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



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Narcotic Addiction Treatment  
And Rehabilitation Programs  
In Washington, D. C. B-166217

BY THE COMPTROLLER GENERAL  
OF THE UNITED STATES

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APRIL 20, 1972



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

B-166217

BEST DOCUMENT AVAILABLE

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 Washington, D.C. This is the first in a series of five reports to be issued pursuant to your request. Other reports will cover the cities of New York, N.Y.; Chicago, Illinois; and San Francisco and Los Angeles, California.

We have discussed the contents of this report with the Administrator of the District's Narcotics Treatment Administration and his staff. Their comments have been incorporated into the report.

We plan to make no further distribution of this report unless copies are specifically requested, and then we shall make distribution only after your agreement has been obtained or public announcement has been made by you concerning the contents of the report.

Sincerely yours,

A handwritten signature in cursive script that reads "James B. Stacks".

Comptroller General  
of the United States

*CTR*  
The Honorable Don Edwards  
Chairman, Subcommittee No. 4  
Committee on the Judiciary # 2500  
House of Representatives

C o n t e n t s

	<u>Page</u>
DIGEST	1
CHAPTER	
1 INTRODUCTION	5
2 NARCOTICS TREATMENT ADMINISTRATION	9
Program goals	10
Treatment modalities	10
Patients in treatment and services available	13
Source of funding	15
Treatment cost of various modalities	15
Criteria used to select patients for treatment	18
Program assessment efforts	19
Program results	21
Results achieved by NTA adult programs	21
Results achieved by NTA youth programs	23
Results achieved by NTA contractors	26
3 ADDITIONAL INFORMATION ON NTA PROGRAM RESULTS AND NTA DATA COLLECTION SYSTEM	29
Program results at the Youth Center	29
Program results at the Community Addiction Treatment Center	31
NTA data collection system	33
4 PROBLEMS AT TREATMENT CENTERS IN THE DISTRICT OF COLUMBIA	36
Staff and staff training	36
Supportive services	37
Physical facilities	38
5 INFORMATION ON OTHER TREATMENT PROGRAMS RECEIVING GOVERNMENT FUNDS	40
Saint Elizabeths Hospital--Last Renaissance	40
Veterans Administration Hospital	41

CHAPTER	<u>Page</u>
Narcotic Addict Rehabilitation Act	43
D.C. Department of Corrections work release program--Residential Treat- ment Center	46
 APPENDIX	
I Letter dated October 15, 1971, from Chair- man, Subcommittee No. 4, House Committee on the Judiciary	47
II Narcotics Treatment Administration treatment centers	48
Community Addiction Treatment Center	48
Criminal Justice Surveillance Unit	48
Drug Addiction Medical Service--Clinic	48
Drug Addiction Medical Service--Inpa- tient Units	48
Emerge House	49
Detoxification-Abstinence Clinic	49
Far East Addiction Treatment Service	49
G Street Clinic	50
Model Cities Addiction Treatment Pro- gram	50
Narcotic Addict Rehabilitation Corps	50
Narcotic Addict Rehabilitation Corps-- Clinic	51
Youth Center	51
Neighborhood Treatment Center	52
Southeast Neighborhood Action Board-- Adult Program	52
Southeast Neighborhood Action Board-- Youth Program	53
Bonabond Step-one	53
III Indicators of the size of the District's addiction problem	54
Estimates of number of narcotic addicts	54
Narcotic arrests Reported by Metropoli- tan Police Department	56
Number of Addicts Appearing Before Dis- trict of Columbia Superior Court	57

APPENDIX	<u>Page</u>
Narcotic offenders at the District jail	57
Bureau of Narcotics and Dangerous Drugs list of known addicts and estimate of total addicts	58
IV Map of narcotic addict treatment centers dis- cussed in this report	59

ABBREVIATIONS

BDC	Blackman's Development Center
CATC	Community Addiction Treatment Center
DAMS	Drug Addiction Medical Service
GAO	General Accounting Office
NARC	Narcotic Addict Rehabilitation Corps
NTC-RTC	Neighborhood Treatment Center - Residential Treatment Center
NTA	Narcotics Treatment Administration
SENAB	Southeast Neighborhood Action Board

D I G E S T

WHY THE REVIEW WAS MADE

This is the first of five reports requested by the Chairman of the Subcommittee on programs for treatment and rehabilitation of narcotic addicts. This report concerns programs in Washington, D.C. Other reports will cover programs in New York, N.Y.; Chicago, Illinois; and San Francisco and Los Angeles, California.

The General Accounting Office (GAO) was asked to obtain for each city data on

- the amount of money spent by governmental agencies on narcotic treatment and rehabilitation programs,
- numbers of addicts being treated under various types of treatment,
- goals of the programs,
- criteria to measure accomplishments of the programs, and
- efforts by sponsors to measure the effectiveness of programs.

GAO was not asked to evaluate program performance.

The Subcommittee is concerned that, in developing legislation for narcotic treatment and rehabilitation programs, adequate provision be made for assessment of the programs so that the Congress and the executive agencies will have a basis on which to take action to improve the programs.

FINDINGS AND CONCLUSIONS

The number of narcotic addicts in the District of Columbia has been estimated at 20,000. The number of narcotic addicts is difficult to determine for any area because there is no accepted definition of the term "narcotic addict," no reliable or complete reporting system, and no means of identifying a person as an addict unless he is arrested or enrolls in a treatment program.

1 The Narcotics Treatment Administration (NTA) carries out most of the addiction treatment programs in the District of Columbia. The agency was organized in February 1970 as a part of the D.C. Government to lead and

coordinate a comprehensive community effort against the problem of heroin addiction. NTA provides services through 12 treatment centers it operates and through four centers operated by contracts with private organizations. Since February 1970, NTA has received Federal support totaling about \$12.3 million. (See p. 15.)

NTA has set four primary goals in treating and rehabilitating addicts.

- Assist the addict in finding productive employment or job training.
- Stop illegal drug use.
- Eliminate criminal behavior.
- Keep the addict under treatment.

NTA has initiated several studies to determine how well its programs are achieving these goals. NTA periodically collects data on employment status, urinalyses, arrest records, and duration of treatment for each patient in the studies. This data is summarized and evaluated at 6-month intervals.

Results of the study after 18 months showed:

- For 450 adult patients, that 84 (19 percent) met all program treatment goals and that 124 additional patients (27 percent) had been in treatment for 18 months but had failed to meet one or more of the program goals. Employment posed the largest problem. (See p. 22.)
- For 150 youth patients, that two (1 percent) met all program treatment goals and that 18 additional youths (12 percent) remained in treatment but failed to meet one or more of the other program goals. (See p. 24.)

NTA research studies are discussed in detail on page 21.

NTA also has conducted studies of the results being achieved by its contractors. (See p. 26.)

NTA's data collection system is being expanded to include a number of new reports summarizing data for all patients at a treatment center and for all NTA patients. GAO believes that the data in these reports should provide a means for continually assessing program results.

To obtain additional information on the results of NTA's drug treatment programs, GAO analyzed reported information for selected groups of NTA patients. (See pp. 29 and 31.)

GAO visited all the treatment centers operated by NTA and its contractors to obtain information on problems and needs of the centers and ways to improve the drug treatment program. According to program administrators, counselors, and patients, NTA needs include:

- Additional and better trained staff members to provide more effective services to patients.

--Additional supportive services, such as job placement, training, and recreation, for patients.

--Better physical facilities. (See ch. 4.)

AGENCY COMMENTS

The Administrator of NTA told GAO that, during NTA's 1st year of operation, emphasis was placed on growth and that as many patients as possible were enrolled in treatment programs. During its 2d year, NTA's growth rate was lower and its efforts were concentrated on broadening services to its patients and restructuring many treatment centers.

In the 1st year most treatment centers offered all types of treatment. During the 2d year many centers began to specialize in one type of treatment--abstinence, methadone maintenance, or detoxification.

Currently, according to the Administrator, NTA is becoming increasingly concerned about the total human needs of each patient. NTA attempts to meet as many of the patient's needs as possible at the treatment centers. When NTA cannot provide services, it acts as a "broker" to arrange for services to be provided by other agencies. The Administrator has stated that NTA never should expect to meet all the needs of its patients because to do so would involve duplicating many social service functions provided by other governmental agencies.

Presently most of NTA's counselors are ex-addicts. The Administrator acknowledged that more and better trained counselors were needed. He advised GAO that ex-addict counselors usually were effective but indicated that many of them resisted training which would increase their effectiveness. He stated that NTA needed to work on this problem and to hire more professionals as counselors.



## CHAPTER 1

### INTRODUCTION

Our Nation today is faced with a serious narcotic addiction problem. The President, in his January 20, 1972, state of the Union message, remarked that:

"A problem of modern life which is of deepest concern to most Americans--and of particular anguish to many--is that of drug abuse. For increasing dependence on drugs will surely sap our Nation's strength and destroy our Nation's character."

In a June 17, 1971, message to the Congress, the President described the nature of the drug problem, as follows:

"Narcotic addiction is a major contributor to crime. The cost of supplying a narcotic habit can run from \$30 a day to \$100 a day. This is \$210 to \$700 a week, or \$10,000 a year to over \$36,000 a year. Untreated narcotic addicts do not ordinarily hold jobs. Instead, they often turn to shoplifting, mugging, burglary, armed robbery, and so on. They also support themselves by starting other people--young people--on drugs. The financial costs of addiction are more than \$2 billion every year, but these costs can at least be measured. The human costs cannot. American society should not be required to bear either cost."

Throughout the Nation questions are being asked concerning the most effective way to deal with this problem. Standards setting forth the results expected from treatment and rehabilitation programs are vague, and frequently there are no standards. Results of various methods of treatment are debated by experts. Data on the number of addicts in the Nation is based on educated guesses, at best. Data on people in treatment throughout the country generally is lacking as is data on program costs and results achieved.

Because of the seriousness of the narcotic addiction problem and the need for information to arrive at rational decisions, the Chairman, Subcommittee No. 4 of the House Committee on the Judiciary, requested GAO to assist the Congress in obtaining information on the progress being made in the rehabilitation of narcotic addicts. The Subcommittee Chairman asked that GAO's review include programs receiving Federal, State, or local funds in five cities--Washington, New York, Chicago, Los Angeles, and San Francisco--and that individual reports be prepared for each.

GAO was asked to obtain for each city data on the amount of money being spent by Federal, State, and local agencies on narcotic rehabilitation programs and the extent of program assessment efforts being made by the funding agencies. GAO was not asked to evaluate program performance.

The Subcommittee is concerned that, in developing legislation related to the treatment and rehabilitation of narcotic addicts, adequate provision be made for program assessment efforts so that the Congress and the executive agencies will have a basis for taking action to improve the programs.

This report is concerned with treatment and rehabilitation programs for narcotic addicts in the District of Columbia funded by the D.C. Government; the Department of Health, Education, and Welfare; the Department of Justice; the Office of Economic Opportunity; and the Veterans Administration. Locations of treatment centers are shown on the map in appendix IV. Treatment agencies not receiving Government funds were not included in our review.

In February 1972 there were nearly 3,800 narcotic addicts receiving treatment in programs supported with Federal or D.C. funds. The amount of funds provided for these programs by the Federal or the D.C. Government was about \$5.9 million for fiscal year 1971. About \$4.7 million of these funds were available for programs administered by NTA.

