANY PEOPLE DOES THE PROGRAM SERVE AND IS THERE A WAITING LIST?

Through December 24, 1971, 4,379 patients had been admitted with 3,762 still in treatment. By that time program capacity had reached 5,300. The unused capacity was due to an increase in patient capacity of approximately 1,000 in late 1971 and to the normal phasing-in operations of clinics already opened.

By June 30, 1972, the program had 6,000 patients in treatment in 37 units. The waiting list was 7,500. According to HSA, limited patient capacity results in applicants' waiting 4 months before being admitted to a treatment unit.

WHAT DOES THE PROGRAM COST AND WHO SUPPLIES THE MONEY?

Funds available for fiscal year 1972 amounted to $13.9 million as follows:

Source of funds	Amount (millions)
NACC	$ 4.2
Law Enforcement Assistance Administration	.6
New York City	5.0
Medicaid	4.1
Total	$13.9

As of July 1, 1972, the programwide average cost per patient a year as determined by program officials was $1,200.

HOW IS PROGRAM PERFORMANCE MEASURED AND WHAT DO THE LATEST RESULTS SHOW?

HSA-Methadone is one of the programs which Columbia University, acting under contract with NACC, evaluates. Success criteria, listed below, were established by the program and Columbia University's School of Public Health and Administrative Medicine. They include

--admissions (the program's position is that success can be measured by the number of people who voluntarily apply for its treatment),

--rate of retention over time, and

--patient functioning while in treatment. (Includes arrest rates, employment rates, educational efforts, dependence on public assistance, and opinions of the unit staff.)

Admission and termination data are maintained and each treatment unit compiles a status report each month for patients in treatment. Finally, urinalysis results are reported for each patient.

In May of 1972 Columbia reported to NACC that as of December 31, 1971:

--Of the 3,802 patients admitted during 1971, 86 percent, or 3,270, remained in treatment.

--Of the 118 patients admitted during 1970, 76 percent, or 90, remained in treatment.

Columbia also said in the same report that, upon entry of the first 500 patients to the program, 22 percent were employed or homemakers. Of the 350 who remained for 1 year, 50 percent, or 175, were employed or homemakers.

A profile of 202 patients entering and leaving treatment in 1971 from HSA-Methadone and another methadone maintenance program in Westchester County, New York, showed that

--58 percent left voluntarily,

--20 percent were discharged for reasons of behavior which include continued abuse of alcohol or other drugs,

--3 percent died,

--4 percent moved out of the greater New York City area,

--2 percent were transferred to other treatment facilities because of medical or psychiatric problems, and

--13 percent were arrested and incarcerated.

CHAPTER 5

HEALTH SERVICES ADMINISTRATION

AMBULATORY DETOXIFICATION

New York City, through HSA, offers detoxification services using methadone to narcotic addicts in an outpatient setting. This program was designed to provide addicts with immediate relief from the physical discomfort associated with withdrawal from narcotics and also to help break the link between crime and addiction.

THE PROGRAM, ITS MODALITY, AND ITS GOAL

The program has been designed to provide a means of eliminating dependence on narcotics by using methadone in decreasing doses over a period of approximately 1 week until the individual is physically drug free. HSA also hopes to motivate and channel those in the program into long-term treatment modes after they are detoxified.

Ambulatory detoxification is an effort to intervene in the lives of previously unreached addicts. It recognizes that there are, and will continue to be, many addicts who may initially refuse any form of long-term treatment and that many addicts require temporary relief to inhibit their need to finance their habits through crime.

HSA, as of June 30, 1972, was operating seven ambulatory detoxification clinics. Each clinic is designed to serve 100 patients a week or 5,200 a year.

All facilities are outpatient clinics operated by hospitals. Counseling services are provided and a typical staff for a clinic includes 1 doctor, 3 nurses, 4 counselors, 1 secretary, and 2 security guards--a total of 11.

The city is developing extensive referral links to other treatment programs to minimize the revolving door aspect of the ambulatory detoxification service (i.e. frequent return for detoxification services).

HOW A PROGRAM PARTICIPANT IS SELECTED

Heroin addicts not seriously addicted to other drugs, not detoxified within the previous 30 days under this or some other program, and not showing serious medical problems may be admitted for treatment. The admission process includes an interview with a counselor, a check with HSA's central office for multiple application and recent detoxification history, and a medical examination by a clinic physician.

HOW MANY PEOPLE DOES THE PROGRAM SERVE AND IS THERE A WAITING LIST?

From its inception in July 1971 through June 22, 1972, the program has served 11,611 addicts, of which 1,956 were readmissions to the program. The number of addicts treated has been limited by some of the clinics not being fully operational during the entire period.

WHAT DOES THE PROGRAM COST AND WHO SUPPLIES THE MONEY?

Program officials estimate that the average cost per patient for 1 detoxification treatment would be $40 assuming 10 clinics operating at full capacity and being totally funded. Funding sources were as follows:

Source of funds	Amount	Period
Model Cities	$1,285,000	7-1-71 to 6-30-72
Office of Economic Opportunity	403,000	10-1-71 to 9-30-72
New York City	389,000	7-1-71 to 6-30-72
Total	$2,077,000	

HOW IS PROGRAM PERFORMANCE MEASURED AND WHAT DO THE LATEST RESULTS SHOW?

The Center for Social Research of the City University of New York has conducted an evaluation of the first year of program operation, July 1971 to June 1972, and issued a report. During this period seven detoxification clinics were operating. The evaluation was twofold--part I utilized statistics compiled by the program and part II consisted of an independent followup

survey of program applicants. The evaluation considered such factors as: (1) number of addicts served and number completing treatment, (2) number of addicts never treated before, (3) cost of treatment, (4) illicit drug use by addicts before, during, and after treatment, (5) number of addicts referred to long-term treatment, and (6) criminal behavior of addicts before, during, and after treatment. Evaluation results are summarized below.