According to NTA there were approximately 20,000 narcotic addicts in the District of Columbia as of

September 30, 1971. NTA officials admit, however, that they cannot attest to the reliability of the estimate because it is based, in part, on an estimating technique developed in New York City which may have no applicability or validity in the District, and, in part, on several other techniques which rely on a number of unproven assumptions and relationships.

The task of determining with any degree of reliability the number of narcotic addicts in the District, or in any other area, is made extremely difficult because there is no commonly accepted definition for the term "narcotic addict," no reliable or complete reporting system, and no means of identifying a person as a narcotic addict unless he is arrested or enrolls in a treatment program. The methods used by NTA to estimate the number of narcotic addicts in the city and certain other indicators which provide some insight into the size of the District's addiction problem are discussed in appendix III.

An estimate of the annual cost of heroin addiction in the District is provided by a November 1970 report entitled "The Economics of Drug Addiction and Control in Washington, D.C.," prepared by the District's Department of Corrections through its Office of Planning and Research. The report estimated that the annual cost of heroin addiction in the District might exceed \$200 million. This represents an estimated outlay of (1) \$175 million for the illegal acquisition of heroin by addicts, (2) \$8 million for police and court costs, (3) \$9 million for jail and parole expenses, and (4) \$13 million in earnings lost to those addicted to heroin.

The \$175 million estimate was based on the assumption that there were 15,000 addicts in the District and that the cost of an average heroin habit in the District at that time was about \$40 a day. The daily cost of an average heroin habit was based on information obtained by NTA from residents of the District's jail during a study conducted in August and September 1969.

The report states that addicts finance their habits through a combination of means which include (1) "pushing" or selling drugs, (2) prostitution, (3) obtaining funds from family or relatives, (4) working in legitimate, though

low-wage, occupations, especially in the early stages of addiction, and (5) burglary, larceny, and robbery.

The Department's report states that, to estimate the amount of property and money that heroin addicts must steal to support their habits, several assumptions must be made as to how addicts obtain heroin and as to the sources of funds available to heroin addicts. These assumptions, according to the report, are based on discussions with program officials and not on the empirical research which is essential for reaching valid conclusions.

It was assumed in the report that 20 percent of all heroin consumed by the addict population is obtained by pushing. The report points out that this does not mean that 20 percent of all addicts are pushers but that 20 percent of the heroin used by addicts is obtained for services rendered in the distribution system.

The report has assumed, concerning the funds required for heroin purchases, that:

1. 60 percent are obtained through burglary, robbery, and larceny.
2. 15 percent are obtained through legitimate sources.
3. 15 percent are obtained through prostitution.
4. 10 percent are obtained through other illegal activity, such as forgery, auto theft, and confidence games.

It was assumed also that, of the amount gained by theft, 20 percent would be stolen money and 80 percent would be stolen property that could be converted to money for approximately one third of the property's value.

On the basis of these assumptions, the November 1970 report showed that, to obtain the \$175 million needed annually by 15,000 addicts to support their habits, the addicts would steal cash and property valued at \$273 million and would obtain \$22 million through other illegal activities, such as forgery, auto theft, and confidence games; \$33 million through legal activity; and \$33 million through prostitution.

## CHAPTER 2

### NARCOTICS TREATMENT ADMINISTRATION

NTA was established within the Department of Human Resources, District of Columbia, in February 1970 to lead and coordinate a comprehensive community effort to cope with the problem of heroin addiction in the District. The Administrator of NTA informed us that, during NTA's 1st year of operation, primary emphasis was placed on enrolling as many patients as possible and that a variety of treatment modalities was offered at all treatment centers. During NTA's 2d year of operation, the rate at which new patients were added slowed down and NTA began to expand its services from a medically oriented mode of operation to a more comprehensive approach designed to meet patients' total needs (i.e., treatment, education and job placement, etc.). As part of this broadening process, NTA adopted the concept of specialized centers which offered one primary modality of treatment.

NTA's stated objectives are to provide comprehensive and effective treatment for all addicts in the District, to carry out research to increase the understanding of heroin addiction, and to advance a major educational and preventive program aimed at reducing the recruitment of new heroin addicts. Our review considered only the treatment programs of NTA, not its research and education programs.

As requested by the Chairman of the Subcommittee, we obtained the following information on NTA's treatment and rehabilitation programs.

- Program goals.
- Treatment modalities.
- Patients in treatment and services available.
- Source of funding.
- Treatment cost of various modalities.
- Criteria used to select patients for treatment.
- Program assessment efforts.
- Program results.

## PROGRAM GOALS

NTA has four primary goals for all patients.

- Productive and self-fulfilling social functioning in a job or training program.
- Cessation of illegal drug use.
- Elimination of criminal activity.
- Retention in treatment.

## TREATMENT MODALITIES

NTA operates 12 treatment centers throughout the city, including inpatient and outpatient centers and a surveillance unit for persons who must demonstrate that they can remain drug free as a condition of their probation or parole. In addition, NTA has contracts with community-based private agencies to provide services for heroin addicts at four other centers. Two of the 16 centers provide both inpatient and outpatient services, two provide only inpatient services, and the other 12 are outpatient centers. Most of the centers offer one predominant modality of treatment in keeping with NTA's present operating concept of specialized clinics.

NTA's program design makes extensive use of methadone treatment. Methadone is an addictive synthetic narcotic which shares many pharmacologic properties with morphine, heroin, and other opiate drugs. Methadone, when used to treat chronic heroin addiction, has several unique properties. A single dose, taken orally, suppresses withdrawal symptoms in a heroin-dependent person for 24 to 36 hours. If given in large enough doses, it also blocks the euphoric effects of heroin. Additionally, methadone-addicted persons, unlike heroin addicts, do not continually need increasingly larger quantities to prevent withdrawal effects, once their daily doses are in the range of 40 to 80 milligrams of methadone a day.

General categories of treatment, as defined by NTA, are:

- Abstinence--for patients attempting a drug-free life but needing the support of counseling and urine monitoring.
- Methadone detoxification--for patients desiring to withdraw from physical addiction with minimal discomfort. Decreasing dosages of methadone are given on an inpatient or outpatient basis. Methadone detoxification periods are scheduled to range from 2 weeks to 6 months but may be extended beyond 6 months, depending on patient needs.
- Methadone maintenance--for eligible candidates usually at least 18 years old with a minimal 2-year history of heroin addiction who voluntarily consent to treatment. Daily stabilization doses of methadone which satisfy the craving for heroin and block its effects are given over a prolonged period of time.
- Methadone hold--for immediate treatment, with methadone, of walk-in patients prior to determination within no more than 2 weeks of the most appropriate treatment regimen after complete examination, diagnosis, and consultation.
- Urine surveillance--for patients referred for drug use evaluation or needing to demonstrate that they can remain drug free for a specified period of time, i.e., awaiting court action or validation of a motor vehicle license.

NTA's methadone maintenance clinics are designated as induction or stabilization clinics. There is only one induction clinic. This clinic serves new methadone maintenance patients who require from 4 to 6 weeks to become stabilized on blocking doses of methadone. The induction clinic operates 7 days a week because new patients must take their methadone at the clinic and do not have take-home privileges. Once stabilized, the patient is transferred to a stabilization clinic where there is less contact with the clinic and the patient is allowed weekend take-home privileges for methadone. Stabilization clinics operate on a 5-day week. As treatment progresses and the

patient becomes more advanced in the program, secures a steady job, uses no illegal drugs, and generally fits into society as a functional citizen, he may take home as much as a 3-day supply of methadone.

PATIENTS IN TREATMENT AND SERVICES AVAILABLE

Any resident of the District of Columbia who is found to be a narcotic addict is admitted by NTA for treatment. In addition, we were advised by NTA that there is no waiting list for treatment. Briefly during the spring and summer of 1970, intake proceedings had to be stopped because facilities were full. As soon as this situation was remedied, people were again admitted to treatment on a first-come-first-served basis.

Within the first 2 years of its operation, the number of patients enrolled in NTA treatment programs grew considerably. In February 1970 NTA had 153 patients in treatment. The following table shows the treatment modality for all 3,506 reportable patients at NTA or contractor centers as of February 4, 1972.

NTA and Contractor Patient Count  
As of February 4, 1972

	Type	Total patients	Modality			
			Absti-nence	Mainte-nance	Detoxifi-cation	Hold
NTA centers:						
Community Addiction Treatment Center	Outpatient	417	12	403	2	-
Criminal Justice Surveillance Unit	"	214	211	-	-	3
Drug Addiction Medical Service Clinic	"	552	9	509	32	2
Drug Addiction Medical Service--in-patient	Inpatient	58	29	16	11	2
Emerge House	"	27	18	3	6	-
Detoxification-Abstinence Clinic	Outpatient	319	28	3	287	1
Far East Addiction Treatment Service	"	366	16	270	80	-
G Street Clinic	"	298	-	295	3	-
Model Cities Addiction Treatment Program	"	345	-	342	3	-
Narcotic Addict Rehabilitation Corps	Inpatient and outpatient	70	58	11	-	1
Narcotic Addict Rehabilitation Corps Clinic	Outpatient	246	2	243	1	-
Youth Center	"	251	33	55	155	8
Total		<u>3,163</u>	<u>416</u>	<u>2,150</u>	<u>580</u>	<u>17</u>
Contractor centers:						
Neighborhood Treatment Center	Outpatient	99	86	1	12	-
Southeast Neighborhood Action Board--adult	"	134	4	105	16	9
Southeast Neighborhood Action Board--youth	"	31	31	-	-	-
Bonabond Step-one	Inpatient and outpatient	79	79	-	-	-
Total		<u>343</u>	<u>200</u>	<u>106</u>	<u>28</u>	<u>9</u>
Total NTA and contractor centers		<u>3,506</u>	<u>616</u>	<u>2,256</u>	<u>608</u>	<u>26</u>
Percentage of total patients in treatment		<u>100%</u>	<u>18%</u>	<u>65%</u>	<u>16%</u>	<u>1%</u>

Services available at centers differ, depending on such factors as staffing, patient case load, physical limitations of the facility, and the needs of the patients.

All centers offer individual counseling and utilize urine testing to determine illegal drug use. Observed urine specimens are usually taken two times a week.

Most centers also offer some supportive services such as job placement, education and training assistance, health services, housing assistance, financial aid, and assistance in obtaining furniture and clothing. The extent to which such services are provided depends on the availability of staff. We noted that some centers have individual staff members who specialize in job placement or education and training, but most often all of these functions must be performed by the counseling staff in addition to their regular duties. In addition, centers are required to perform an outreach function to seek out patients who have dropped out of the program and to persuade them to return to treatment. The extent to which the outreach function is performed depends on staff availability.

Services available at each of the NTA and contractor centers are more fully discussed in appendix II.

## SOURCE OF FUNDING

Since its organization in February 1970, NTA has received the following financial support.

	<u>Total</u>	<u>Fiscal year</u>		
		<u>1970</u>	<u>1971</u>	<u>1972</u>
District of Columbia appropriation:				
Directly to NTA	\$ 4,914,200	\$354,000	\$2,690,200	\$1,870,000
Indirectly through the Department of Corrections	<u>1,386,500</u>	<u>240,400</u>	<u>417,300</u>	<u>728,800</u>
Total appropriated	<u>\$ 6,300,700</u>	<u>\$594,400</u>	<u>\$3,107,500</u>	<u>\$2,598,800</u>
Federal grants:				
Office of Economic Opportunity	678,300			
Department of Housing and Urban Development	215,200			
National Institute of Mental Health	923,800			
Law Enforcement Assistance Administration	<u>4,217,300</u>			
Total grants	<u>6,034,000</u>			
Grand total	<u>12,334,700</u>			

## TREATMENT COST OF VARIOUS MODALITIES

We were unable to obtain actual per patient cost data for the various treatment modalities because NTA does not accumulate costs on a treatment-center basis. We asked NTA officials to provide us with estimated per patient costs for the various methods of treatment. Since many of the treatment centers operated by NTA offer a combination of treatment methods and services, it was necessary for NTA to develop models for typical treatment centers. NTA chose to develop models for a methadone maintenance center, a detoxification-abstinence center, and a halfway house.