Number served

As of June 22, 1972, 13,701 addicts had applied to the program. Of 11,611 who received medication on the first day of the 7-day program, 5,300 left and 6,311 completed the program.

Treating unreached addicts

The report stated that data for 998 patients showed that 45 percent had not been treated for drug addiction previously.

Cost of treatment

Cost data on six clinics indicated that, during the initial year of program operations, costs averaged about $60 for patients who began treatment and about $100 for patients who completed detoxification. Overall average cost was $11 per patient-day. The report projected that in 1972 and 1973 the costs per patient would decrease to $40 to $45 for those beginning treatment and to $70 to $75 for those completing detoxification. Overall cost would be $8 per treatment-day.

Illicit drug use

Urine samples were collected for approximately 80 percent of patients treated on day 1 and day 6 or 7 at clinics selected on a rotating basis. Heroin traces were found for 69 percent of day 1 patients and 29 percent of day 6 and 7 patients.

To further assess the effectiveness of the program in reducing illicit drug use, program officials interviewed a number of program participants during treatment 1 week after detoxification and several months after detoxification to determine the extent of illicit drug use.

The report stated that the ambulatory detoxification program accomplished its goal of reducing heroin abuse during the week of the detoxification cycle. The report also stated that, of the 156 patients interviewed, 79 percent said they had not used any heroin during the 7-day cycle, 11 percent said they had used less heroin, and 10 percent said they had used the same amount or more. The report stated that the longer patients participated in the program, the higher the percentage of patients who became heroin free or decreased their heroin use.

Of the 156 patients for whom data was available, the report stated that 67 percent claimed to have been heroin-free 1 week after the detoxification cycle ended, 17 percent said they were using less heroin than they had used before the cycle, 12 percent said they used the same amount, 3 percent said they were using more, and 1 percent said they were on methadone maintenance.

Several months after completion of the detoxification cycle, the 156 patients were contacted to determine what their heroin use was then compared to before detoxification. The report showed the following results:

	Percent
No heroin	36.5
Less than before cycle	37.2
Same as before cycle	9.6
More than before cycle	6.4
Jail	3.2
Methadone maintenance	7.1

Long-term referrals

The report stated that through March 23, 1972, 2,285, or 36 percent, of 6,439 patients beginning medication had been referred to a long-term treatment agency. The status of these patients as disclosed in the report was as follows:

Long-Term Addiction Treatment

Referral Results July 1971 to March 23, 1972

	Number	Percent of number referred
Patients beginning treatment cycle	6,439	
Patients referred for long-term treatment	2,285	35.5
Outcome of referral:		
Still in treatment		19.9
Entered treatment, then left		6.9
Waiting list		4.9
Rejected		3.0
No show		31.0
No followup: unknown result		34.3

Criminal behavior of patients

According to the report data collected in a followup survey of 143 patients did not conclusively demonstrate the program's effect upon addict criminal behavior, although the data suggests that patients reducing heroin use also reduce their criminal activity. The following results for interviewed patients were included in the report.

	During cycle	Week after	At time of interview
No illegal activities	32.2%	37.8%	34.7%
Much less	44.8	40.6	36.8
Little less	7.7	7.7	8.3
Same amount	11.9	13.3	16.7
Little more	2.1	.7	1.4
Much more	1.4	-	.7
Jail	-	-	1.4

In summary, the report stated that evaluation of the Ambulatory Detoxification Program revealed the following strengths: (1) over 11,000 patients were treated, (2) almost half had not been previously treated for drug addiction, (3) heroin habits had been significantly reduced, and (4) apparently criminal behavior was also reduced as a consequence of reduced habit size. The report noted several program weaknesses including: (1) patients had to wait at times 1 or more days to begin medication and no cycles started on a weekend, (2) no control system was available to verify that addicts were not enrolled in another program that dispensed methadone, and (3) medical test followups for abnormal or positive tests were not in evidence on program records.

CHAPTER 6

CITY PRISON DETOXIFICATION

The New York City Department of Correction detoxifies heroin addicts in the Manhattan House of Detention (the Tombs), the Brooklyn House of Detention, the Adolescent Remand Shelter on Rikers Island, the Bronx House of Detention, and the Women's House of Detention. The program is aimed at humanely alleviating withdrawal pains from narcotic use for the thousands of addicts filtering through these detention centers.

THE PROGRAM, ITS MODALITY, AND ITS GOAL

The program is a voluntary methadone detoxification program for persons entering the five houses of detention and is designed to get an addict through withdrawal humanely rather than "cold turkey" (i.e. withdrawal without the aid of medication). The program began in 1965 in the Women's House of Detention where addicts were detoxified in a clinical setting. This arrangement was continued when a second clinic was opened in the Manhattan House of Detention for men in July 1970.

Starting in March 1971 the men's program was significantly expanded and detoxification was carried out in a cellblock setting rather than in a clinical setting. Those in methadone maintenance programs before entering detention and scheduled for discharge within 3 weeks of entering detention are provided with methadone maintenance.

HOW A PROGRAM PARTICIPANT IS SELECTED

Every person entering one of the houses of detention offering detoxification services is examined by a physician to determine whether he is a narcotic addict needing and desiring detoxification. The physician explains the procedures and the dangers of a methadone overdose to the addict. If the addict accepts treatment, he is immediately started on the detoxification program. An addict is not forced to accept methadone. Anyone who refuses methadone treatment is

offered treatment with tranquilizers. Those using amphetamines and barbiturates are treated separately, using tranquilizers for withdrawal.

HOW MANY PEOPLE DOES THE PROGRAM SERVE AND IS THERE A WAITING LIST?

The Department has not set any one capacity level but has been able to treat every addict within 10 hours of admittance. On an average about 800 male inmates are undergoing treatment at one time.

From March 22, 1971, through December 11, 1972, 45,147 male addicts had been detoxified as shown below.

Facility	Detoxified
Tombs	21,045
Brooklyn House of Detention	10,454
Adolescent Remand Shelter	11,480
Bronx House of Detention	2,168
Total	45,147

From 1965 through December 1972, 22,029 women have been detoxified in a clinical setting.

WHAT DOES THE PROGRAM COST AND WHO SUPPLIES THE MONEY?

As of July 1, 1972, the City Prison Detoxification program had received Federal funds from the Law Enforcement Assistance Administration through the City's Criminal Justice Coordinating Council. The grant was for 2 years and amounted to about $1,261,000 which included State matching funds of about $254,000.

HOW IS PROGRAM PERFORMANCE MEASURED AND WHAT DO THE LATEST RESULTS SHOW?

Success of the detoxification program is measured in relation to the Department's basic objective of being able to get an addict through withdrawal with a minimum of suffering.

The Department believes that the suffering which accompanies withdrawal has resulted in attempted and actual suicides. No suicides or attempted suicides had occurred among detoxified addicts between March 1971 and February 16, 1973.

CHAPTER 7

ADDICTION RESEARCH AND TREATMENT CORPORATION

The Addiction Research and Treatment Corporation (ARTC) began operations with the intent to develop and operate an experimental outpatient program for methadone treatment and related services for ambulatory addicts.

THE PROGRAM, ITS MODALITY, AND ITS GOAL

The program's goal is to help neighborhood addicts become responsible, drug-free citizens. Specific program objectives are

--to enable addicts to achieve drug-free status,

--to help addicts obtain employment,

--to help addicts stabilize their family units,

--to get addicts to relate to the community in a socially acceptable manner, and

--to lessen crime.

A major priority is to obtain community involvement in the solution of the drug problem. The program is seeking to coordinate its efforts with community organizations to broaden education and prevention efforts and to increase community awareness of the services provided by the program and other mental and physical health facilities in the area.

The program director views methadone maintenance as an instrument for enticing an addict to enter the program with the hope of eventual withdrawal from all drugs. The use of methadone is viewed for most patients as only the beginning step in their rehabilitation. The short-range treatment goal is detoxification and stabilization while the long-range goal includes rehabilitation and eventual withdrawal from all drugs.

The program dispenses medication in nine clinics and furnishes the following types of methadone treatment.

--Methadone maintenance without attempting methadone withdrawal.

--Methadone maintenance followed by methadone withdrawal at a gradual rate in the second year of treatment with the hope of obtaining total abstinence.

--Ambulatory methadone detoxification which includes the use of methadone as a detoxifying agent over several months and supported by psychological services.

Other program facilities include a day-care center for patients who have exceptional difficulty in adjusting to the program, a low intervention clinic where counseling is the only service provided, an inpatient therapeutic community where some patients are completely drug free while others are maintained on methadone, and a clinic for patients who are doing well.

Supportive medical and social services include

--outpatient medical care,

--counseling to aid in the transition from a heroin addict to a methadone patient,

--psychiatric screening,

--group therapy,

--job development,

--education, and

--legal services.

The program as of February 1972 employed a staff of 250. About 15 to 20 percent of the staff have college degrees. Emphasis is placed on hiring black staff members with academic credentials and knowledge and experience of ghetto life.

HOW A PROGRAM PARTICIPANT IS SELECTED

All heroin addicts who are over 21 years of age, residents of the geographical area covered by ARTC's program, not suffering from serious psychoses or other drug habits, and have been addicted for at least 2 years are eligible for treatment.

The program uses five intake sources

--street outreach,
--diversion from the court system,
--referral after release from prison,
--voluntary admissions, and
--referrals from NACC and other agencies.

HOW MANY PEOPLE DOES THE PROGRAM SERVE AND IS THERE A WAITING LIST?

From its inception in October 1969 through June 1972, the program had treated about 1,800 persons. As of June 30, 1972, 1,375 patients were in treatment. The program has the capacity to treat 1,400 at any time. Ordinarily there is no waiting list for center services.

After a patient has completed his intake application, a urine specimen is taken to verify the use of heroin and a check is made with the Methadone Data Office at Rockefeller University to make sure that the applicant is not receiving methadone elsewhere. This is followed by a full medical examination. If there are no medical problems to preclude methadone treatment, he is accepted. The intake procedure, from application to acceptance, generally takes from 7 to 10 days.

WHAT DOES THE PROGRAM COST AND WHO SUPPLIES THE MONEY?

Program funds have been received from the National Institute of Mental Health (NIMH), New York City, the Model Cities, the Law Enforcement Assistance Administration, and New York State as follows.

Source of funds	Amount [a]10-3-69 to 10-31-70	11-1-70 to 10-31-71	11-1-71 to 10-31-72
NIMH	$ 854,906	$1,373,242	$1,400,409
New York City (note b)	574,497	728,763	832,950
Model Cities	148,337	-	-
Law Enforcement Assistance Administration (note b)	144,141	128,888	-
Medicaid	-	386,621	1,070,392
Total	$1,721,881	$2,617,514	$3,303,751

[a]Inception.

[b]Funds from this source were actually available as of September 1, 1969.