The methadone maintenance and detoxification-abstinence models provided for average staffing patterns, average salary and benefit payments, and estimates of such other operating expenses as travel, equipment, rent, supplies, methadone, and urinalysis. The models also considered the estimated cost of administrative overhead for Department of Human Resources personnel.

The model for the halfway house consisted of a typical operating budget for the residential center at 456 C Street, Northwest, which is a halfway house for patients referred by the criminal justice system. Estimates were included in the budget for NTA centralized treatment support and for Department of Human Resources overhead.

NTA estimated average annual per patient costs, as follows:

<u>Treatment method</u>	<u>Total</u>	<u>Annual per patient costs</u>			
		<u>Direct</u>	<u>Treatment support</u>	<u>NTA administrative direction</u>	<u>Dept. of Human Resources overhead</u>
Outpatient methadone maintenance	\$1,001	\$ 655	\$150	\$110	\$ 86
Outpatient detoxification-abstinence	2,032	1,308	300	220	208
Residential Halfway house	6,225	4,096	938	688	503

It should be noted that the operating costs of the halfway house may be higher than the operating costs of halfway houses in other programs around the country because the patients being treated in the NTA model are parolees from criminal institutions over whom NTA has been assigned custody. More staff is required to maintain custody over these people than is required at halfway houses where patients are admitted voluntarily and are free to leave at any time.

The Administrator of NTA suggested that it would be meaningful to compare the cost of treating addicts with the cost to society of not treating them. As indicated on page 8, the Department of Corrections estimated that annually 15,000 addicts steal cash and property valued at \$273 million and obtain another \$22 million through such other illegal activities as forgery, auto thefts, and confidence games. This amounts to an approximate \$20,000 annual loss to society caused by each addict's criminal activities.

A comparison of the estimated loss to the cost of treating an addict, assuming that the cost estimates are valid and the addict's criminal activities are reduced during treatment, would suggest that the cost of treatment is well worthwhile. We cannot endorse such a conclusion, however,

because we did not verify the validity of the estimated cost of treatment or the estimated cost to society from untreated heroin addiction and because we did not obtain complete information on the extent of addicts' criminal activities before and after entry into treatment.

CRITERIA USED TO SELECT  
PATIENTS FOR TREATMENT

Any resident of the District of Columbia is eligible for treatment by NTA. All applicants for treatment by NTA, whether voluntary or court-recommended, are examined and processed at one central intake facility. Basically, this central facility consists of a medical section and a counseling-intake section. The facility's operations are funded through a grant from the Law Enforcement Assistance Administration of the Department of Justice.

The medical section is responsible for performing a physical examination, which includes blood studies, urinalysis, X-rays, and electrocardiograms, and for obtaining a medical history of each applicant.

The counseling-intake section, in addition to confirming an applicant's age, identification, and referral source, is responsible for counseling and assisting each applicant. Counselors ensure that each person becomes familiar with the program and understands the services available from NTA, including the role of methadone in the control of drug abuse.

Each new applicant is extensively interviewed by a counselor who obtains and records information on employment, educational, military, criminal, and social histories. An extensive drug-abuse history, including a medical opinion as to the extent of drug abuse, is also completed for each applicant. A decision as to the appropriate treatment modality is made jointly by the counselor and the patient. Physicians are available for consultation in this process. After the treatment modality is agreed on (methadone maintenance, methadone detoxification, or abstinence), the patient is sent to the appropriate NTA treatment center. A summarization of important social and medical needs of the patient is sent to the treatment center by the intake unit.

At the treatment center the patient is assigned a permanent counselor and the specific treatment needs, including the dosage level of methadone for the patient, are determined. The treatment recommendations made by the intake unit do not have to be followed if center personnel have reason to believe that they are not appropriate.

## PROGRAM ASSESSMENT EFFORTS

In its 2 years of operation, NTA's program assessment efforts have consisted primarily of follow-up studies for selected patients in four of its treatment programs and at four contractor treatment centers. Data on retention in treatment, arrests, employment, and illegal drug use for the patients is collected and compared with NTA's four primary goals of treatment.

Data utilized to measure the progress of NTA programs is obtained primarily from four different sources--the central intake unit, the individual treatment centers, the urine-testing laboratories, and the Department of Corrections. Much of this data is entered into a centralized computer file system which allows the preparation of reports concerning the effectiveness of treatment methods. At the time of our review, a number of new reports were being prepared which should provide NTA officials with a means for continually assessing the effectiveness of their programs. The NTA data collection systems and the reports being generated by the system are discussed in chapter 3.

In May 1970, 3 months after NTA began operations, its Bureau of Research initiated a study aimed at providing information to enable it to evaluate the results of its treatment programs on 600 randomly selected patients. The patients selected were from the Community Addiction Treatment Center (CATC), the Drug Addiction Medical Service (DAMS) outpatient clinic, the Narcotic Addiction Rehabilitation Corps (NARC) residential halfway house, and the Youth Center--the only centers operated by NTA at that time. For each program 150 patients were selected from those people on the program rolls in May 1970. According to NTA, a total of 1,060 heroin addicts were in treatment on May 15, 1970.

Since May 1970, NTA has been collecting data for the 450 adult patients and 150 youths, by which to measure such factors as retention in treatment, the number of times each patient has been arrested, the extent to which the patients are employed or in a training program, and the extent to which each patient is continuing to engage in illegal drug use. Statistical summaries of program results for this study group have been prepared by NTA at 6 month intervals--

the latest being November 15, 1971. Also, a more comprehensive analysis was prepared to show data for patients as of May 15, 1971--1 year after initiation of the study.

In addition, a new study was initiated in January 1971 of 379 patients at the same four centers. The objectives of this study are to measure the same factors discussed above. We were also advised that NTA's Bureau of Research was making a comparative study of the effects of treatment on patients who entered NTA treatment programs voluntarily as opposed to those who entered via the criminal justice system. NTA estimates that this study will be completed around April 1972. In addition, NTA has collected data on the results being achieved by four of its contractors.

## PROGRAM RESULTS

Program results as shown by NTA's assessment efforts are discussed below. Patients in youth programs were primarily in methadone detoxification treatment while those in the adult programs were primarily methadone maintenance patients. NTA stated that its youth programs differ significantly from its adult programs and that the two should be considered separately.

We have not drawn any conclusions from the information summarized below because NTA has not established standards as to what constitutes acceptable program results. We did not verify the results reported by NTA.

### Results achieved by NTA adult programs

As of May 15, 1971, 12 months after the start of the study, NTA found that, of the 450 patients:

- 232 (52 percent) were still in NTA treatment programs;
- 104 (23 percent) were arrested sometime during the 1-year period;
- 109 (24 percent) of the original group were employed or in training, either full- or part-time;
- 160 of the 232 patients who remained in treatment had their urinalysis results studied during the 12th month of the study: 72 (45 percent) tested positive for illegal drug use during the month--five (3 percent) tested positive every time and 67 (42 percent) tested positive some of the time--and 88 (55 percent) tested negative every time.

A summary analysis of the 12-month study showed that, overall, 105 (24 percent) of the 450 adult patients were retained in treatment for 1 year and met all program goals. An additional 127 (28 percent) were retained 1 year but did not meet one or more of the program goals.

NTA found that those patients who had elected to be placed on methadone maintenance were more likely to remain in treatment and satisfy all program goals than were those in detoxification or abstinence programs. Moreover, NTA stated that those patients on high doses of methadone (60 milligrams or more) were more likely to remain in treatment than patients on low-dose methadone.

As of November 15, 1971, 18 months after the start of the study, NTA found that, of the 450 adult patients:

- 208 (46 percent) were still in NTA treatment programs;
- 126 (28 percent) had been arrested sometime during the 18-month follow-up period;
- 76 (17 percent) of the original group were still in treatment and were employed or in a training program;
- 109 of the 208 patients who remained in treatment had their urinalysis results studied during the period October 24 to November 21, 1971: 34 (31 percent) tested positive for illegal drug use during the 1-month period--seven (6 percent) tested positive every time and 27 (25 percent) tested positive some of the time--and 75 (69 percent) tested negative every time.

NTA's summarization of the results of the 18-month study showed that 84 (19 percent) of the 450 adult patients studied met NTA's program goals of (1) retention in treatment, (2) employment or training, (3) arrest free, and (4) cessation of illegal drug use, either completely or on a regular basis. An additional 124 adult patients (27 percent) had been retained in treatment for 18 months but had not satisfied one or more of the other NTA program goals.

According to NTA, employment posed the largest problem in the rehabilitation process. Of the 450 patients, 137 (30 percent) were retained in treatment, were arrest free, and were not using illegal drugs, except on a sporadic basis, but were not employed at the time the study was made. The summarization noted also that, after 18 months, it was

likely that at least some of the dropouts represented patients who had completed treatment and were living productive lives in the community.

A graph illustrating the results of the first research study for each of the adult and youth programs after 18 months is shown on page 27.

With respect to NTA's second research study involving 272 adult patients in the same three treatment programs discussed above, its Bureau of Research found after the first 6 months that, of the 272 patients:

- 131 (48 percent) were still in NTA treatment programs;
- 36 (14 percent) had been arrested sometime during the 6-month follow-up period;
- 49 (18 percent) of the original group were still in treatment and were employed or in a training program;
- 112 of the 131 patients who remained in treatment had their urinalysis results studied during the last 4 weeks of the 6-month period: 71 (64 percent) tested positive for illegal drug use during the 4-week period--13 (12 percent) tested positive every time and 58 (52 percent) tested positive some of the time--and 41 (36 percent) tested negative every time.

#### Results achieved by NTA youth programs

As of May 15, 1971, 12 months after the start of the study of the youth programs, i.e., those for patients under 20, NTA found that, of the 150 youths:

- 24 (16 percent) were still in NTA treatment programs;
- 81 (54 percent) were arrested sometime during the 12-month period;
- 13 (9 percent) were still in a treatment program and were employed or in a training or educational program;

--23 of the 24 youths who remained in treatment had their urinalysis results studied during the period April 11 to May 8, 1971: six (26 percent) tested positive for illegal drug use during the 1-month period--one youth (4 percent) tested positive every time and five (22 percent) tested positive some of the time--and 17 (74 percent) tested negative every time.

As of November 15, 1971, 18 months after the start of the study, NTA found that, of the 150 youths:

--27 (18<sup>(1)</sup> percent) had remained in NTA treatment programs;

--92 (61 percent) were arrested at sometime during the 18-month period;

--11 (7 percent) were still in a treatment program and were employed or in a training program;

--21 of the 27 youths who remained in treatment had their urinalysis results studied during the period October 24 to November 21, 1971: 11 (53 percent) tested positive for illegal drug use during the 1-month period--six youths (29 percent) tested positive every time and five youths (24 percent) tested positive some of the time--and 10 (47 percent) tested negative every time.