HOW IS PROGRAM PERFORMANCE MEASURED AND WHAT DO THE LATEST RESULTS SHOW?

The program is evaluated from sociological, criminological, and medical points of view by Columbia, Harvard, and Yale Universities, respectively. Evaluation objectives are to provide feedback for program improvement and to inform the public of program results. Program evaluation is required by the funding sources. Evaluation results are reported to NIMH, the Criminal Justice Coordinating Council, the New York City comptroller's office, Model Cities, ASA, and the New York State Safe Streets Crime Control Planning Board.

Success criteria established by the evaluation teams include the following

--abstinence from use of drugs other than methadone,
--employment, schooling, and homemaking,
--stable family life,
--social adjustment in the community, and
--decline in criminal behavior.

Evaluation data is compiled independent of the program. Urine specimens are collected under observation; patients' police records are checked when they enter the program and

periodically thereafter; patients are interviewed; and school and employment records are checked.

The teams also conduct a number of research projects including

--determination of proper methadone dosage level,

--determination of who uses the program to see which aspects of it are successful, and

--construction of a model to predict who will be successful in the program.

In May 1972 Columbia published a "Profile of Active and Terminated Patients in a Methadone Maintenance Program." The basic analysis was done on 428 ARTC patients for whom preadmission data was available. This report concluded that:

--Patients over 35 years of age at the time of admission are most likely to remain in treatment.

--Early addiction and a low degree of participation in conventional social activities were strong indications of those most likely to drop out of treatment.

--Because of an increasingly younger addict population, programs will have increasing difficulties retaining patients.

--A much larger segment of the patient population will consist of young patients who became addicted as adolescents and therefore are likely to have a low degree of social integration. Early addiction will most likely result in their not finishing high school, not being steadily employed, and having a high degree criminal involvement.

CHAPTER 8

PHOENIX HOUSE

Phoenix House is a drug free, therapeutic program consisting of a number of residential facilities where drug abuse and addiction are treated as a personality disorder which does not respond to traditional psychiatric treatment. Literature published by Phoenix House about its program indicates that Phoenix does not believe addiction can be cured by transferring the individual's dependence from one drug to a more socially acceptable drug, such as methadone.

THE PROGRAM, ITS MODALITY, AND ITS GOAL

Prospective residents are initially enrolled in neighborhood residential centers where they are helped to break the drug habit. When an addict is drug free and ready to commit himself to the full-time and long-term program, he is admitted to a long-term residential facility. The overall program goal is the full rehabilitation and socialization of the addict which includes being drug free and employed or in school.

The long-term residential facilities are usually four- or five-story tenements which have been renovated largely by Phoenix House residents. These residences are generally in neighborhoods noted for their incidence of drug abuse and crime.

Once admitted, the residents assume the responsibilities of running their own home--from building and improving facilities to making and serving meals.

The heart of the treatment program is the encounter where each resident is confronted about his behavior and attitudes by those persons with whom he lives and works. Feelings are expressed openly and honestly by each resident so that he may see a true reflection of himself.

Participants are also offered education and vocational training. The minimal education goal is a high school diploma or a high school equivalency certificate.

The Phoenix program uses 13 residential facilities called Phoenix Houses and 7 induction units called Phoenix Centers located in and around New York City. Each Phoenix House has a capacity of 70 to 80 residents. Each house has a director and two assistant directors, all of whom have had experience in overcoming addiction in a therapeutic community and have been drug free for at least 3 to 4 years.

HOW A PROGRAM PARTICIPANT IS SELECTED

Participants are either referred by the courts or are voluntary walk-ins to the Phoenix Centers. Phoenix induction units have a staff of ex-addicts who supervise daily job programs, orientation, interviews, and encounter groups. The induction period at Phoenix Centers allows time for testing motivation and for detoxification so that participants are drug free when they enter a Phoenix House. After about 3 weeks an accepted candidate becomes a resident in a Phoenix House. The residential treatment phase ranges from 14 to 20 months followed by a transitional reentry period to prepare him to leave the house and to return to life in the community. During this period the ex-addict lives in the Phoenix House for an additional 4 to 8 months and either works or goes to school outside the house.

HOW MANY PEOPLE DOES THE PROGRAM SERVE AND IS THERE A WAITING LIST?

Since its inception in May 1967 through May 1972, the program has served 4,677 addicts. The May 1972 population was 1,158 residents.

In addition, the program normally has 50 to 250 persons in the induction phase which constitutes the waiting list.

WHAT DOES THE PROGRAM COST AND WHO SUPPLIES THE MONEY?

The Phoenix House program for fiscal year 1972 cost $5.6 million. Funds were received from the State and city, private donations, and donations of residents' welfare checks. About 50 percent of the funds were received from ASA and NACC.

Phoenix House estimates that it costs about $11 a day or $4,000 annually per resident.

HOW IS PROGRAM PERFORMANCE MEASURED AND WHAT DO THE LATEST RESULTS SHOW?

The research unit of Phoenix House has issued several papers which commented on various areas of narcotic addict treatment and rehabilitation. A February 1972 research paper dealt with the relationship between an addict's criminal activity and exposure to residency in a Phoenix House therapeutic community.[1] Since about 70 percent of Phoenix residents did not complete the program and only 40 percent[2] remained more than 12 months, the study attempted to assess the effects of treatment on those who had dropped out.

The study included 254 residents who had left the program between January 1, 1968, and March 31, 1969. Arrest rates were determined for 1 year before and 1 year after residence in a Phoenix House. Half the 254 dropouts had been arrested during the year before entering the program. After leaving the program, their arrest rates dropped to about one-third.

In addition, the study showed that the longer these 254 dropouts remained in residence, the greater the reduction from their preprogram arrest rate. For those who had remained in the program less than 3 months, the reduction was about 7 percent. For the groups which remained 3 to 5, 6 to 8, and 9 to 11 months, there was a 40- to 50-percent reduction in arrest rates. The arrest rate for those who remained more than a year dropped by 70 percent.

The study concluded that, even for those addicts failing to complete the program, arrest rates are lower than they were before entering a Phoenix House. Also, the longer the residence period, the more significant the reduction in arrests.

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[1]The Phoenix director informed GAO that this study had been accepted for publication by the Journal of the American Medical Association.

[2]According to the Phoenix director, a March 1972 study based on about 1,150 admissions showed that 45 percent stayed at Phoenix 12 months or longer.

As another significant measure of the program's performance, Phoenix points to the fact that as of March 1972, 150 former residents had received high school equivalency diplomas and 250 residents were working toward a high school diploma.

As of March 1972, 261 persons had graduated from the Phoenix program. To become a graduate one must reside outside a Phoenix House and be either employed or a full-time student. He must have been drug free for at least 24 months. Two hundred of the 261 graduates were employed by private or public drug programs (60 at Phoenix); 50 were employed by private industry, and 11 had returned to school. About 60 percent of the graduates have kept in touch with Phoenix.

CHAPTER 9

DAYTOP VILLAGE

Daytop Village is a drug-free, self-help community, which features therapy and encounter sessions in addition to hard work. Daytop aims to return the addict to society by moving him through five separate rehabilitation phases from induction to gaining and holding outside employment.

THE PROGRAM, ITS MODALITY, AND ITS GOAL

Daytop Lodge began in 1963 as a demonstration project funded by the National Institute of Mental Health. It was incorporated in 1965 under the name of Daytop Village as a nonprofit charitable corporation. The program was disrupted in 1968 by administrative conflicts between its staff and board of directors. The outcome was that many of the staff and residents abandoned the facilities which then became virtually inoperative. In January 1969 those who had remained or returned to the program began to revitalize its operations. Since then Daytop has continued to function with the assistance of a newly structured administrative staff and board. Funds have been furnished primarily by NACC.

Daytop's goal is the eventual and reasonably prompt integration of an addict into society as a drug-free citizen. Treatment is provided in both a residential and ambulatory setting. Persons participating in the residential program are mainly hard core addicts whose rehabilitation requires long-term residential supervision. Residential treatment is given in five phases which take about 18 months.

--Phase I deals with induction and orientation. It uses group therapy, educational seminars, recreation, and in-house work assignments (1 month).

--Phase II continues phase I but includes home visits and outside community activities, such as speaking engagements (10 months).

--Phase III continues group activities and includes training in Daytop job assignments. It also involves outside social activities (2-1/2 to 3 months).

--Phase IV involves job responsibilities at Daytop's outreach centers with the continuation of group therapy (1-1/2 to 2 months).

--Phase V includes holding a job outside of Daytop or attending school. Group therapy continues (3 to 4 months).

Therapy, encounter sessions, and work are the basic tools used in the program.

Participants in the ambulatory treatment program are generally younger and have been abusing drugs for a shorter time. The program takes about 12 months. Daytop has four residential or therapeutic communities--Staten Island, Manhattan, Swan Lake, and Millbrook, New York--and five ambulatory units or outreach centers--Brooklyn, Manhattan, Bronx, and Mount Vernon, New York; and Trenton, New Jersey.

Daytop's staff numbers about 100 and consists of doctors, clinical, administrative, research, consultant, and other personnel. The clinical staff consists primarily of ex-addicts with no professional training in the traditional sense, but with extensive backgrounds in working with drug addicts. Residents with some promising clinical abilities are encouraged to work for the program upon graduation and receive needed training prior to graduation.

Daytop has contractual arrangements with the following government agencies for treating addicts: NACC, ASA, the Westchester Community Mental Health Board, and Model Cities of Trenton.

HOW A PROGRAM PARTICIPANT IS SELECTED

Daytop applicants are referred from probation, parole, NACC and other agencies, private medical personnel, and a special prison project under which attempts are made to bring into treatment persons who have court cases pending. Also, some are walk-ins. The prospective resident is interviewed by five Daytop-trained ex-addicts. If he is self-motivated and free of serious psychiatric and/or medical problems, the candidate is accepted. Those with health problems are referred to more appropriate places for treatment.

HOW MANY PEOPLE DOES THE PROGRAM SERVE AND IS THERE A WAITING LIST?

Because of the 1968 internal conflict, most of the residents' records and data files were lost or misplaced. Therefore, reliable data relating to program participants prior to January 1969 was not available.

Between January 1969 and December 1972, 1,880 persons entered the residential facilities and 431 graduated. Between January 1970 and December 1972, 1,669 persons entered the ambulatory units. On December 31, 1972, 459 were in the residential program and no one was waiting to be admitted--94 were in the ambulatory program.

WHAT DOES THE PROGRAM COST AND WHO SUPPLIES THE MONEY?

For the year ended December 31, 1972, Daytop received about $2.3 million.

The sources of funds for 1972 follow:

Source of funds	Amount
NACC	$1,932,048
ASA	210,971
Trenton	70,180
Westchester County	59,009
"The Concept" (off Broadway show)	4,278
Contributions	7,991
Investment and other income	20,631
Total	$2,305,108

According to Daytop the per diem cost for the residential program was $11.39 per resident for the year ended March 31, 1972, or about $4,200 annually. Daytop computes per diem rates by dividing average patient-load into actual and/or projected expenditures for its residential program.