The Bureau of Research reported that, after 18 months, only two (1 percent) of the 150 youths included in the study group had remained in treatment for 18 months, were employed, were arrest-free, and were either not using any illegal drugs at all or were not using illegal drugs on a regular basis. An additional 18 youths (12 percent) remained in treatment but failed to satisfy one or more of the other program goals.

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<sup>1</sup>The percentage of patients retained after 18 months is higher than the percentage retained after 12 months because it includes three patients who dropped from the treatment program and subsequently returned.

A comparison of the results of the first youth program study with the first adult program study is shown by the graphs on page 27.

With respect to NTA's second research study involving 107 patients in treatment in the youth program, its Bureau of Research found after the first six months of treatment that, of the 107 youths:

- 45 (42 percent) were still in NTA treatment programs;
- 27 (25 percent) had been arrested sometime during the 6-month follow-up period;
- 19 (18 percent) of the original group were still in treatment and were employed or in a training program;
- 35 of the 45 patients who remained in treatment had their urinalysis results studied during the last 4 weeks of the 6-month period: 21 (60 percent) tested positive for illegal drug use during the 4-week period--two (6 percent) tested positive every time and 19 (54 percent) tested positive some of the time--and 14 (40 percent) tested negative every time.

Results achieved by NTA contractors

To evaluate the effectiveness of its contract programs, NTA made a study of 302 addicts being served by four contractors. The number of patients selected for the study entered treatment programs at the following facilities during the period September 15, 1970, through January 14, 1971.

Southeast Neighborhood Action Board (SENAB)	88
Bonabond, Step-one	81
Blackman's Development Center (BDC) (note a)	81
Neighborhood Treatment Center (NTC) and Residential Treatment Center (RTC) (note b)	<u>52</u>
Total	<u>302</u>

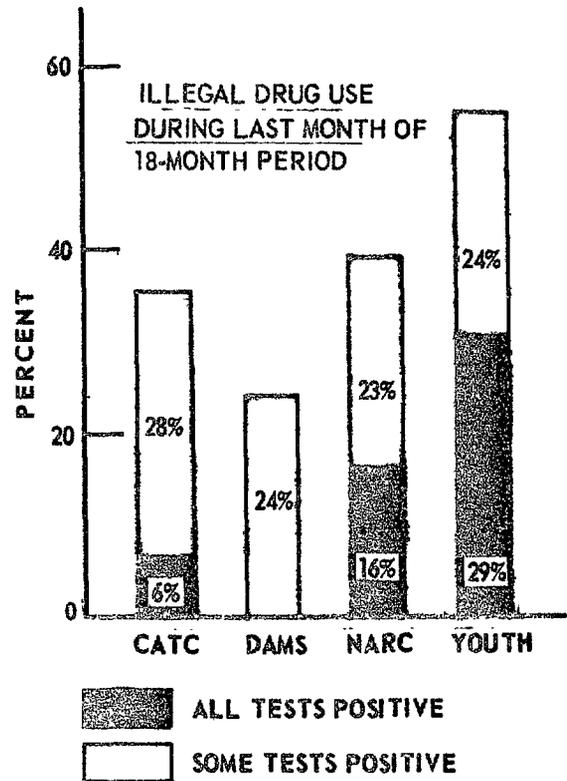
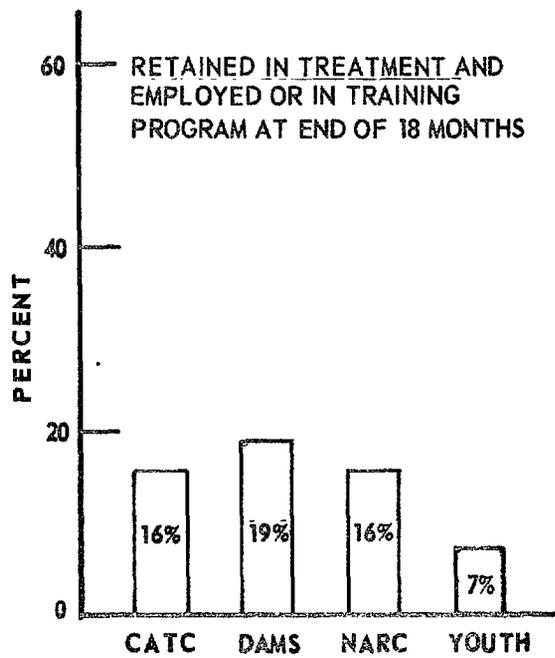
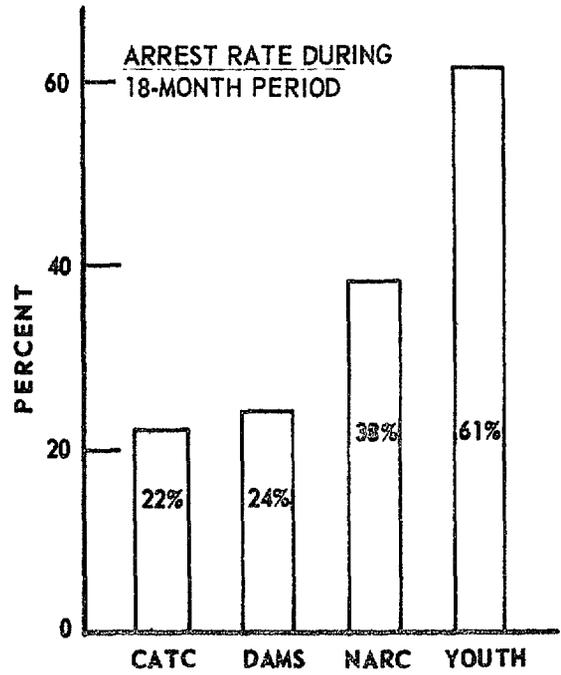
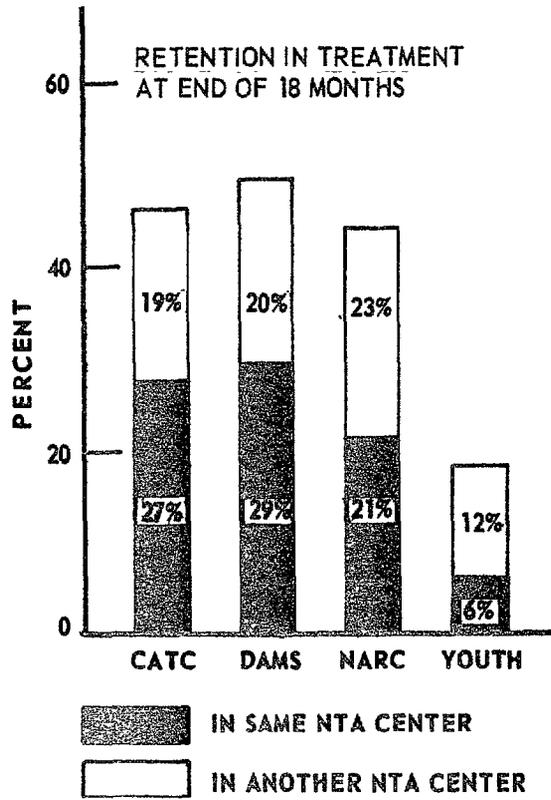
<sup>a</sup>At the time of our review, BDC was no longer an NTA contractor.

<sup>b</sup>Both NTC and RTC are located in the same building. Although RTC has never been an NTA contractor, it was included in the study because of its proximity to NTC.

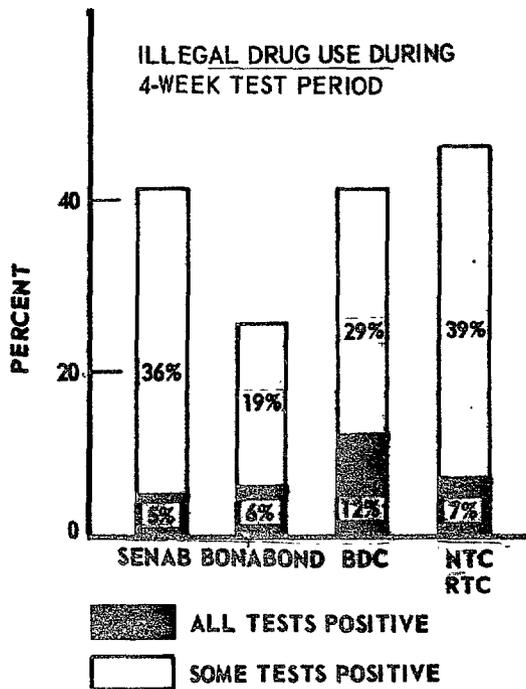
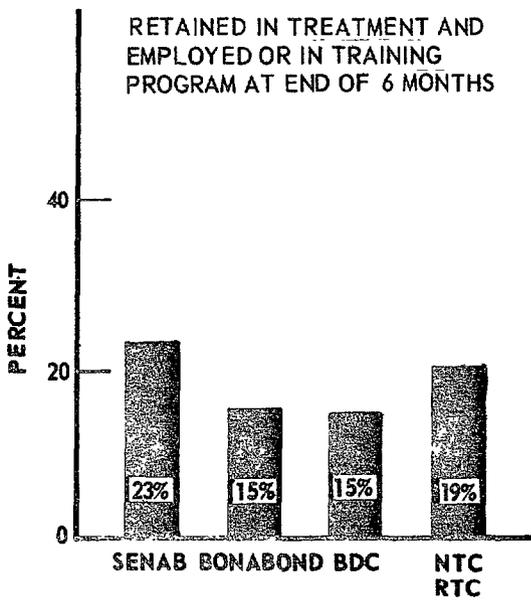
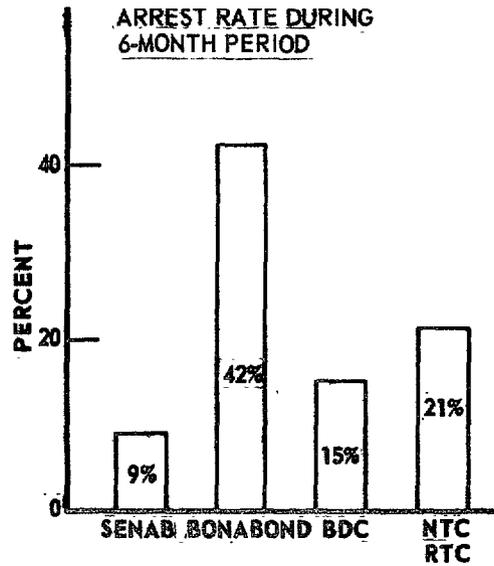
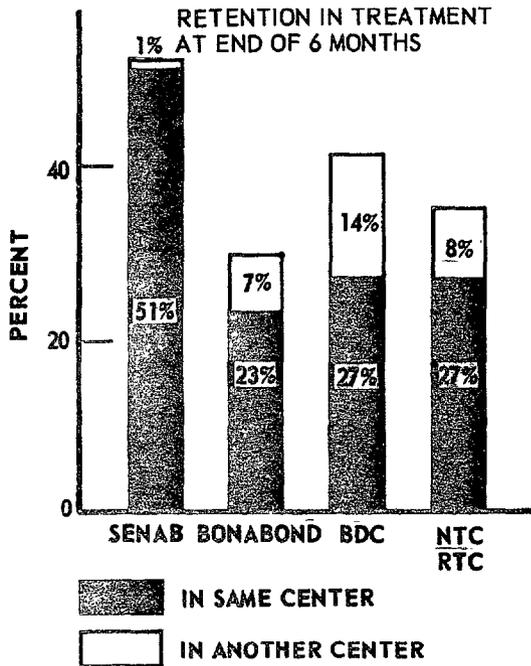
Some of the findings disclosed by this study are illustrated graphically on page 28. In summary, the study showed that, after 6 months

- each of the four contractors had 52 percent or less of the original group still in treatment;
- 23 percent, or less, of each of the original groups were employed or in training programs, on either a full- or part-time basis;
- for each of the four contractors, 9 to 42 percent of the original group had been arrested during the 6-month period; and
- for each of the four contractors, 25 to 46 percent of those tested during a 4-week period showed some indication of illegal drug use.