HOW IS PROGRAM PERFORMANCE MEASURED AND WHAT DO THE LATEST RESULTS SHOW?

Daytop's success criteria are complete abstinence from drugs and social productivity, such as being employed or in school. Data for measuring success is collected through interviews with persons who have completed or dropped out of the program. All program evaluation is done by the professional staff in Daytop's research department.

A Daytop study shows that 234 (52 percent) out of 454 persons entering the residential program in 1971 dropped out and 5 (1 percent) were expelled.

A December 1971 Daytop posttreatment study of persons who had been out of the program at least 6 months showed that:

--Of 66 graduates interviewed, 61 (92 percent) had not reverted to drug use.

--Of 24 dropouts interviewed, 12 (50 percent) had not reverted to drug use.

--None of the graduates had been arrested.

--Four dropouts had been arrested.

--Of the graduates, 55 (83 percent) were employed for some time after leaving Daytop; 43 were in drug rehabilitation agencies.

--One-fourth of each group was going to school.

CHAPTER 10

HORIZON

Horizon is a 5-year demonstration project jointly funded by NIMH and the city. Its major intent is to provide addicts with a positive learning environment which will facilitate their abstention from drugs, and their reentry into society as productive persons.

THE PROGRAM, ITS MODALITY, AND ITS GOAL

The program began in May 1969 under a NIMH grant to New York City. The modalities used are all drug free and include a therapeutic residential community program, ambulatory treatment (adults and youth), "blockwork" (i.e. community education and relations) components, and a yoga program.

The average length of treatment in the residential community is 12 to 16 months during which emphasis is placed on personal growth through the use of encounter groups, peer group pressure, role models (Horizon staff who are ex-addicts living in the outside world), and drama workshops. Participants also receive informal education from more educated residents and volunteer teachers from the community.

The ambulatory treatment centers offer several levels of treatment--a preinduction walk-in clinic, ambulatory treatment for users of "hard" drugs such as heroin, and a yoga program for users of "soft" drugs such as barbiturates and amphetamines. In the preinduction phase, a daily 2-hour orientation is held for addicts who are not motivated enough to attend a regular 8-hour induction program. The induction program requires 1 week of steady participation. The ambulatory program is much like the therapeutic community program except that it is on an outpatient basis. The yoga program is used as a primary therapeutic tool along with more traditional forms of therapy such as encounter groups.

Activities of the blockwork component include providing public relations within the community, establishing better

relationships between the police and the community, and organizing the community to deal with the problems of their environment.

Horizon advised us that the ambulatory youth treatment center had 103 youngsters who had been referred from local schools in the program as of January 9, 1973. They receive educational aid through volunteer teachers, take part in encounter groups, and are involved in cultural programs, such as the performance of plays for the community.

Horizon's seven facilities are located in the Lower East Side of Manhattan--two residential facilities, two ambulatory centers, one induction center, and two blockwork components.

HOW A PROGRAM PARTICIPANT IS SELECTED

Applicants are accepted only if they have no major mental or physical problems and if they return to the induction center for 3 consecutive days after initial application. Preference is given to residents of the Lower East Side. Prospective participants come from walk-ins, staff contacts with correctional institutions, hospitals, and referrals from the community.

HOW MANY PEOPLE DOES THE PROGRAM SERVE AND IS THERE A WAITING LIST?

From inception through December 1972, the program served 3,131 persons, of whom 811 were treated in 1972. Program capacity at the time of our fieldwork was 375--80 for pretreatment induction and 295 for ambulatory and residental treatment. As of December 31, 1972, 230 addicts were in treatment which resulted in only about 53 percent of the treatment facilities' being used.

The former ASA Commissioner advised us that Horizon may be the wrong program in the wrong area. He also told us that, if the area cannot support Horizon, then in all probability the program would be cut.

WHAT DOES THE PROGRAM COST AND WHO SUPPLIES THE MONEY?

Horizon has been supported by a NIMH grant and the city. Expenditures from inception in May 1969 through April 30, 1972, totaled about $3.5 million. The budget for the year ending April 30, 1973, is about $2.5 million--about $1.5 million from NIMH and $1 million from New York City.

The estimated annual cost per person at Horizon, as supplied by ASA, was $3,377 for the ambulatory treatment units, $3,706 for the therapeutic communities, and $1,786 for the youth center.

HOW IS PROGRAM PERFORMANCE MEASURED AND WHAT DO THE LATEST RESULTS SHOW?

Since the program's inception, the Fordham Institute of Social Research has been involved in an ongoing study which has provided program description data rather than program evaluation data. Its aims are:

--To develop a theory of why people turn to drugs, how this can be prevented, and once addicted, how to treat them.

--To understand the political viability of treatment approaches (influence on program development exerted by social, legal, and political pressures).

--To learn the impact of treatment upon addicts.

--To learn the effect of community intervention efforts upon the target area.

A representative of Horizon told us that formal criteria had not been established to measure program performance. She also said that Horizon would consider someone a success if he was going to school or working and was not on drugs.

Through 1972 only 104 people had finished the program.

CHAPTER 11

ODYSSEY HOUSE

Odyssey House is a drug-free therapeutic community featuring a structured environment designed to bring about positive changes in addicts, such as being drug free, gainfully employed, attending school, or not engaged in criminal activity. Odyssey attempts to reorient addicts toward living in the community outside of Odyssey House as drug-free and productive citizens.

THE PROGRAM, ITS MODALITY, AND ITS GOAL

Odyssey House, Inc., is a voluntary nonprofit agency which began in January 1966 as a pilot research program at New York City's Metropolitan Hospital. Its orientation in late 1966 toward a drug-free therapeutic approach led to the removal of the Odyssey program from affiliation with the hospital.