**SUMMARY OF 18 - MONTH FOLLOW - UP STUDY OF NTA PATIENTS**



## SUMMARY OF 6 - MONTH FOLLOW - UP STUDY OF CONTRACTOR PATIENTS



## CHAPTER 3

### ADDITIONAL INFORMATION ON NTA PROGRAM RESULTS

#### AND NTA DATA COLLECTION SYSTEM

To obtain additional information on the results of NTA's drug treatment programs, we analyzed reported information for selected groups of patients at two NTA treatment centers--the Youth Center and the Community Addiction Treatment Center. In addition, we considered the adequacy of NTA's data collection system to provide information for program assessment purposes.

#### PROGRAM RESULTS AT THE YOUTH CENTER

To obtain an indication of program retention rates and illegal drug use, we selected for study a group consisting of the entire case load of patients--293 youths--receiving treatment at the Youth Center as of April 11, 1971. At that time about 63 percent of the youths were methadone detoxification patients.

The month of April was selected because this was the first month that urinalysis data was available on the patient monthly record printouts from the NTA central computer file system. For the period April through November 1971, we examined the monthly printouts to determine the number of the 293 patients who dropped out of NTA treatment programs and the number who used illegal drugs while in treatment, as shown by urinalyses. We did not analyze data for new patients entering treatment after April 11, 1971.

Our analysis showed that, during the 8-month period, 169 patients, or 55 percent of the test group, dropped out of NTA treatment programs. Our analysis showed also that a relatively consistent percentage of patients continued to show signs of illegal drug use each month, as illustrated by the schedule on page 30.

Month	Test group patients remaining in program	Patients using illegal drugs once		Patients using illegal drugs twice		Patients using illegal drugs three or more times	
		Number	Percent	Number	Percent	Number	Percent
April	278	79	28	22	8	59	21
May	203	44	22	23	11	37	18
June	186	45	24	28	15	39	21
July	158	35	22	17	11	20	13
August	149	35	24	12	8	25	17
September	145	46	32	17	12	25	17
October	129	32	25	12	9	21	17
November	124	24	19	9	7	13	11
Average percent of illegal drug use			25		10		17

We found that patients frequently would be "dirty" (use illegal drugs) one month and be "clean" (not use illegal drugs) the next month. What this appears to show is that a large percentage of the youths continuing in treatment at the Youth Center are continuing to use illegal drugs on an intermittent basis. This can best be illustrated by the following tabulation of individual case records.

1971	Patient 1		Patient 2		Patient 3		Patient 4		Patient 5	
	Dirty tests	Total tests								
April	2	10	2	11	4	4	8	8	-	6
May	-	15	1	7	3	13	5	10	-	5
June	1	12	-	6	1	11	6	6	1	8
July	-	9	-	-	-	9	3	9	-	9
Aug.	3	12	1	1	-	1	3	7	1	12
Sept.	-	11	1	1	-	-	7	10	-	11
Oct.	1	9	3	8	5	8	1	6	-	9
Nov.	-	10	-	4	-	10	3	8	-	11

As can be seen by the above tabulation, some patients would go several months without having dirty urine tests and then would produce dirty urine tests during the next several months. In other cases there was evidence of continued illegal drug use each month by the patients, either part of or all the time. In still other cases the rate of illegal drug use was very nominal.

PROGRAM RESULTS AT THE  
COMMUNITY ADDICTION TREATMENT CENTER

As of April 11, 1971, there were 558 male and female patients receiving treatment at the Community Addiction Treatment Center. Most of the patients were adults receiving methadone maintenance treatment. Our analysis of reported information showed that, as of mid-February 1972, 274, or 49 percent, of these 558 patients had dropped out of NTA treatment programs.

We also analyzed the results of the urine tests for the period April 1971 to February 1972. Our analysis showed that an average 21 percent of the patients tested each month were positive for illegal drug use once during each month, an average 11 percent were positive for illegal drug use twice during each month, and an average 17 percent were positive for illegal drug use three or more times during each month. The results of this analysis are comparable to the results of the analysis at the Youth Center. (See p. 30.)

To get an indication of whether the patients in treatment were being arrested, we also searched records at the District jail for the period April 1971 to February 1972. These records showed the names of all males arrested and detained at the jail. These records did not show the names of males arrested but released on bond after a hearing or the names of women arrested. Consequently our findings, as discussed below, probably understate the actual arrest rate.

We found that 43, or 10 percent, of the 417 male patients registered at the Community Addiction Treatment Center on April 11, 1971, were arrested and detained at the District jail sometime during the 10-month period. Of these 43 patients, 29 were arrested once, 12 were arrested twice, and two were arrested three or more times. The most common charges for those arrested were possession of narcotics, larceny, and robbery. During the month of their arrests, 26 of the 43 patients were active in the program.

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We have not drawn any conclusions from the results of the work performed at the Youth Center and at the Community

Addiction Treatment Center, because, as stated on page 21, NTA has not established standards as to what constitutes acceptable program results.

## NTA DATA COLLECTION SYSTEM

As stated previously much of the data required to enable program officials to make assessments of program effectiveness is gathered from four different sources--the central intake unit, the individual treatment centers, the urine-testing laboratories, and the District of Columbia Department of Corrections. At the central intake unit, a complete medical and drug history is obtained from each patient, along with his criminal history. The treatment centers generate data on the number of contacts with each patient; number of urine specimens taken; category of treatment that the patient is in; number of counseling sessions in which the patient participates; employment status of the patient; and the number of milligrams of methadone, if applicable, that the patient is given each day. The urine specimens are analyzed at two contract laboratories for the presence of narcotics, and the results are reported to NTA.

At the time of our review, much of the data generated was being entered into a computerized central file system at NTA's Bureau of Computer Systems. Some of the reports being produced by this system prior to the start of our review were:

- Biweekly urine report--An alphabetical listing of all patients by treatment center showing the test results of each urinalysis.
- Master patient register--An alphabetical listing, produced weekly, of all registered patients. The report includes for each patient such information as the date the patient entered into treatment, the date of last contact with the patient, the treatment center to which the patient is assigned, and the treatment modality in which the patient is registered.
- Methadone and counseling report--An alphabetical listing, by treatment center, showing the days each patient received counseling and methadone and the quantity of methadone the patient was given.
- Patient monthly record--A report listing the treatment activity of every patient, including methadone

given, counseling received, the results of urinalyses, and employment status.

We noted that a number of new reports initiated after December 1971 contained summary data for all patients at a center and for all NTA patients. Some of these reports were:

- Methadone inventory report--A monthly report, by treatment center, showing the total quantity of methadone dispensed each day and the number of patients receiving methadone.
- Weekly inactive report--An alphabetical listing, by center, of the patients who became inactive (no contact with the program for 14 days) in the 1-week period preceding the report. This report allows centers to initiate outreach work promptly.
- Weekly report on patient population (in three parts)-- This report shows and summarizes by centers and all NTA patients (1) new admissions by race, sex, age, and referral source, (2) reason for patients' dropping out, if known, (3) dropout analysis, including patients' referral source, time in treatment, last methadone dosage, counseling received during last 2 weeks, percentage of illegal drug use in last 2 weeks, duration of illegal drug use, age, modality, sex, race, and employment status.
- Patient profile report--Summarizes, by center and for all NTA patients, the age, employment or education status, marital status, duration of addiction, percentage of dirty urine tests in last 2 weeks, number of times admitted to program, and schooling completed.
- Urine and counseling summary--A monthly report by center showing how many patients gave urine specimens, the total number of specimens taken, how many patients received counseling, and the total number of counseling sessions. Data is summarized by centers and for all NTA patients.

--Dropout analysis report--Provides summary information on patients who dropped out of the program. Includes information on age, sex, race, employment status, marital status, education, length of addiction, number of times admitted to treatment, time in treatment, and last dosage of methadone for all dropouts.

At the time of our review, no reports were being produced that showed arrest data. To date arrest data has been obtained by NTA only for those patients included in studies made by the Bureau of Research. This data was obtained by manually searching District jail arrest files and records of the juvenile court. NTA officials informed us that they would be able to obtain magnetic tape records of arrests from the Police Department, which should increase their ability to determine whether any NTA patients had been arrested.

We believe that the information included in the reports currently being produced should provide a means for continually assessing program results.

## CHAPTER 4

### PROBLEMS AT TREATMENT CENTERS IN THE

#### DISTRICT OF COLUMBIA

As part of our review, we visited all the treatment centers of NTA and its contractors to obtain information on problems being encountered, operational needs of the centers, and ways in which the drug treatment process could be improved. At most centers we spoke with the administrator or his assistant and sometimes with some of the counselors and patients. The most frequent responses from these persons follow.

- Additional and better trained staff members are needed to provide more effective services to patients.
- Additional supportive services, such as job placement, training, and recreation, are needed for patients.
- Better physical facilities are needed for patients.

#### STAFF AND STAFF TRAINING

Most of the treatment center administrators and their staff members informed us that one of their greatest needs was for additional and better trained staff members. For example, several treatment center administrators stated that one of the greatest needs of their counselors was training in basic writing and communication skills. Others told us that they needed more staff members in order to better serve patients' needs.

The administrator of one treatment center, where the patient-to-counselor ratio was 94 to 1 at the time of our visit, stated that he needed additional staff members and that he felt that more professional employees were needed to provide supportive services. At another center the administrator expressed the opinion that an effective patient-to-counselor ratio was about 25 to 1 as opposed to the 56 to 1 ratio that existed at his center at the time of our visit. This administrator stated also that professional staff

members were needed to handle supportive services and that an outreach team could be used to contact patients who had dropped out of the program to encourage them to return.

The administrator of another center advised us that he presently had enough staff members but indicated that a high turnover of staff members, as a result of employees' being transferred to better jobs at other NTA facilities, had caused his center to be less effective than it could have been.

At another center the administrator told us that most counselors never had held jobs or never had been given any responsibilities prior to coming with NTA. The administrator said that, although these counselors performed well in most cases, he felt that they were hampered in carrying out their duties because of a lack of training and experience.

#### SUPPORTIVE SERVICES

Detoxification or stabilization of an addict usually is only the beginning of the treatment process for narcotic addiction. Experts have stated that detoxification (the process of eliminating an addict's physical addiction to heroin) usually can be accomplished in a relatively short period (up to 2 weeks) in an inpatient or outpatient surrounding. Stabilization of an addict on methadone to a point where the methadone eliminates the craving for heroin and blocks the euphoric effects of heroin usually can be accomplished in a few weeks.

After a heroin addict is detoxified or stabilized on methadone, the treatment process does not, and should not, end. According to experts in the field of narcotic addiction and many of the administrators of NTA's treatment centers, many addicts are in need of more education, job training, and psychological assistance. Many require job-placement assistance.