Its treatment and rehabilitation approach is that of a psychiatrically oriented therapeutic community in a long-term residential program using both professional and ex-addict expertise.

Treatment involves the following phases:

--The induction phase is accomplished through community involvement centers in areas with a high incidence of drug abuse. There, trained ex-addicts conduct group therapy sessions with addicts. Through this it is hoped that addicts will be motivated to enter the Odyssey program.

--The treatment phase attempts to bring about a positive personality change in a addict. This is accomplished through the therapeutic structured environment of the residential facility.

--The posttreatment or reentry phase reintroduces the patient to functioning in society and comes after satisfactory progress in the earlier phases of treatment.

Odyssey has seven residential facilities and three storefront community involvement centers in New York City. Treatment facilities are also located in New Jersey, New Hampshire, Michigan, Utah, Nevada, and Connecticut.

Odyssey had contractual agreements with NACC and ASA for operation of some of its New York City facilities.

Odyssey had a staff (professional and ex-addicts) of 150 as of March 1972. The prerequisite for employment of an ex-addict is that he be a graduate of the program. Approximately 10 percent of all Odyssey graduates become full-time staff members. About 90 ex-addicts were working at Odyssey in March 1972.

HOW A PROGRAM PARTICIPANT IS SELECTED

There are no rigid criteria for acceptance of a program participant. Referral sources range from the court system to religious and educational institutions. Two-thirds of the applicants come from the criminal or family courts. Applicants are screened through several levels to test their desire to enter Odyssey. Those under 18 years of age are accepted without screening. The screening involves close supervision and observation of an addict which includes medical and psychological testing, meeting with residents, and being appraised in terms of motivation by both professional staff and residents.

HOW MANY PEOPLE DOES THE PROGRAM SERVE AND IS THERE A WAITING LIST?

In all of its facilities, Odyssey has served 4,235 inpatients and about 15,000 outpatients from inception in May 1967 through December 31, 1972. During 1972 approximately 426 inpatients were served and the average daily census was 320. A total of 2,700 outpatients were seen during 1972 at storefront and community involvement centers. An Odyssey representative advised us that most of those treated were from New York City.

Odyssey's capacity in New York City is 400 persons which is expected to increase to 600 by the end of 1973.

There is no waiting list because all who meet the requirements are accepted immediately regardless of capacity.

WHAT DOES THE PROGRAM COST AND WHO SUPPLIES THE MONEY?

Funding sources for the New York City facilities vary from private organizations to governmental agencies. For the 6-month period ended June 30, 1972, available funds totaled about $760,000.

Daily patient costs are calculated in two categories--adult and adolescent. The adult cost is about $15 a day, or $5,475 per year, and the adolescent cost is about $21 a day, or $7,665 per year. The inclusion of a complete educational program recognized by New York State causes the higher adolescent cost.

HOW IS PROGRAM PERFORMANCE MEASURED AND WHAT DO THE LATEST RESULTS SHOW?

Patients meeting the following criteria are considered successes:

--Completion of the inpatient phase which averages 14 months.

--Drug free over this period of time based upon daily urine testing.

--Having at least 6 months in reentry living and working outside of the program but still meeting the drug-free criteria.

Less definite criteria for measuring success include:

--An individual's response to both group and individual psychotherapy.

--The degree of change exhibited by each individual in terms of ability to complete job functions.

--Ability to handle responsibilities.

--Ability to exercise authority properly.

These criteria are directly related to the objectives and the philosophy of the Odyssey House program.

Program effectiveness is based on daily reporting of urinalysis results, weekly reports and program notes made by the professional staff, length of time an individual has spent in the program, and the degree of progress or development that each individual demonstrates.

Program outcome data furnished us by Odyssey shows that for a 4-year period approximately 45 percent of 2,500 new admissions to Odyssey House had left against medical advice or had been expelled within a week after entering due to poor motivation. In total, 990 patients, or 40 percent of the total new admissions, stayed in the program through completion of treatment. Of the initial 41 graduates, 39 were found to be leading drug-free lives.

Odyssey further reported that, of those who had dropped out of the program during treatment, about 50 percent had become readdicted, 20 percent had remained drug free, and 30 percent could not be located.

CHAPTER 12

NEW YORK STATE ADDICT COMMITMENT PROGRAM

New York State law created NACC in 1966 principally to bring about the rehabilitation of narcotic addicts and also provided for the civil or criminal commitment of addicts to NACC for treatment and rehabilitation. The commitment program which began in April 1967 is a comprehensive rehabilitation effort combining drug-free therapy and methadone maintenance in residential and ambulatory settings.

THE PROGRAM, ITS MODALITY, AND ITS GOAL

The program, administered by NACC, treats addicts committed by the courts. Treatment takes place in controlled residential centers and in community-based centers which provide aftercare services.

NACC's controlled residential centers range from minimum security camplike institutions to high-security centers. According to a NACC official, the addicts' residence averages 4 to 5 months during which time they undergo detoxification, physical buildup, and a proper determination of the type of additional treatment needed. While in residential treatment, the addict may receive group therapy, individual counseling, and educational skills training at a rate commensurate with his ability to progress.

Upon completion of treatment in a residential facility, an addict receives continued support and therapy in an aftercare program. NACC's aftercare program is designed to ease the change from life in the residential facility to a socially acceptable mode of life in the community. NACC provides for three levels of community-based aftercare--residential aftercare, community care, and field service.