NTA has recognized the need for such supportive services, and many of its treatment centers have attempted to provide these services. As indicated in the preceding section of this chapter, however, many of NTA's treatment centers are in need of additional counselors, particularly

counselors having the training and skills necessary to provide supportive services.

One administrator of an NTA treatment center informed us that there was a need for such additional supportive services as job training and placement, particularly in fields where job opportunities existed. Another treatment center administrator stated that his center's greatest need was for job opportunities for patients. According to this administrator job opportunities for ex-addicts are particularly difficult to develop.

The administrator of one center told us that the main problem at his center was boredom on the part of patients, due to a lack of organized activities. At the Youth Center, which serves only persons under 21 years of age, we observed that, outside of an outdoor basketball hoop on a post in the parking lot, there was little recreation equipment. The administrator advised us that he hoped to obtain some recreation equipment in the near future. He also told us that there was an even more pressing need for jobs and job training for the youths at the center.

#### PHYSICAL FACILITIES

For the most part the treatment centers we visited in the District of Columbia were located in buildings ranging from old residences, usually in need of repair, to converted warehouses. At a number of centers, the condition or size limitations of the physical facilities appeared to hamper operations. For example, individual counseling had to be done in large open rooms with several counselors and patients sharing the rooms. In other cases the facility was in such bad physical condition that it could not possibly add to the desire of a patient to stay in the program.

We met with the Administrator, NTA, to discuss our observations at the treatment centers. At this meeting the Administrator explained that, during NTA's 1st year of operation, emphasis was placed on growth and that as many patients as possible were enrolled in treatment programs. NTA's 2d year of operation, according to its Administrator, involved a lower growth rate than the 1st year but its efforts were concentrated on broadening supportive services

for its patients and restructuring many treatment centers to offer specialized treatment, such as methadone maintenance or detoxification. In NTA's 1st year, most centers offered all modalities of treatment.

Currently, according to the Administrator, NTA is becoming increasingly concerned about the total human needs of each patient. NTA attempts to meet as many of the patient's needs as possible at the individual treatment centers and to act as a "broker" to arrange for services to be provided by other agencies when NTA itself cannot provide them. The Administrator has stated that NTA never should expect to meet all the needs of its patients because to do so would involve duplicating many social service functions--job training and placement and education--provided by other governmental agencies. The Administrator has stated also that NTA therefore has to find some middle ground in this area in which to operate.

The Administrator acknowledged that the need for additional and better trained counselors was a problem. Most of NTA's counselors are ex-addicts. He advised us that ex-addict counselors usually functioned quite well but indicated that many of them resisted training which would make them more effective. He indicated that NTA needed to work on this problem and to hire more professionals as counselors.

## CHAPTER 5

### INFORMATION ON OTHER TREATMENT PROGRAMS

#### RECEIVING GOVERNMENT FUNDS

In addition to NTA programs, there are four other programs in the District of Columbia that are supported by Federal or District of Columbia funds. The location of the centers operated as part of these programs are shown on the map which is included as appendix IV. The table below shows the number and treatment status of patients as of February 1972.

Program	Type	Total patients	Patients by modality		
			Absti-nence	Mainte-nance	Detoxi-fication
Saint Elizabeths Hospital-- Last Renaissance	Inpatient	26	26	-	-
Veterans Administration Hospital	Inpatient and outpatient	117	-	102	15
Narcotic Addict Rehabilitation Act--aftercare	Outpatient	84	71	13	-
D.C. Department of Corrections work release program-- Residential Treatment Center	Inpatient	<u>24</u>	<u>19</u>	<u>3</u>	<u>2</u>
Total		<u>251</u>	<u>116</u>	<u>118</u>	<u>17</u>

#### SAINT ELIZABETHS HOSPITAL--LAST RENAISSANCE

This therapeutic community, modeled after Synanon in California and Phoenix House in New York, has been operating since July 1970 and is located in Holly House at Saint Elizabeths Hospital. Last Renaissance is funded as part of the hospital's operation by the National Institute of Mental Health. Since the opening of the program, about 200 applicants have been accepted. About half of the patients drop out of the program within the first 3 months. At the time of our review, there had been 12 patients who had met all the program's goals before leaving Last Renaissance.

Patients are limited to residents of the Southeast area of the District. Admission to the program is through an interview process which attempts to determine whether

the applicant has a genuine desire to rid himself of the use of drugs. Before admission to the house, all patients must be detoxified with methadone at the hospital or without drugs at Last Renaissance.

The goals of the program are to free persons from drug use and to give them a new value system and improved life style. Upon entry to the drug-free program, patients are not permitted contact with anyone outside the Last Renaissance community for at least 6 weeks. This is done to orient them to the life style of the community and to help them stay with the program.

Patients live in the community voluntarily and may leave at any time. Treatment consists of (1) group sessions held once a week, (2) encounter groups held three times a week, and (3) individual counseling on request. As a patient progresses within the program, he enters the reentry phase which consists of getting a job so that he can be ready to reenter society as a productive citizen when he leaves the program. Both the individual and the staff share in the decision of when the patient is ready to leave the program. This decision is based largely on the patient's progress in the program and his motives for leaving. The success of the program is measured by the return of the patients to the community as productive citizens.

Because Last Renaissance is funded as part of Saint Elizabeths Hospital, there is no cost directly attributable to the program other than the hospitalwide per diem rate of \$41.09. On the basis of an average population of 30, the program would cost approximately \$450,000 annually, or about \$15,000 a year for each patient.

#### VETERANS ADMINISTRATION HOSPITAL

Methadone detoxification, methadone maintenance, and abstinence treatment are available to inpatients and outpatients at the Washington, D.C., Veterans Administration Hospital. Admission to the treatment program is available to any eligible veteran. Patients may be referred by other agencies or may simply walk in. The goal of the program, which has been operating for about 1 year, is to help each patient obtain a meaningful life style, which includes

(1) relief from physical pain, (2) a feeling of "belonging" by involvement in the program, and (3) self-esteem resulting from his ability to find employment and to manage his own affairs outside the program.

After a patient is admitted to the program, a physician and the patient determine the most suitable method of treatment. Mental attitude and vocational abilities are ascertained to establish specific therapy and treatment needs. Treatment consists of group therapy, urine surveillance, and individual counseling. Family therapy to assist in the rehabilitation of the patient is also available. Supportive services offered by the drug treatment unit are being expanded.

Program assessment consists of consideration of (1) the retention rate, (2) patient participation in the program, (3) interrelation between staff and patients, and (4) staff satisfaction with individual patient's progress in the program. This assessment does not involve a formal procedure but does involve personal contact of the program director, staff, and patients.

The program director told us that there were no overall statistics available on persons dropping out of or completing the program. We were advised by the Veterans Administration that a data collection system was initiated in January 1972. Statistics compiled showed that in January 1972 seven inpatients had completed treatment, 29 inpatients had transferred to the outpatient program, three outpatients had transferred to the inpatient program, and 81 outpatients had dropped out of the program without completing treatment.

On the basis of per diem rates for the drug program at the hospital, the annual cost would be about \$16,300 for an inpatient and about \$1,370 for an outpatient. With an average annual count of 20 inpatients and 100 outpatients, the total annual cost would be about \$463,000. The treatment unit has a staff of about 35 and is planned for a total patient load of 200.

## NARCOTIC ADDICT REHABILITATION ACT

The Narcotic Addict Rehabilitation Act, passed in 1966 (28 U.S.C. 2901), provides for:

- Pretrial civil commitment for treatment, in lieu of prosecution, of addicts charged with certain Federal crimes (title I).
- Sentencing to commitment for treatment of addicts convicted of certain Federal crimes (title II).
- Civil commitment for treatment of addicts not charged with criminal offenses (title III).

Titles I and III of the act are administered by the National Institute of Mental Health. Inpatient treatment is given at either the Lexington, Kentucky, clinical research center or at a contractor facility. This phase of treatment occurs after it has been determined that an addict is suitable for treatment. Following the inpatient phase of treatment, the patient receives aftercare from a community organization under contract with the National Institute of Mental Health.

Title II is administered by the Bureau of Prisons, Department of Justice. Inpatient care is provided at a Federal correctional institution. Upon the patient's release from the institution, aftercare is provided in the community by an organization under contract with the Bureau of Prisons.

We were informed that under all three titles there were 84 patients undergoing aftercare as of February 7, 1972. The Bureau of Rehabilitation of the National Capital Area is the present aftercare contractor for both the National Institute of Mental Health and the Bureau of Prisons.

Aftercare consists of (1) individual therapy, (2) group therapy, (3) urine surveillance, (4) training, (5) job placement, (6) assistance--money, clothing, housing--as needed, (7) family counseling, and (8) medical aid. Those aftercare patients on methadone maintenance receive their medication at one of the NTA clinics. Although aftercare generally is rendered on an outpatient basis, such

treatment, if the counselor believes that a patient would benefit from a short stay in a residential treatment setting, can be provided in one of the residential facilities that the Bureau of Rehabilitation operates.

Assessment efforts are directed toward the individual rather than toward the program as a whole. Factors considered include (1) urinalysis results, (2) employment, (3) patient's attitude, (4) change in life style, and (5) family relationship.

The Bureau of Rehabilitation started furnishing after-care for the title II program in August 1969 and for the title I and III programs in September 1969. The following table summarizes available data on program results through February 7, 1972.

	<u>Titles I and III</u>	<u>Title II</u>
Total number of patients	80 <sup>a</sup>	87
Patients active in program	36	48
Patients successfully completing program	6	(b)
Patients discharged as failures	25	-
Patients recommitted to Clinical Research Center	3 <sup>c</sup>	-
Patients violating provisions of the act and returned to institution	-	39
Patients to be recommitted but still on the streets (note d)	8	-
Patients transferred to another after-care agency	2	-

<sup>a</sup>Includes patients transferred to the Bureau of Rehabilitation when it became the aftercare contractor.

<sup>b</sup>This is a 3-year program, and there have been no completions since the Bureau of Rehabilitation became the aftercare contractor.

<sup>c</sup>As of February 7, 1972, only three recommitments were at the Clinical Research Center. Twenty others had been recommitted but were back in aftercare, or had successfully completed the program, or had been discharged from the program.

<sup>d</sup>Patients whose performance was unsatisfactory and who were recommended for recommitment to the Clinical Research Center.

Contract cost data follows.

	Fiscal year 1971 <u>actual</u>	Fiscal year 1972 <u></u>
National Institute of Mental Health contract	\$82,725	Not to exceed \$191,245
Bureau of Prisons contract	71,300	Not to exceed \$155,225.76

The Bureau of Prisons contract provides for a monthly cost for each patient of about \$100. The National Institute of Mental Health contract is a cost-reimbursement contract with the cost for each patient being determined by actual services received.

D.C. DEPARTMENT OF CORRECTIONS  
WORK RELEASE PROGRAM--  
RESIDENTIAL TREATMENT CENTER

The District of Columbia Department of Corrections operates a work release program which permits a person convicted of certain offenses to be released to work at his employment or to seek employment when such a privilege is deemed justifiable by the judge of the sentencing court. The privilege may be granted at the time sentence is imposed or later. It may be revoked at any time, either by the Department of Corrections or by the court.

The Department of Corrections has 13 halfway houses functioning in this program. Only two, however, are used for the treatment of narcotics addicts. One--the Narcotic Addict Rehabilitation Corps--is operated by NTA. The other--the Residential Treatment Center--is contractor operated.

The Residential Treatment Center is operated by the Bureau of Rehabilitation of the National Capital Area. A staff of approximately 11 provides services to an average population of 24 males. Patients are required to attend individual counseling services twice a week, to participate in group therapy sessions at least four times a week, and to give observed urine specimens three times a week. The center also offers family therapy, vocational assistance, job placement, and short-term financial assistance.

Evaluation of the program's success is centered primarily around measures of the patients' performance, which include (1) relation with therapists, (2) results of urinalyses, and (3) a comparison with patients at other halfway houses in the city. There were no overall statistics available on program performance. The program director did state that he believed that about 70 percent of the patients released from the program were doing well.

The contract with the Department of Corrections provides for payment of \$18.35 for a patient-day. On the basis of an average 24 patients, the cost would amount to \$160,746 annually, or about \$6,700 a patient.

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

October 15, 1971

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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

NARCOTICS TREATMENT ADMINISTRATION

TREATMENT CENTERS

COMMUNITY ADDICTION TREATMENT CENTER

The Community Addiction Treatment Center is a methadone maintenance stabilization clinic with a staff of about 22. Counseling and supportive services are designed to meet the needs of three primary groups of addicts: addicts who continue to use illegal drugs; addicts who have an alcohol problem; and addicts with behavioral problems. In addition to individual counseling, group therapy sessions are held to meet the needs of each group.

CRIMINAL JUSTICE SURVEILLANCE UNIT

This facility has a staff of 23 and provides counseling and urine surveillance for individuals who must demonstrate the ability to remain abstinent as a condition of parole, probation, or presentence investigation. Surveillance is also provided for those who must remain drug free to obtain or regain their driver's licenses.

DRUG ADDICTION MEDICAL SERVICE--CLINIC

This methadone maintenance stabilization clinic operates with a staff of about 21 who place emphasis on intensive counseling with the objective of improving the patients' life style. Capacity is planned for 500, and patients are being transferred to other NTA facilities to reach this level. Group encounter sessions are a part of the intensive counseling.

DRUG ADDICTION MEDICAL SERVICE--INPATIENT UNITS

This facility has an inpatient capacity of 70 consisting of two 35-bed units. One unit is used for methadone detoxification purposes. The other is a residential rehabilitation unit offering methadone maintenance and abstinence services.

EMERGE HOUSE

Emerge House is one of two NTA facilities serving the youth. Patients living voluntarily in the house may be enrolled in an abstinence or methadone detoxification program. Methadone is not dispensed at the house but is obtained at another NTA facility. Group and individual therapy along with the requirement that all residents work or attend school are intended to help the patient attain the goal of changing his life style. The program does not isolate the participants from the community but rather tries to help them adjust to the community and become part of it.

DETOXIFICATION-ABSTINENCE CLINIC

The emphasis in this clinic is toward assisting patients to become completely free of all drug use including methadone. Patients entering this clinic are those that are considered to have the desire and motivation to free themselves entirely from the use of drugs.

Detoxification schedules setting forth the duration of the detoxification period are worked out between the patients and the medical staff. Methadone is given during this period in decreasing amounts. The schedules vary depending on the patients' physical conditions, tolerance levels, and mental attitudes, but usually the periods are no longer than 3 months. Patients who are unable to complete the detoxification period may elect to transfer to another facility and another program such as methadone maintenance. The most important aspect of this program is considered to be counseling through which a change in life style is attempted.

FAR EAST ADDICTION TREATMENT SERVICE

The Far East Addiction Treatment Service is an exception to the specialized facility concept. This treatment center provides the full range of treatment modalities to both inpatients as well as outpatients for a specific service area in the Northeast section of the city. At the time of our fieldwork, a building was being renovated for use as an inpatient facility planned for a capacity of 48. Abstinence, methadone detoxification, and methadone maintenance services will all be available to residents of the center.

Outpatient services are also provided. All patients make at least four contacts with the program each week. Methadone maintenance patients meet with their counselors five times a week. Of particular interest is that the outpatient program has an outreach function which attempts to contact all persons who drop out of the program.

#### G STREET CLINIC

This is a methadone maintenance stabilization clinic with a staff of about 20. The overall objective of this treatment center is to help a patient fit back into society by making him more responsible to himself. Extensive counseling is continued even after patients have demonstrated the ability to remain free from illegal drug use. If a patient misses 2 consecutive days, the clinic staff has an outreach team which attempts to locate him and persuade him to return to treatment. The clinic is designed to eventually serve a patient population of 500.

#### MODEL CITIES ADDICTION TREATMENT PROGRAM

This is NTA's only methadone maintenance induction clinic. The facility operates with a staff of about 23 to serve new methadone maintenance patients referred from central intake. Treatment consists of intensive counseling while a patient is brought to a stabilization level of methadone dosage. Outreach is a part of this program, and an attempt is made to contact all patients who miss 3 consecutive days of treatment. A medical doctor is a full-time member of the staff and is available to meet health needs of the new patients.

Patients are usually transferred to an NTA methadone maintenance stabilization clinic in 4 to 6 weeks. The time of transfer is based on urinalysis results, employment status, and the opinion of the patient's counselor.

#### NARCOTIC ADDICT REHABILITATION CORPS

This halfway house, with a capacity of about 65 and a staff of about 20, treats male referrals from the criminal justice system on an inpatient basis. The center is operated by NTA as a part of the District of Columbia work release

program. About 95 percent of the patients come directly from penal institutions and the remaining 5 percent come from parole supervision or other halfway houses. All patients are required to remain in the program and all are within 6 months to a year of their release date from the criminal justice system. The program's goal is to prepare a man for his return to society.

Each resident of the house is assigned to a treatment family consisting of several other patients and two counselors. Also a treatment board at the house consists of the total staff and a representative from each treatment family. This board meets twice a week to discuss special patient problems and to administer privileges or punishment.

Patients are required to obtain employment outside the house and are required to make their whereabouts known at all times.

#### NARCOTIC ADDICT REHABILITATION CORPS--CLINIC

This center is a methadone maintenance stabilization clinic located in the basement of the Narcotic Addict Rehabilitation Corps halfway house. Counseling and urine surveillance are required of all patients. Voluntary group counseling sessions are also held. Job counseling and referral for training and education are available. Training, education, involvement in the program, and employment are considered to be important indications of progress. The center is staffed by about 16 people and has the capacity to serve around 350 patients.

#### YOUTH CENTER

This center is another exception to NTA's concept of specialization in that it operates to serve all treatment needs of young addicts under 21 years of age. The center has a staff of about 15 and a capacity to serve about 300. Group and individual counseling, urine surveillance, an outreach program for dropouts and limited recreation activities make up the program. Completion of a renovation program at the center should make more space and facilities

## APPENDIX II

available at the house. Notwithstanding the goals of detoxification and eventual abstinence, the importance of education, training, and employment is recognized as essential to making the patient a part of society.

### NEIGHBORHOOD TREATMENT CENTER

This center is operated by the Bureau of Rehabilitation of the National Capital Area<sup>1</sup> under contract with NTA. The primary modalities of treatment at this outpatient center are detoxification and abstinence. No methadone is dispensed on the premises. Patients in a methadone detoxification program obtain their medication at the Drug Addiction Medical Services clinic.

The staff of about 11 provides individual counseling, urine surveillance, and group therapy sessions. Job placement, training, assistance, and referrals for welfare and education are among the supportive services offered. Family-oriented cultural and recreational programs, as well as drug prevention and education activities, are part of the program. A Citizens Advisory Committee made up of local merchants, residents, and organizations makes this program a part of the community.

### SOUTHEAST NEIGHBORHOOD ACTION BOARD--ADULT PROGRAM

This predominantly methadone maintenance program is funded through a contract with NTA and operated by the Southeast Neighborhood Action Board. Services offered by the staff of twelve are generally limited, because of the number of patients, to urine surveillance and counseling. Because of a high patient case load, individual counseling is done on an as-needed basis as determined by a patient's progress and performance.

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<sup>1</sup>The Bureau of Rehabilitation of the National Capital Area is a private nonprofit community service agency which also operates a work release halfway house for narcotic offenders under contract with the D.C. Department of Corrections and also provides aftercare services for Narcotic Addict Rehabilitation Act patients. (See ch. 5.)

Although there was only a 15- to 20-patient waiting list at the time of our visit, we were told that about 650 patients had been in the program at one time or another but had dropped out. Program officials plan to start outreach work and expand to a larger facility with more staff if an extension of the NTA contract can be negotiated.

#### SOUTHEAST NEIGHBORHOOD ACTION BOARD--YOUTH PROGRAM

This youth program is operated by Southeast Neighborhood Action Board under contract to NTA. The project had just gotten under way at the time of our review. Eventually, the project is expected to serve 60 inpatients at a therapeutic halfway house and 240 outpatients from the juvenile population of the Anacostia area of Washington.

#### BONABOND STEP-ONE

This drug-free residential facility is operated by Bonabond, Inc., a community service organization under contract with NTA. The program started as a halfway house with several sources of patient referral. Currently all patients are court referrals of young male addicts between arrest and trial. Men come for at least 90 days and take part in a drug-free program of therapy and counseling which places emphasis on the psychological aspects of addiction. The goal of the program is to help a young man direct his thinking against drugs and to adapt to society. The program includes urine surveillance, group encounters, a social studies course, and tutoring.

INDICATORS OF THE SIZE  
OF THE DISTRICT'S ADDICTION PROBLEM

The task of determining with any degree of reliability the number of narcotic addicts in the District of Columbia or in any other area is made extremely difficult because there is no commonly accepted definition for the term "narcotic addict," no reliable or complete reporting system, and no means of identifying a person as a narcotic addict unless he is arrested or enrolls in a treatment program. The methods used by NTA to estimate the number of narcotic addicts in the city and certain other indicators which provide some insight into the size of the District's addiction problem are discussed below.

ESTIMATES OF NUMBER OF NARCOTIC ADDICTS

One estimate of the number of narcotic addicts in the District of Columbia was based on an estimating technique developed by the Deputy Chief Medical Examiner for New York City.

The Deputy Examiner for New York City reported that in 1968 about 1,000 narcotic-related deaths had occurred in New York City. At that time, the city had approximately 50,000 names on its narcotic register. The register is used to compile data on numbers of addicts from a variety of sources such as treatment agencies and law enforcement agencies.

The Deputy Examiner also found that about one half of those addicts who died from narcotic-related causes were listed on the city's narcotic register. Relating these two known factors, the Deputy Examiner concluded that one out of every 100 people on the register died of narcotic-related causes in 1968. This factor multiplied by the number of known narcotic-related deaths produced a result of 100,000, which was assumed to be the approximate total number of narcotic addicts in the city. The Deputy Examiner informed us that the 100,000 estimate seemed to be in line with other estimates of narcotic addicts for the city.

The Deputy Examiner informed us that, although about half of the 1,000 narcotic-related deaths were directly attributable to an overdose of heroin, he did not draw any relationship between the number who died as a result of a heroin overdose and the number that was on the city's narcotic register.

To estimate the number of narcotic addicts in the District, NTA used the technique developed in New York City but assumed that there was a direct relationship between the number of narcotic overdose deaths and the total narcotic addict population (an assumption which NTA believes can be corroborated). Since about half of the narcotic-related deaths in New York City were caused by overdoses of heroin, NTA assumed that an estimate of the total number of narcotic addicts not in treatment in the District of Columbia could be made by simply multiplying the number of narcotic overdose deaths by 200.