Residential aftercare is designed for persons who lack the resources to take up living in the community or who may be slow to adjust to outside living. Community care is intended for persons who have the resources to live outside a NACC residence, but who require additional daily assistance in terms of counseling concerning job, educational, social,

or personal problems. Field service is for persons who require less supervision and support and who are best adjusted to resuming life in the community.

There are 16 comprehensive NACC facilities providing more than one treatment approach. Treatment in these facilities consists of medical services including psychiatry and nursing, counseling, individual and group therapy, education, and psychological and recreational services. Methadone stabilization is provided in four of these centers. Upon stabilization an individual is released to the methadone maintenance outpatient program nearest his home. All but one of these facilities provide some form of residential treatment. In addition to the 16 facilities, NACC has 2 facilities which provide only counseling and vocational services.

HOW A PROGRAM PARTICIPANT IS SELECTED

An addict can be committed to NACC by either a civil or criminal process. The first applies mainly to addicts who have not been arrested; the second, to addicts who have been arrested and convicted of crimes.

The law provides that under the civil process an addict, or a person believing someone to be an addict, can file a petition for commitment with the New York State Supreme Court. Then, through the legal process, a jury or judge may determine that a person is an addict; whereupon, the judge can issue an order committing the addict to the care and custody of NACC for a period not to exceed 3 years.

The criminal commitment process is an involuntary proceeding triggered by arrest. At arraignment any arrestee suspected of being an addict may be given a medical examination to determine whether he is a narcotic user. If a person is convicted, the medical finding of narcotic use becomes the basis of a criminal commitment proceeding, and the judge can commit the addict to NACC in lieu of sentencing. If the criminal conviction is for a misdemeanor, the commitment to NACC is 3 years at maximum and for a felony, 5 years at maximum.

An addict may be eligible for a conversion of a criminal charge to civil commitment as an alternative to criminal

commitment. He is eligible for this option only if he has not previously been convicted of a felony. However, if the present charge is a felony, the district attorney must consent to dismissal of the charges in return for a civil commitment for a maximum of 3 years.

Once an addict is committed to NACC, he is held for a period until he can be placed in a treatment facility. For civilly committed addicts this detention occurs at two NACC facilities, the Edgecombe Center for men and the Manhattan Center for women. For those criminally committed and those under civil commitments stemming from criminal charges, the time is spent in one of the city's houses of detention. The addicts' commitment periods are running during this detention time which might last from a few days to several months.

Until April 1971 NACC accepted everyone committed, although legally it could have chosen not to do so. Because of budgetary cuts NACC stopped accepting commitments in April 1971. Civil commitment was reopened in August 1971 and criminal intake resumed in June 1972.

HOW MANY PEOPLE DOES THE PROGRAM SERVE AND IS THERE A WAITING LIST?

As of June 30, 1972, NACC was treating 9,649 addicts in its commitment program, 2,155 in residential facilities, and 7,494 in aftercare. All but about 400 of these were being treated in NACC-run facilities. Since the program's inception in 1967 through June 30, 1972, 21,600 addicts had been committed to NACC for treatment.

WHAT DOES THE PROGRAM COST AND WHO SUPPLIES THE MONEY?

For the fiscal year beginning April 1, 1972, about $48 million was appropriated for the commitment program.

In terms of the cost of treatment in a controlled residential facility, a NACC study estimated the cost at $9,700 per person a year. However, because of the variety of the treatment programs used and the varying length of controlled residential treatment, this amount is not representative of the per patient cost.

HOW IS PROGRAM PERFORMANCE MEASURED AND WHAT DO THE LATEST RESULTS SHOW?

NACC reports concerning its commitment program have not been outcome oriented. The Criminal Justice Coordinating Council has reached this same conclusion. However, the information which follows provides some indication of NACC's program effectiveness.

A February 1971 study by the Criminal Justice Coordinating Council which, in part, considered effectiveness of NACC treatment, cited information obtained from NACC which indicated that 44 percent of those entering aftercare were continuing successfully in this phase of treatment. The remainder had either absconded while in aftercare or had reverted to drug use. Also, of the 526 people discharged from the program between April and September 1970, only 97, or 18.4 percent, completed treatment through the aftercare phase of the program without absconding or relapsing to drug use at least once.

As discussed on page 17, NACC has devised a data collection system that it believes will produce more than typical demographic output data and will enable it to demonstrate program results in considerable detail.

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY
WASHINGTON, D.C. 20515

October 15, 1971

Honorable Elmer B. Staats
Comptroller General of the United States
Washington, D. C. 20548

Dear Mr. Staats:

To assist the Subcommittee in its continuing consideration of legislation concerned with the treatment and rehabilitation of narcotic addicts, we would appreciate having the General Accounting Office make a review and provide a report on program assessment efforts made by Federal, State, and local agencies involved in narcotic rehabilitation activities. The Subcommittee's concern is that in developing legislation for treatment and rehabilitation, adequate program assessments are made to provide a basis for the Congress and the executive agencies to take action to improve the rehabilitation programs.

For an appropriate mix (Federal, State, and local) of programs, your review should provide information on the treatment modality, program goals, and established controls and techniques for measuring program accomplishments. The Subcommittee also desires information on program costs including, if possible, information on amounts spent on program assessment efforts. The information gathered should be supplemented by your comments on any identified weaknesses relating to the efforts of program sponsors to evaluate program effectiveness. We would appreciate your suggestions as to actions needed to improve such efforts.

These matters have been discussed with your staff. Any other suggestions you or your staff may have in fulfilling our objective will be appreciated.

Your report would be most helpful if it could be available to the Subcommittee by June 1972.

Sincerely,

Don Edwards

Don Edwards
Chairman
Subcommittee No. 4