To determine the number of narcotic overdose deaths in the District of Columbia, unexplained deaths in fiscal year 1971 were surveyed by the District of Columbia Coroner's Office for the possibility of narcotic overdose. This survey attributed 75 deaths to narcotic overdose. NTA then multiplied this number by 200 and added the result to 2,700, which was the average number of addicts in treatment with NTA during fiscal year 1971, to produce an estimate of 17,700 narcotic addicts in the District.

Another estimating technique used by NTA assumes that the number of addicts who volunteer for treatment but drop out can be used to estimate the total number of addicts in the District of Columbia not currently receiving treatment. For example, for the period September 27 through October 13, 1971, NTA found that, of a total of 186 patients who volunteered for treatment, 43, or about 23 percent had been previously registered with NTA but had dropped out of treatment. This percentage was divided into the total number of addicts who had registered for treatment with NTA but subsequently dropped out--3,679--to arrive at an estimate of the total number of addicts not currently receiving treatment--15,900. An estimate of about 20,000 addicts for the District was made by adding the 15,900 to the number of addicts receiving treatment.

### APPENDIX III

This method of computing the District of Columbia narcotic addict population was considered to have some merit after NTA found that a comparable 23 percent of all narcotic addicts appearing before the Superior Court in September 1971 had registered at some time with NTA but had dropped out of treatment.

Still another estimating technique used by NTA attempted to draw a relationship between the number of narcotic addicts known to NTA and those known to the Bureau of Narcotics and Dangerous Drugs. In May 1971, NTA found that about one fourth of the 1,225 addicts known to the Bureau were also known to NTA. At this time there were about 5,000 addicts known to NTA. Assuming that addicts were not being counted twice, NTA simply multiplied four times the number of addicts known to it to produce another estimate of about 20,000 addicts in the District of Columbia.

As previously stated, the validity of the estimated number of narcotic addicts for the District can be questioned because, as admitted by NTA officials, the estimating techniques rely on a number of unproven assumptions and relationships.

#### NARCOTIC ARRESTS REPORTED BY METROPOLITAN POLICE DEPARTMENT

The following information, provided by the Narcotic Branch of the Morals Division of the District's Metropolitan Police Department, shows the number of persons arrested and charges placed for violations of laws regulating the illicit traffic and use of narcotics and dangerous drugs during calendar year 1971.

	<u>Persons arrested</u>	<u>Additional charges</u>	<u>Total charges</u>
Harrison Narcotic Act (sale)	96	4	100
Harrison Narcotic Act (possession)	558	51	609
Marihuana Tax Act (sale)	15	-	15
Marihuana Tax Act (possession)	4	7	11
Controlled Substance Act (sale)	318	-	318
Controlled Substance Act (possession)	600	121	721
Uniform Narcotic Act (heroin)	770	146	916
Uniform Narcotic Act (marihuana)	595	66	661
Drug Abuse Control Act	33	20	53
Dangerous Drug Act	217	192	409
Possession of implements of crime	700	835	1,535
Present in illegal establishment	108	223	331
Uttering forged narcotic prescription	15	-	15
Maintaining common nuisance	-	81	81
Total	<u>4,029</u>	<u>1,746</u>	<u>5,775</u>

The total changes placed exceed the number of persons arrested because more than one change may have been placed against an individual at the time of arrest. These figures do not reflect indictments by the grand jury. According to the Narcotic Branch, figures for grand jury indictments could increase the totals in felony cases by as much as 10 percent.

NUMBER OF ADDICTS APPEARING BEFORE  
DISTRICT OF COLUMBIA SUPERIOR COURT

In early 1970 the Chief Judge of the Superior Court started a urine testing program to determine whether the following persons were narcotic addicts: (1) arrested persons, (2) persons undergoing presentence investigation, and (3) persons on probation. A staff of paraprofessional counselors was assigned to the central cellblock in the court to interview all persons, other than those arrested for petty offenses, to come before the court.

The procedure followed was to observe, interview, and make a recommendation to the arraigning judge, through the D.C. Bail Agency, on whether a person should be tested for narcotic use. On the basis of this recommendation and on the basis of any representations made by the prosecution or defense counsel, a determination was made in open court, at the time bail was set, whether urine testing should be required as a condition of release. During 1971 about half of the 1,500 persons brought before the court were recommended for urine testing and about half of those tested showed positive results for the use of heroin.

NARCOTIC OFFENDERS AT THE DISTRICT JAIL

To obtain an indication as to use of heroin in the District, NTA made a study during August and September 1969 of 225 men admitted to the District's jail. Interviews were held with the prisoners and urine specimens were collected from 129. This study showed that 45 percent of the 225 offenders were addicted to heroin. The report on this study also stated that the sample was representative of the jail population and concluded that 45 percent of persons admitted to the jail could be described as addicted to heroin. No projection of the total number of addicts was made.

BUREAU OF NARCOTICS AND DANGEROUS  
DRUGS LIST OF KNOWN ADDICTS AND  
ESTIMATE OF TOTAL ADDICTS

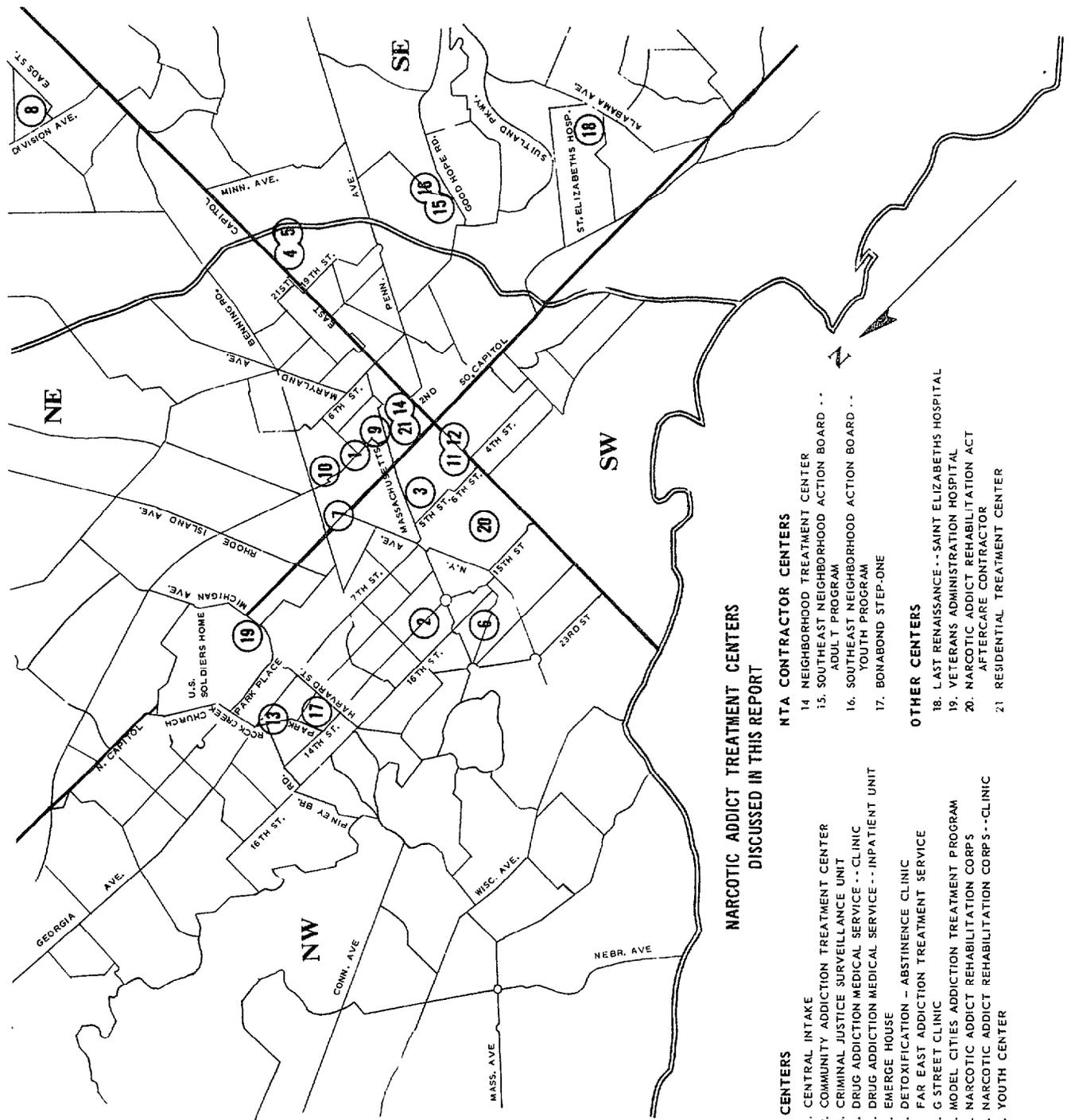
Another indicator of the size of the addiction problem in the District is the number of addicts reported by the Bureau of Narcotics and Dangerous Drugs of the Department of Justice. The Bureau has reported the following numbers of known addicts for the District.

1966	1,164
1967	1,106
1968	1,162
1969	1,636
1970	1,743
1971	2,524

The Bureau estimated the total number of addicts in the District as of December 31, 1971, at 14,634.

To determine the number of persons using narcotics, the Bureau asks local enforcement agencies to furnish information on the arrested person when there are clear indications that the person is addicted to the use of narcotic drugs. The reporting process is strictly voluntary and agencies use their own judgment as to whom they should report as an addict. Because of these two factors, there is reason to believe that the total number of addicts reported to and by the Bureau is understated. For example, only 27 percent of the people identified as narcotic addicts by NTA's study of residents at the District jail had been reported to the Bureau.

A further reporting problem is that, although the Bureau accepts information from all sources, health and social agencies apparently are reluctant to provide names to the Bureau either because the confidentiality of the doctor-patient relationship may be violated or because they fear that the names may be used for law enforcement purposes.



**NARCOTIC ADDICT TREATMENT CENTERS  
DISCUSSED IN THIS REPORT**

**NTA CENTERS**

- 1. CENTRAL INTAKE
- 2. COMMUNITY ADDICTION TREATMENT CENTER
- 3. CRIMINAL JUSTICE SURVEILLANCE UNIT
- 4. DRUG ADDICTION MEDICAL SERVICE -- CLINIC
- 5. DRUG ADDICTION MEDICAL SERVICE -- INPATIENT UNIT
- 6. EMERGE HOUSE
- 7. DETOXIFICATION -- ABSTINENCE CLINIC
- 8. FAR EAST ADDICTION TREATMENT SERVICE
- 9. G STREET CLINIC
- 10. MODEL CITIES ADDICTION TREATMENT PROGRAM
- 11. NARCOTIC ADDICT REHABILITATION CORPS
- 12. NARCOTIC ADDICT REHABILITATION CORPS -- CLINIC
- 13. YOUTH CENTER

**NTA CONTRACTOR CENTERS**

- 14. NEIGHBORHOOD TREATMENT CENTER
- 15. SOUTHEAST NEIGHBORHOOD ACTION BOARD -- ADULT PROGRAM
- 16. SOUTHEAST NEIGHBORHOOD ACTION BOARD -- YOUTH PROGRAM
- 17. BONABOND STEP-ONE

**OTHER CENTERS**

- 18. LAST RENAISSANCE -- SAINT ELIZABETHS HOSPITAL
- 19. VETERANS ADMINISTRATION HOSPITAL
- 20. NARCOTIC ADDICT REHABILITATION ACT AFTERCARE CONTRACTOR
- 21. RESIDENTIAL TREATMENT CENTER

BEST DOCUMENT AVAILABLE